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## RESTRANTS

**LOCATOR NUMBER**

- **CHAPTER:** M03
- **TAB:** 01
- **POLICY #:** 768

### Disciplines / locations to which this multidisciplinary policy applies:

- □ Health Information Management
- □ Pharmacy
- □ Acute Care Hospital Nursing
- □ Housekeeping
- □ Plant Operations
- □ Ambulatory Services
- □ Information Systems
- □ Radiology
- □ Home Health
- □ Laboratory
- □ Rehabilitation Services
- □ HPCC
- □ Legal Services
- □ Respiratory
- □ Physician Offices
- □ Nutrition
- □ Security
- □ Rehab Hospital
- □ Other

Date Originated: 9/07  Reviewed/No Revision:  3/08, 2/09, 9/09, 1/11, 5/11, 10/12, 2/13, 5/13, 6/13, 1/14, 3/14, 4/14, 8/14, 6/15  Next Review Date: 6/17

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**Reviewed by:**

- P&P Committee 6/9/15
- Clinical Practice Council: Nicole Caldwell, RN  Date: 6/10/15

**Clinical Education Council**

- Education Completed: □  Date: 6/11/15

- Education Plan Required: □ Yes □ No: Lisa Dunmyer, MSN, RN-BC  Date: 6/11/15

**Approved by:**

- Policy Administrator: Donna Giannuzzi, RN, MBA, NEA-BC, CPCO  Date: 6/2015

**As Needed:**

- Medical Director:  Date: 

- Board of Directors:  Date: 

## PURPOSE:

To minimize the use of restraints to situations where all alternatives / least restrictive measures have been determined to be inadequate, for the purpose of promoting a safer environment for the patient.
To ensure that, in situations necessitating the use of restraints, that adequately trained staff members apply them appropriately and that the use of restraint is based upon on-going physical and behavioral assessment by nurses and physicians.

To ensure that the decision to use restraint is driven by comprehensive individual assessment that concludes, that for this patient, at this time, the use of less intrusive measures poses a greater risk than the risk of using a restraint.

To prevent emergencies which have the potential to lead to the use of restraint.

To ensure restraint use is discontinued once the patient’s condition no longer necessitates the use of restraints.

To ensure that application of restraints is done by staff with completed competencies to do so.

To ensure that the assessment of need/ongoing need for restraint is completed by an RN as per policy guidelines.

**SCOPE:**

Applies to healthcare professionals in the hospital who are involved in applying restraints.

**DEFINITION OF TERMS:**

Licensed Independent Practitioner (LIP): a M.D. or D.O. recognized by the State and the facility as having the ability under his/her license to independently order medications or restraints.

LIP Designee: MDs and DOs may delegate the ordering of restraints to either a PAs or ARNPs which is allowed by State and Federal Regulations.

Primary / Attending Physician: the physician responsible for the management and care of the patient.

The following definitions explain the intent of the device and whether or not restraint standards apply.

**Restraint Standard Applies:**

Physical Restraint: 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.

Chemical Restraint: drug 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.

Seclusion: involuntary confinement of a person alone in a room or area where the person is physically prevented from leaving.

Non Violent, Non Self-Destructive (Medical Surgical / Management) Restraint – A restraint used to promote medical surgical healing.
Violent, Self-Destructive (Behavioral Health) Emergencies: an *unanticipated* outburst of severely violent, aggressive destructive behavior that poses an imminent danger to the patient and others.

**Restraint Standard Does Not Apply:**

Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and related post-procedure care process (example: surgical positioning, IV arm boards, radiotherapy procedures, orthopedically prescribed devices, protection of surgical and treatment sites in pediatric patients)

Voluntary Mechanical Support: used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be impossible without the use of such as mechanical support not generally considered a restraint.

Immediate recovery from anesthesia that occurs when the patient is in the ICU or PACU is considered part of the surgical procedure.

NOTE: Once the patient is awake and there is a need to utilize restraint for a non-violent, non self-destructive indication (i.e., prevent disruption of lines / tubes, etc.), the restraint policy and required standards apply, no matter where the patient is located.

Protective equipment such as helmets or secure sleeve splints when no other restraint type is used.

Restrictive Devices Applied by Law Enforcement (Forensic) Officials: handcuffs and other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons and are not involved in the provision of health care.

A Security Guard / Patient Care Attendant inside or outside a patient’s room does not constitute seclusion – this is considered an *alternative*.

Time Out: a brief, less than thirty minutes, voluntary separation from program, activity, or other patients, initiated by the patient or at the request of the staff to help the patient regain self-control.

Age or developmentally appropriate protective safety interventions (such as stroller, safety belts, swing safety belts, high chair lap belts, raised crib rails and crib covers) that a safety-conscious provider outside a health care setting would utilize to protect an infant, toddler, or preschool aged child would not be considered a restraint.

Instances when four (4) side rails up are not considered a restraint:

A. Raising four (4) side rails if the patient is not physically able to get out of bed regardless of whether the side rails are raised or not (i.e. non mobile patients such as quadriplegic, comatose, unresponsive etc.)

B. Raising four (4) side rails for patients on a bed that constantly moves to improve circulation or prevents skin breakdown, raised side rails are a safety intervention to prevent the patient from falling out of bed.

C. Four (4) side rails raised when patient placed on seizure precaution. Padded side rails are used to protect the patient.
PHILOSOPHY:

It is the philosophy of Lee Memorial Health System to work towards providing a restraint free environment, to reduce the overall use of restraints through the utilization of alternative / least restrictive measures, and to not employ the use of seclusion as a treatment method.

