LEE HEALTH
POLICY & PROCEDURES

RESTRAINTS	LOCATOR NUMBER

TYPE

☐ **System-wide -** A formal statement of values, intents (policy), and expectations (procedure) that applies to every employee throughout the System.

☒ **Multidisciplinary/Interdisciplinary** - A formal statement of values, intents (policy), and expectations (procedure) that applies to more than one discipline and is usually of a clinical nature. **Check below all areas to which this applies.**

☐ **Departmental -** A formal statement of values, intents (policy), and expectations (procedure) exclusive to a particular department or group of people within a department at one or multiple locations that does not impact any other area.

CHAPTER: M03

TAB: 01

POLICY #: 768

Disciplines / locations to which this interdisciplinary policy applies:

☐ Health Information Management	☐ Pharmacy	☒ Acute Care Hospital Nursing
☐ Environmental Services	☐ Plant Operations	☐ Outpatient Services
☐ Information Systems	☐ Radiology	☐ Home Health
☐ Laboratory	☐ Rehabilitation Services	☐ Skilled Nursing Services
☐ Legal Services	☐ Respiratory	☐ Physician Offices
☐ Nutrition	☐ Public Safety	☐ Rehab Hospital
☐ Other _____	_____	_____

Date Originated: 9/07	Reviewed/No Revision:	Dates Revised: 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, 7/15, 9/15, 10/15, 5/16, 11/16, 3/17, 6/17, 8/17, 10/17, 1/18, 3/18, 5/18, 3/19	Next Review Date: 3/21

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Education Completed: Date: 5/1/19

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As Needed:

Medical Director: **Date:**

PURPOSE:

To delineate the requirements and responsibilities for the use of restraints in situations where all alternatives / least restrictive measures have been determined to be inadequate, for the purpose of promoting a safer environment for the patient. Every effort will be made to minimize the use of restraint through thorough assessment and intervention as outlined within.

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 ensure that, in situations necessitating the use of restraints, that adequately trained staff members (with completed competencies to do so) apply them appropriately and that the use of restraint is based upon on-going physical and behavioral assessment by nurses and physicians.

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

To ensure that the initial and ongoing need for restraint use is done by an RN as per policy guidelines and that the restraint is discontinued once the patient's condition no longer necessitates the use of restraints.

SCOPE:

This policy applies to healthcare professionals in the hospital who are involved in applying restraints.

NOTE: For any adult patient on the Obstetric unit, if restraints are needed a MET team is to be called and restraint/required documentation will be managed by the MET/CCO nurse.

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.

Face-to-Face Evaluation: An evaluation required to be done and documented for each episode requiring the application of violent / self-destructive (behavioral) restraint. This evaluation must be completed and documented within one hour **after** the application of the restraint and obtaining the restraint order. This evaluation is required to be done by the LIP involved in the care or by a trained Administrative Supervisor to assess the patient's response to the restraint application.

- If the one hour face-to-face is done by the Administrative Supervisor, the attending physician or other LIP responsible for the care of the patient must be consulted as soon as possible after completion of the evaluation and this contact must be documented in the electronic health record (EHR) utilizing either the Face-to-Face smart text or by filling out the One Hour Face-to-Face form (FM# 5792). The form should be placed on the patient's chart and scanned into the EHR upon discharge.

Hard Restraints: Refers to limb restraints that are "hard", generally made of leather or a non-pliable plastic material.

Soft Restraints: Refers to limb restraints that are "soft", generally made of fabric or foam.

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.

- This includes: four side rails, specialty chair (lap hugger), roll or soft belt, mittens, limb restraint, vest restraint and blanket restraint (Pediatrics).

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. Chemical restraints are not used at Lee Health.

Bed Enclosure Bed: a hospital bed, canopy, and mattress system designed to provide a safe, controlled environment for patients at extreme risk of injury.

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 manage documented conditions in order 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, staff and others.

4 Point Restraint: use of restraints on all four limbs simultaneously. Use of 4-point restraint can be for non-violent or violent behaviors.

- When the behaviors that the patient is exhibiting are not manageable utilizing traditional de-escalation techniques, unanticipated based on clinical status and pose the threat of harm to the patient or to others, the use of 4 point restraints to manage the patient must be handled under the violent, self-destructive (behavioral health) emergency guidelines and monitoring requirements.

- When the patient is exhibiting conditions (not inconsistent with clinical status) that interfere with medical surgical care: i.e., a disoriented patient unable to follow directions with a leg wound and wound vac who is using hands and feet to attempt to dislodge wound vac (and those behaviors are clearly documented) the guidelines and monitoring required follow those outlined for the non-violent, non-self-destructive (medical surgical management) restraint.

Restraint Standard Does Not Apply:

A medically necessary positioning or securing device used to maintain the position, limit mobility or temporarily immobilize the patient 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)

IV Arm Boards: to stabilize an IV as long as arm board is not tied down or otherwise attached to the bed. If the entire limb is immobilized such that the patient cannot access his/her body, the IV arm board is considered a restraint.

Patients Requiring BiPAP Ventilation: Patients on BiPAP should not have their upper extremities restrained or restricted, in order to afford patients the opportunity to remove the mask in event of respiratory distress or whenever necessary. Patients requiring restraints and BiPAP at the same time should have medical supervision and appropriate level of care (such as ICU environment).

Voluntary Mechanical Support: used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible 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 restraints 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.

Note: If a patient can easily remove a device, the device would not be considered a restraint. In this context, “easily remove” means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff. For example, side rails can be put down by the patient and not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied, considering the patient’s physical condition and ability to accomplish the objective (i.e., transfer to a chair, get to the bathroom in time).

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.

- Security Guards may assist with the application of violent, self-destructive (behavioral) restraints in behavioral emergencies under the direct supervision of a registered nurse or physician who has documented competency and training on the restraint policy.

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 a child would not be considered a restraint.

Instances when four (4) side rails up **<u>are not</u>** considered a restraint:

A. Raising four (4) side rails on children 8 years of age and younger or children with developmental delays.

B. 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.)

C. Raising both stretcher side rails or four (4) bed 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 (i.e., stretcher when bed is not available).

D. Raising four (4) side rails when patient placed on seizure precaution. Padded side rails are used to protect the patient.

PHILOSOPHY:

It is the philosophy of Lee Health 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:

A. 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.

B. Restraint use is limited to only emergencies where there is a risk for the patient harming himself/herself or others, utilizing the least restrictive method possible to assure safe medical care of the patient.

C. Oversight of restraint implementation will be done through reporting and auditing by unit leadership.

D. Protection of the patient and preservation of the patient's rights, dignity and well-being during restraint will be done by:

- Respecting the patient as an individual
- Maintaining a clean and safe environment
- Utilizing the least restrictive measures appropriate for the clinical situation
- Encouraging the patient to continue to participate in own care
- Maintaining the patient's modesty
- Preventing visibility to others
- Maintaining comfortable body temperature
- Provide for safe application and removal of the restraint by qualified staff
- Monitor and meet the patient's needs while in restraints

E. 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.

F. 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. The physician/LIP or designee ordering the violent self-destructive (behavioral) restraint, or the Administrative Supervisor who is trained to complete the face-to-face evaluation, will