The hospital leadership seeks to identify opportunities and reduce risks associated with restraint use through the introduction of preventative strategies, innovative alternatives, and process improvement. The result is an organizational approach to restraint that protects the patient’s health and safety while preserving his / her dignity, rights, and well being. Leadership demonstrates its commitment to the aforementioned by providing and/or promoting:

A. Ongoing staff orientation and training.
B. Patient and family education, as appropriate.
C. The development and promotion of preventive strategies.
D. The use of safe and effective alternatives/least restrictive measures, including adequate human resources.
E. The integration of restraints into the Performance Improvement (PI) activities of the organization, for the purpose of reducing restraint use.

POLICY:

The patient has the right to be free from any form of restraints that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff. By respecting these tenets of human dignity, and self-determination, restraints shall be employed only when alternatives/least restrictive measures are not successful in assuring safe medical care of the patient.

A. Prevent, reduce and eliminate the use of restraints by:
   1. Preventing emergencies situations that have the potential to lead to the use of restraints,
   2. Limiting use of restraints only to emergencies where there is a risk of the patient Harming himself/herself or others, using the least restrictive method possible,
   3. Encouraging oversight of restraint implementation by reporting and auditing by unit leadership.
B. Protect the patient and preserve the patient's rights, dignity and well being during restraint use by:
   1. Respecting the patient as an individual;
   2. Maintaining a clean and safe environment;
   3. Utilizing the least restrictive measures appropriate for the clinical situation.
a) If the least restrictive measure includes the need for a dual restraint, a separate order is required for each type of restraint used with clinical rationale for each documented.

4. Encouraging the patient to continue to participate in own care;

5. Maintaining the patient's modesty;

6. Preventing visibility to others;

7. Maintaining comfortable body temperature.

C. Provide for safe application and removal of the restraint by qualified staff.

D. Monitor and meet the patient's needs while in restraints.

D. Re-assess and encourage release of restraints as soon as possible.

E. Provide Education / Training

1. Medical Staff members receive training on the restraint policy and their role in restraint safety on initial appointment and every two years at reappointment.

2. Patient Care Services staff receives training on the restraint policy, type of restraint, and the safe application and removal of restraint modalities in initial orientation and at least yearly thereafter. (Addendum D)

3. Administrative Supervisors who are trained to complete the face-to-face evaluation receive training during their initial orientation and at least yearly thereafter. When functioning in this role, the following aspects are evaluated and documented:

   a. Evaluation of the patient’s immediate situation,

   b. The patient’s reaction to the intervention,

   c. The patient’s medical and behavioral condition,

   d. The need to continue or terminate the restraint or seclusion.

4. Non-nursing staff (Respiratory Care, Radiology and Rehabilitation staff (PT, OT) are to be trained to the extent they are involved in restraints in initial orientation and at least yearly thereafter.

F. Documentation

Prior to initiating restraints, a clinical note should be entered describing situation leading up to need for restraint, including the actual behaviors observed (matching description on order set), any skin conditions or bruising assessed prior to restraint application, and all changes in patient behavior.
**PROCEDURE:**

Clinical justification for use of restraints:

RN: Notify nursing clinical leadership of all patients that require restraints.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>PATIENT BEHAVIORS</th>
<th>NON VIOLENT, NON SELF-DESTRUCTIVE (MEDICAL-SURGICAL)</th>
<th>VIOLENT OR SELF-DESTRUCTIVE (BEHAVIORAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for Restraints</td>
<td>A restraint used to promote medical / surgical healing</td>
<td>Any unanticipated outburst of severely violent, aggressive or self-destructive behavior that poses an imminent danger to the patient or others. Limited to emergency situations.</td>
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<tr>
<td>Rationale for Use</td>
<td>Cognitive incapacity / dementia / confused</td>
<td>Immediate and serious danger to patient safety or others.</td>
<td>Severe aggressiveness, violent and/or self-destructive behavior.</td>
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<td>Unable to follow directions to avoid injury</td>
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<td>Suicidal/homicidal.</td>
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<td>Line/Tube/Treatment Disruption</td>
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<td>Medication Effects</td>
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<td>Initiation</td>
<td>RN:</td>
<td>RN:</td>
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<td></td>
<td>1. Attempt the use of alternatives/least restrictive measures prior to application of restraint (Addendum B).</td>
<td>1. Attempt the use of alternatives/least restrictive measures prior to application of restraint (Addendum B).</td>
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<td></td>
<td>2. RN assess patient’s needs for restraint and type of restraint. (Addendum A)</td>
<td>2. RN assess patient’s needs for restraint and type of restraint. (Addendum A).</td>
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<td>3. Document med / surg rationale.</td>
<td>3. RN may initiate use of restraint in emergent situations when an LIP or designee is not immediately available (if appropriate, call security for assistance).</td>
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<td></td>
<td>4. RN may initiate use of restraint in emergent situations when an LIP or designee is not immediately available.</td>
<td>4. Document violent or self-destructive behavior.</td>
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<td></td>
<td>5. Notify LIP or designee and obtain telephone or written order within 12 hours of restraint use.</td>
<td>5. Notify LIP or designee and obtain the order as soon as possible but no longer than 1 hour after initiation.</td>
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<td>6. Revise Plan of Care to include Physical Restraint Management.</td>
<td>6. Revise Plan of Care to include Physical Restraint Management.</td>
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<tr>
<td>PATIENT BEHAVIORS</td>
<td>NON VIOLENT, NON SELF-DESTRUCTIVE (MEDICAL-SURGICAL)</td>
<td>VIOLENT OR SELF-DESTRUCTIVE (BEHAVIORAL)</td>
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<tr>
<td>Order from LIP or Designee</td>
<td>1. Use electronic health record Restraint Order set - Select Non Violent, Non Self-Destructive Behaviors (Medical / Surgical) restraint.</td>
<td>1. Use electronic health record Restraint Order set - Select Violent or Self-Destructive Behaviors (Behavioral) restraint.</td>
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<td>2. NO PRN ORDER</td>
<td>2. NO PRN ORDER</td>
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<td>3. Contact LIP or designee for order; must be obtained within 12 hours of initiating restraint (if the initiation of restraint is based on significant change in patient’s condition the RN will immediately notify the LIP or designee).</td>
<td>3. Initial order by LIP or designee obtained within 1 hour.</td>
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<td>4. Patient assessed by LIP or designee and order authenticated within 24 hours of restraint application (see re-evaluation portion of table).</td>
<td>4. Maximum length of order:</td>
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<td>a. 1 hour (age 0-8)</td>
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<td>b. 2 hours (age 9-17)</td>
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<td>c. 4 hours (age 18 and older)</td>
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<td>5. Complete LIP or designee orders include:</td>
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<td></td>
<td>a. Type of restraint (choose only one per order set)</td>
<td>5. Complete LIP or designee orders include:</td>
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<td></td>
<td>b. Criteria/rational for restraint (choose only one)</td>
<td>a. Type of restraint (choose only one per order set)</td>
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<td></td>
<td>c. Duration of restraint</td>
<td>b. Criteria / rational for restraint (choose only one)</td>
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<td></td>
<td>d. Electronic signature, date &amp; time</td>
<td>c. Duration of restraint</td>
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<td>6. If the patient quickly recovers and is released before the LIP or designee arrives to perform the assessment, LIP or designee must still see the patient, complete an assessment and sign the order.</td>
<td>6. If the patient quickly recovers and is released before the LIP or designee arrives to perform the assessment, LIP or designee must still see the patient and complete the face-face assessment.</td>
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<td>8. The Attending physician must be consulted as soon as possible if the attending physician did not order the restraint.</td>
<td>7. The Attending physician must be consulted as soon as possible if the attending physician did not order the restraint.</td>
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<tr>
<td>Educate Patient / Family</td>
<td>Use Information on Restraints (Addendum C)</td>
<td>Use Information on Restraints (Addendum C)</td>
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<tr>
<td>Initial Evaluation by LIP or Designee</td>
<td>LIP or designee evaluates patient within 24 hours of initiation of the order (in person).</td>
<td>In person face-face evaluation by LIP or designee or RN with current competency within 1 hour of restraint application.</td>
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<td>The RN who is trained to conduct the face to face evaluation must consult the attending physician or other LIP or designee responsible to patient care as soon as possible after the completion of the evaluation.</td>
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<tr>
<td>PATIENT BEHAVIORS</td>
<td>NON VIOLENT, NON SELF-DESTRUCTIVE (MEDICAL-SURGICAL)</td>
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<tr>
<td>LIP or Designee Re-evaluation</td>
<td>LIP or designee reassessment and a new restraint order are to be obtained before the end of the following day.</td>
<td>LIP or designee must re-evaluate in person (face-face) at least:</td>
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<td>1. every 1 hour (age 0-8)</td>
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<td>2. every 2 hours (age 9-17)</td>
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<td>3. every 4 hours (age 18 and older)</td>
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<tr>
<td>Assessment by RN</td>
<td>Assess every 2 hours –</td>
<td>Assess every 15 minutes –</td>
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<td></td>
<td>2. Comfort and safety</td>
<td>2. Circulation check</td>
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<td></td>
<td>3. Skin integrity</td>
<td>3. Comfort and safety</td>
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<td></td>
<td>4. Nutritional needs / hydration</td>
<td>4. Skin integrity</td>
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<td>5. Range of motion</td>
<td>5. Nutritional needs / hydration</td>
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<td>6. Elimination needs/Hygiene</td>
<td>6. Range of motion</td>
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<td>7. Rights and Dignity</td>
<td>7. Elimination needs / hygiene</td>
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<td>8. Readiness for release of restraint</td>
<td>8. Rights and dignity</td>
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<td>9. Readiness for release of restraint</td>
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<tr>
<td>Documentation</td>
<td>1. Narrative Notes when applicable.</td>
<td>1. One Hour Face-to-Face Evaluation for Behavioral Restraints Progress Note (FM #5792).</td>
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<td>3. Patient Plan of Care/treatment plan.</td>
<td>3. Patient Plan of Care/Treatment Plan.</td>
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<td>4. Narrative Notes when applicable.</td>
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<tr>
<td>Criteria for Release and Discontinuation of Restraint</td>
<td>1. Restraints must be removed when an alternative to restraints is available and effective and or the patient no longer meets criteria for restraints.</td>
<td>1. Restraints must be removed when patient is no longer violent or self-destructive.</td>
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<td>2. There are no trial releases of restraints. If the restraint is discontinued prior to the expiration of the order, the current order and documentation is discontinued. If the patient again requires restraints, a new order must be obtained within twelve hours of application and an assessment completed by LIP or designee within 24 hours of reapplication.</td>
<td>If patient subsequently meets criteria for non-violent, non-self destructive restraints, a new order for non-violent, non-self destructive restraints must be obtained as outlined in this policy.</td>
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<td>2. There are no trial releases of restraints. If the restraint is discontinued prior to the expiration of the order, the current order and documentation is discontinued. If the patient’s actions again require restraints, a new order must be obtained within one hour of application and a face-to-face assessment completed by the LIP or designee.</td>
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</table>

I. **KEY PROCEDURAL POINTS:**

1. When clinically indicated, a restraint is implemented by an RN who has established competencies in restraint technique. A restraint is to be limited to emergencies. Unless there is an immediate and overriding concern for safety, the restraint is utilized only after all alternative and less restrictive treatment interventions have been tried without success. Actions and alternatives for use of restraints should be documented.
2. All patients who are in restraints should be monitored and reassessed for the need to continue restraints by a qualified RN. All alternatives to physical restraint must be evaluated to include any treatment, medication, or physiologic change that may be precipitating the requirement for restraint.
   a. If the care of the patient is assigned to an LPN, an RN must be co-assigned and is responsible for the monitoring / assessment and documentation of as per policy guidelines.

3. Implementing time-limited orders does not indicate that the intervention must be applied for the entire length of time for which the order is written.

4. Prior to the order for restraints expiring the RN will conduct an in-person assessment. If the patient is not ready for release from restraints the RN will reevaluate the efficacy of the patient's plan of care and revise accordingly.

5. The LIP or designee will:
   a. Review with the staff the physical and psychological status of the patient.
   b. Determine whether restraints should be continued.
   c. Provide staff with guidance in identifying ways to help the individual regain control in order to be released from restraints.

6. The physician’s order must specify:
   a. The restraint type.
   b. The justification for the restraint.
   c. Date and time ordered.
   d. Duration.
   e. Behavior-based criteria for release.

7. Discontinuing Restraint Prior to Expiration of the Order:
   a. Restraints may be discontinued only by an RN who has established competencies regarding restraints as soon as the patient meets the criteria for discontinuation, or a less restrictive measure may be effective, or the patient is no longer at risk of injuring himself.
   b. To discontinue the restraint order, the RN should go into orders management, then active orders. Choose expiring orders and when restraint order is displayed, click on discontinue. The reason for discontinuing the order needs to be completed.
   c. The RN will assess and document the continued need of restraint. The assessment for discontinuation of restraints will be based on:
1) Improved mental status.

2) Patient’s agreement and compliance with instructions for safety.

3) Improved ability to transfer or ambulate without risk or injury.

4) Alternative/ least restrictive measures are effective.

5) Patient’s lines are discontinued or no longer required for medical treatment.

8. If the restraint is discontinued prior to the expiration of the order, and the patient’s actions again require restraints, a new order must be obtained.

If the patient is a patient at the Rehabilitation Hospital and the restraints are being released to allow for family / caregiver training, or when the family or caregiver is working directly with the patient, or staff is performing therapy, then a new order will not be necessary when the restraint is re-applied.

J. Monitoring, assessing, and care of the patient in restraints:

1. When a restraint is used there is an increased need for patient monitoring to assure patient safety, that the least restrictive methods are used, and that the restraint is discontinued as soon as possible. The patient’s initial assessment drives an individualized plan of care, and the frequency of monitoring will be as follows:

   a. Patient should be monitored by an assigned staff member and assessed by a registered nurse at least every 15 minutes for Violent, Self-Destructive and at least every 2 hours for Non-Violent, Non Self-Destructive restraints or more frequently as per patient’s needs. Monitoring to include:

      1) Signs of injury associated with the restraints.

      2) Vital sign monitoring is to be done every 15 minutes for patients in Violent, Self-Destructive restraint.

      3) Vital sign monitoring is to be done as per unit routine for patients in Non-Violent, Non Self-Destructive restraint.

      4) Intake and output.

      5) Nutrition / hydration.

      6) Circulation and range of motion in the extremities.

      7) Hygiene and elimination.

      8) Physical and psychological status and comfort, i.e. skin integrity, comfortable body temperature, the patient’s dignity, mental status and emotional well-being.

      9) Readiness for release from restraint.
b. Other trained care team members may take an active role in collecting data and address attention to needs, i.e. toileting, fluid and nutritional needs as appropriate to their discipline.

K. Patient / family education:

1. The hospital will provide the patient or family member with a formal notice of their rights at the time of admission, and inform the patient or their representative of the patient’s rights. Restraint procedures should be performed in a manner that does not violate the patient’s rights. The role of the family should be in conjunction with the patient’s right to confidentiality.

2. Where appropriate, the patient and/or family should assist in the identification of techniques that may help the patient control his/her actions. The RN will provide the patient/family with an explanation of restraint utilization; the reason for this use and the RN will also offer an explanation as the conditions for release.

3. Provide and document patient/family education. (Addendum C)

L. Documentation:

The clinical record should document a clear progression in how techniques were implemented starting with the less restrictive intervention attempted or considered prior to the introduction of more restrictive measure.

Timeliness of restraint assessment is to be done:

1. Every two hours for non-violent restraints within 30 minutes prior to or 30 minutes after the time.

2. Every 15 minutes for violent restraints within 5 minutes before or after the time.

Only hospital personnel who have received training and demonstrated competency will document information related to the use of restraints within the scope of their license.

Each time a restraint is ordered or is renewed, the following needs to be documented in the electronic health record:

1. Circumstances that led to restraint use.

2. Consideration or failure of non-physical interventions.

3. Notification of the patient's family/significant other, when appropriate.

4. Orders for use including reason, type, duration.

5. Each read back telephone order received from a physician.


7. Education of patient and/or family / legal guardian regarding need for restraint.

8. Monitoring and patient assessments are documented as per policy guidelines.
9. Update plan of care as necessary.

Any injuries that are sustained while in restraint and treatment received for these injuries; or death while in restraint are documented in the clinical record at time of occurrence and reported through the occurrence reporting system.

If restraint is used for longer than initial order, the rationale for supporting the decision to continue the intervention should be documented.

M. Modification to patient’s plan of care / treatment plan:

The plan of care should clearly reflect a loop of assessment, intervention, evaluation and re-intervention. Restraint use must be in accordance with a written modification to the patient’s plan of care.

N. Reporting Requirements:

In accordance with regulatory guidelines –

Any serious patient injury, potentially life-threatening or disabling outcome, or death that occurs while a patient is in restraints will be reported promptly to Risk Management and to the organization’s leadership. Staff members who have the most immediate knowledge of this event should notify Risk Management immediately by phone and then complete an Incident Report prior to the end of the shift that it occurred on. As required by Federal regulation CFR 482. 13 (f)(7) reports will be made to appropriate federal and state Agencies by Risk Management. If indicated, a root cause analysis will be completed. Risk Management will be responsible for notifying Quality and Standards of this event.

Injuries sustained by the patient or staff member are to be reported through the occurrence reporting system and will be subject to an Intense Analysis.

LMHS legal services will review a daily computer generated report of all patients who have died with restraint orders within the last seven days in order to determine if the death should be reported to CMS or can be recorded in the internal log.

1. If the patient dies while in soft, non-rigid wrist restraints or dies within 24 hours after the patient was removed from the soft restraint and was not in seclusion the required patient information will be entered in to the internal restraint log. The log includes patient name, DOB, DOD, Attending, Medical record # and primary diagnosis. A legal staff member will then complete a progress note indicating that the patient was entered into the log and will send the progress note (FM # 2939-A) to Health Information Management (HIM) for placement in the medical record.

2. If the patient was in any other type of restraint (except for soft wrist) when the death occurred or dies within 24 hours after the removal of the restraint the death will be reported to CMS no later than the close of business on the next business day utilizing CMS form #10455 (Report of a hospital death associated with restraint or seclusion). A progress note (FM # 2939) will then be completed indicating that a report was made to CMS and will be sent to HIM for placement in the medical record.
3. Risk Management will be notified by phone and an incident report completed of any death that occurs within one week after restraint where it is reasonable to assume that the patient may have died as a result of the use of the restraint. After a Risk Management review of the report the death will be reported to CMS utilizing form #10455 no later than the close of business on the next business day if it meets statutory requirements for reporting. A progress note (FM # 2939) will also be completed and sent to HIM for placement in the medical record.

O. Performance Improvement:

Restraint usage is reviewed by all appropriate disciplines. Clinical leadership should be notified of any patient in restraints greater than 12 hours.

Prolonged restraint use is analyzed and presented to management for review.

Prolonged restraint use is defined as use of restraint:

1. For greater than 5 days for a medical/surgical restraint, excluding mechanically ventilated patients, and

2. More than 24 hours for a behavioral health restraint.

Measurement and assessment of restraint usage will be monitored with a goal to reduce and eliminate all unnecessary use and limiting the use to emergency situations. Aggregate data on restraint and episodes will be collected from the restraint orders, flow sheet and PI restraint log.

The PI restraint log includes identification of:

- Shift
- Date, time of order
- Staff who initiated the process
- Length of each episode
- Date and time each episode was initiated
- Day of the week each episode was initiated
- Type of restraint or seclusion used (including physical restraint or drug used as restraint)
- Compliance with requirements defined in the standards
- Whether injuries were sustained by the individual or staff
- Age of individual
- Gender of individual

The review of aggregate data gives insight into those least restrictive interventions that were or were not effective in diminishing the use of restraints, and also allows for the analysis of multiple episodes of the use of restraints. The goal of the performance improvement process is to identify and understand the root cause for the use of restraints. Data will be reviewed and analyzed by the appropriate interdisciplinary team. Trends need to be evaluated to identify opportunities to create mechanisms or develop alternatives to restraint utilization.
P. Physician Education:

Physician will have a working knowledge of hospital policy regarding the use of restraints.

ASSOCIATED FORMS:

- **FM # 5792** – One Hour Face-To-Face Evaluation for Violent or Self-Destructive Behaviors
  - Restraints Progress Note

- **FM # 2939** – Progress Notes

- **FM # 2939-A** – Progress Notes – Restraint Log

RELATED POLICIES:

- S01 01 711 Patient Rights and Responsibilities
- M02 04 107 Care of Patient at Risk for Self Harm (Suicide Risk, Baker Act)
- M03 01 714 Patient Transport Intra-Hospital
- M03 03 922 Verbal Orders
- M03 07 706 Patient Leaving Against Medical Advice (A.M.A.)
- M05 00 054 Baker Act Transfer
- S06 00 133 Corrective Action of Nonconformities
- M14 01 558 Medical Staff Medical Record Documentation Performance Improvement Process
- M15 00 118 Charting, Documentation and Nursing Process
- M22 00 054 Baker Act - Involuntary Examination
- S24 01 776 Reporting Deaths Associated with Restraints or Seclusion
- S25 00 403 Management of Serious Safety and Precursor Events

REFERENCES:

- Federal Statue 42 CFR part 482
- NIAHO Accreditation Requirements PR.6 Restraint or Seclusion; Rev 10.1; October 2012
TYPES OF RESTRAINT / SAFE APPLICATION:

To be used only when less restrictive measures have been found to be ineffective to protect the patient. Listed in order of less restrictive to more restrictive:

1. **Four Side Rails**
   Evaluate the space between rails and between rails and mattress to prevent injury or death.

2. **Posey Bed (Pediatrics)**

3. **Specialty Chair (Lap Hugger)**

4. **Roll or Soft Belt**
   Lay belt horizontally across bed with soft flannel side up and the back pad in the middle. Secure short strap to the movable part of bed frame with quick-release ties at waist level out of the patient’s reach. Bring long strap over and around the patient’s waist and back behind the patient through the slot in the back pad. Secure long strap to the movable part of the bed frame out of the patient’s reach with quick-release knots. In order to ensure that the straps do not interfere with breathing, you should be able to slide your open flat hand between device and patient.

5. **Mittens 1 → 2 Mitts**
   Slide the restraint mitt over the patient’s hands with the ties on the posterior side of the hand. Secure the strap around the wrist to hold the unit in position on hand. After the hand has been secured in the mitt, secure the strap ends to the bed frame, wheelchair frame, or secure part of the appliance on which the patient has been placed. Secure the strap out of the patient’s reach. If mittens are not attached to restrict arm movements it is not considered a restraint.

6. **Limb and Vest Restraints**
   Tie the strap(s) to the bed frame, the wheelchair frame, or any secure part of the appliance on which the patient has been placed using a quick release knot. Secure the strap out of the patient’s reach.

7. **Blanket Restraint (Pediatrics)**
   Fold blanket or sheet into a triangle and place on bed. Place child’s head at mid-base of angle. Hold one arm straight next to child’s body and bring blanket over his/her arm, trunk, and opposite arm. Tuck under back and pin if necessary.
Addendum B

ASSESSMENT OF RISK FACTORS, INTERVENTIONS AND ALTERNATIVES TO RESTRAINT USE:

Non-physical techniques are preferred interventions. The type of physical intervention selected should take into consideration information learned about the patient’s initial assessment.

A. A comprehensive assessment of the patient must determine that the risk associated with the use of a restraint is outweighed by the risk of not using it. The use of an anatomical, physical, and psychological assessment for risk factors by the RN and/or the physician facilitates the limited and justified use of restraints. Planning for, that is, being proactive rather than reacting to, the patient’s actions/behavior protects the patient’s health and safety and allows for the implementation of preventative strategies that would be of the greatest benefit to the patient. Initial assessment at admission should identify:

1. Techniques, methods, and tools used to assist the patient in controlling their behavior.
2. Any medical condition or physical disability that would place the patient at greater risk.
3. Any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint.

B. Specific factors to consider as part of the assessment include, but are not limited to:

1. Disorientation to person, place, or time.
2. Memory disturbances.
3. Fluctuating levels of awareness.
4. Alteration in sleep/wake cycle.
5. Perceptual disturbance.

C. The following conditions or situations should be considered as part of the assessment for a change in mental status or confusion at the time of admission or during stay:

1. Emergency admission or admission from an institution.
2. Cognitive impairment/brain damage/dementia/delirium; respiratory insufficiency/hypoxia; urinary problems/incontinence; fracture; physical illness (two or more); or severity of illness.
3. Pain or other physical discomfort.
4. ADL impairment; altered mobility/low level of activity.
5. Large number of medications (four or more); drugs with anticholinergics or CNS effects; drug or alcohol abuse; narcotic use; psychoactive drug use; drug toxicity; or drug withdrawal.
6. Dehydration/volume depletion; fluid/electrolyte and metabolic disturbances, nutritional deficiencies; and other abnormal laboratory values; proteinuria; azotemia; abnormal arterial blood gases and sodium level; elevated creatinine and while blood cell count, blood glucose, BUN, anion gap, AST and PT; low blood potassium, calcium, serum albumin and hematocrit.

7. Abnormal body temperature; symptomatic infection; UTI; respiratory infection.

8. History of limited social contact.

9. Recent hospitalization, recent surgery under general anesthesia.

10. Recent change in living situation or environment.

11. History of falls or other trauma.

12. Recent stroke or seizure; sensory impairments.

13. Primary metastatic brain tumors or other malignancies.

14. Cardiac arrhythmia/myocardial infarction.

15. Other physiological changes that may be causing or contributing to the altered behavior patterns such as: oxygen perfusion, blood glucose changes, blood chemistry, etc.

16. Types and/or combinations of medications to determine if any may be contributing to the behavior.

17. Types and/or combinations of treatment modalities.

D. Assessment should identify precipitating factors and interventions to be eliminated whenever possible. Attempts should be made to evaluate and use the following interventions/alternatives when possible and in response to the patient’s assessed needs:

1. Monitoring:
   a. Companionship; staff or family stays with patient.
   b. Room near or visible from nursing station.
   c. Close, frequent observation.

2. Environmental Measures:
   a. Be sure patient has and is using eyeglasses, hearing aids as appropriate.
   b. Place patient near nursing station.
   c. Place mattress on floor.
   d. Leave side rails down.
   e. Decrease stimulation; quiet surroundings, appropriate lighting, relaxing music.
   f. Call light accessible at all times.
   g. Quick response to call light.
   h. Orientation of patient to surroundings.
   i. Occupied bed in low position with brakes locked.
j. Room / halls clear of obstacles such as excess equipment.
k. Use of bed check alarm device.
l. Availability of bedside commode.
m. All familiar possessions, photographs.
n. Rocking chair.

3. Comfort Measures:
   a. Address pain management or other sources of physical discomfort.
   b. Comfortable positioning and clothing, keeping patient clean and dry.
   c. Reduce noise and avoid waking up patient during periods of sleep, if possible.
   d. Gentle touch, soothing voice.

4. Interpersonal Skills:
   a. Use short, simple sentences.
   b. Speak slowly and clearly, pitching voice low to increase likelihood of being heard; do not act rushed, do not shout.
   c. Allow enough time for patient to respond.
   d. Explain procedures to reduce patient anxiety.
   e. Tell patient what you want done rather than what not to do.
   f. Have reality links available, i.e. TV, radio, calendar, clock.
   g. Pleasant, consistent interaction with patient and family.
   h. Involve patient in conversation.
   i. Actively listen to patient, offer reassurance. Observe behaviors and try to identify the message, emotion or need that is being communicated.

5. Staffing:
   a. Consider assessed patient needs and behavior as well as patient/staff safety when making assignments.
   b. Flexibility to allow for assignment changes as per patient needs/behavior.
   c. Consistency in staffing, i.e. assigning staff familiar to patient as often as possible.

6. Regular Toileting:
   a. Establish consistent toileting schedule: q 2 hours while awake, 1-2 times at night.
   b. Encourage patient to ask for assistance at first feeling of toileting need; respond to patient’s needs promptly and positively.
   c. Check for constipation/full bladder as indicated.

7. Education:
   a. Educate patient/family/significant other to patient deficits and have consistent plan of approach; reeducate/remind them of goals/potentials on ongoing basis.
   b. Solicit patient/family/significant other ideas for alternative measures.
c. Provide patient/family significant other with opportunities for control; offer choices.

8. Diversional / Repetitive Devices (specific to the patient’s interest and abilities):
   a. Distract patient with videos, TV, photographs; reading materials.
   b. Purposeful activity, i.e. puzzles or sorting.
   c. Provide a diversional activity for hands, i.e. rubber ball, squeezing devices, baseball mitt, folding washcloths, stuffed animals, purses or wallets containing various items, spools of thread, cars and trucks, etc.
   d. Sensory aids.
   e. Provide alternative system for sensory deficiencies, if needed.

9. Medication/Nutritional:
   a. Implement any interventions necessary to assist in adjustment of treatment to stabilize physiological changes by notifying the physician.
   b. Hide or disguise lines and tubes.
   c. Discontinue all lines that may no longer be medically necessary and initiate oral as opposed to IV or NG feedings.

An ongoing assessment by the qualified RN, with input from other disciplines as appropriate, is critical in determining whether the intervention decision was effective.
Addendum C

LEE MEMORIAL HEALTH SYSTEM

INFORMATION ON RESTRAINTS

FOR PATIENTS / FAMILY MEMBERS

On occasion, some of our patients/residents may experience a temporary episode of confusion or behavioral changes that may pose a risk of injury to themselves or others. Conditions that may contribute to confusion are:

- Medication side effects
- Hearing loss
- Vision loss
- Oxygen deprivation
- Fluid imbalance
- Change in surroundings
- Infections
- Decrease of blood flow to brain/arteriosclerosis

Confusion or dangerous behaviors can prevent you/your family member from accurately assessing physical surroundings that could cause harm. During these temporary episodes, the physician and nurses may identify the need for restraint to safely care for you/your family member. These devices may be in the form of vests, belts, or wrist or ankle restraints. While restraints are in place, your family member will be observed frequently by all Nursing to assist you/family member with your/his or her care.

As you / your family member's physical condition improves, and the confusion and dangerous behavior decreases, you/he/she will be assessed for the continued need for a restraint. You/your family member's safety and emotional needs are always a primary concern to us while you/he/she is with us at Lee Memorial Health System.

Patient Rights: All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only 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 R & R - 482.13 (e). The hospital will provide the patient or family member with a formal notice of their rights at the time of admission (patient handbook), and inform the patient or their representative of the patient's rights in a language that the patient understands.
Addendum D

STAFF TRAINING AND COMPETENCY ASSESSMENT

The organization educates and assesses the competency of staff in their safe use and in minimizing their use before they participate in using restraints or seclusion. All hospital staff involved in meeting patient’s needs will be educated upon hire, before they participate in any use of restraint or seclusion, and at least yearly thereafter.

A. All direct patient care staff receive ongoing training and demonstrate an understanding of:

1. The underlying causes of threatening behaviors.
2. Sometimes an individual may exhibit an aggressive behavior that is related to a medical condition and not related to his/her emotional condition.
3. How their own behaviors can affect the behaviors of the individuals they serve.
4. The use of de-escalation, medication, self-protection, and other techniques.
5. Recognizing signs of physical distress in individuals who are being held, restrained.
6. The use of non physical interventions.
7. The safe application and use of all types of restraints used in the hospital.

B. In addition, training requirements for staff who are authorized to physically apply restraints include:

1. Choosing the least restrictive intervention based on an individual needs.
2. Physical holding techniques.
3. Application and removal of mechanical restraints.

C. Training requirements for staff who are authorized to perform the patient assessment:

1. The above listed core skills.
2. Taking vital signs and interpreting their relevance to the physical safety of the individual in restraint.
3. Recognizing nutritional/hydration need.
4. Checking circulation and range of motion in the extremities.
5. Addressing hygiene and elimination.
6. Addressing physical and psychological status and comfort.
7. Assisting individuals in meeting behavior criteria for discontinuation of restraint.

8. Recognizing readiness for discontinuance of restraint.

9. Recognizing when to contact a physician to evaluate/treat the individual’s physical status.

D. Requirements for staff who are authorized to initiate restraints and/or perform evaluations/re-evaluations:

1. Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way an individual reacts to physical contact.

2. The use of behavior criteria for the discontinuance of restraint and how to assist the individual to meet these criteria.

E. Additional Educational Requirements for selected Registered Nurses who may perform the one-hour face-to-face after initiation of the Restraint:

1. The one-hour face-to-face may be completed by a qualified registered nurse who has been trained in accordance with the above requirements and additionally trained to be able to evaluate:

   a. The patient’s immediate situation.

   b. The patient’s reaction to the intervention.

   c. The patient’s medical and behavioral condition.

   d. The need to continue or terminate the restraint.
# ACUTE CARE NON-VIOLENT RESTRAINTS

## Timeline Example for Restraint Use & Orders

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/19-0950</td>
<td>Patient exhibits medical reasons for restraints</td>
</tr>
<tr>
<td>6/19-1000</td>
<td>Patient exhibits medical reasons for restraints</td>
</tr>
<tr>
<td>6/19-1015</td>
<td>Alternative measures unsuccessful</td>
</tr>
<tr>
<td>6/19-1215</td>
<td>Apply appropriate type of restraint</td>
</tr>
<tr>
<td>6/20-1215</td>
<td>Nurse obtains VO from LIP and documents the non-violent restraint tab</td>
</tr>
<tr>
<td>6/20-1415</td>
<td>Order is discontinued, and a new order is required</td>
</tr>
<tr>
<td>6/21-0600</td>
<td>Restraints removed, and documentation discontinued</td>
</tr>
</tbody>
</table>

## NURSE
- Attempt use of alternative measures and document
- Head to Toe Assessment
- Psycho Social
- Note: Nurse has 12 hrs to obtain order from LIP/Designee
- LIP calls back and can't get to computer, provides VO for restraints
- Continue Q2H monitoring and document
- Restraints removed
- Documentation discontinued
- Nurse calls at end of shift

## LIP/DESIGNEE
- LIP calls back and can't get to computer, provides VO for restraints
- Co sign VO, assess patient and need for restraints
- Note: Get new order for next 24 hours if continued restraints are needed

*Red text indicates EPIC Documentation*
## ACUTE CARE VIOLENT / DESTRUCTIVE RESTRAINTS

### ACUTE CARE - VIOLENT/DESTRUCTIVE RESTRAINTS - ADULT: Timeline Example

<table>
<thead>
<tr>
<th>6/19-0950</th>
<th>0950</th>
<th>1050</th>
<th>1450</th>
<th>1600</th>
<th>1700</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient exhibits Violent/ Destructive reasons for restraints</td>
<td>Apply appropriate type of restraint</td>
<td>Nurse obtains VO from LIP in 1 hour Enters VO into Orders Mgmt</td>
<td>Continue Q15 minute monitoring</td>
<td>Restraints removed</td>
<td>Patient Cooperative</td>
</tr>
<tr>
<td></td>
<td>Initiate Q15 minute monitoring Document flowsheet Violent restraint tab</td>
<td>Face-to-face assessment by competent RN Supv. in 1 hr. If not done by LIP/ Designee</td>
<td></td>
<td>Order is discontinued Orders Mgmt</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revise POC to include physical restraint mgmt. Plan of Care</td>
<td>Behavioral restraints progress note (Form #5792) by person completing face-to-face assessment</td>
<td>Documentation discontinued Document flowsheet</td>
<td>Revise Care Plan Plan of Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: Nurse has 1 hr to obtain order from LIP/Designee by either - LIP/Designee enters CPOM - or Nurse gets VO Documentation Flowsheet “Call to Physician”</td>
<td></td>
<td>Note: No down grading of restraints. If patient no longer requires restraints for violent behavior but later needs restraints for non-behavior issue, new order is needed.</td>
<td>Nurse calls for order from LIP/ Designee Document flowsheet Call to Physician</td>
<td></td>
</tr>
<tr>
<td><strong>NURSE</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LIP/Designee provides order within 1 hr.</td>
<td>LIP/Designee must re-evaluate face-to-face</td>
<td></td>
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<tr>
<td></td>
<td>LIP/Designee provides new order Q4H *if violent/destructive behavior requires continued restraints</td>
<td></td>
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<tr>
<td></td>
<td>Note: If patient quickly recovers and is released before LIP/Designee performs assessment, LIP/Designee must still complete face-to-face and provide order</td>
<td></td>
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</tr>
<tr>
<td><strong>LIP/DESIGNEE</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LIP/Designee calls back and enters order</td>
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</tbody>
</table>

* Red text indicates EPIC Documentation

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\* Max. Time of Order

| 1 HR | 0-8 yrs old |
| 2 HRS | 9-17 yrs old |
| 4 HRS | 18 and older |

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Standards & Quality Work Product 6/19/13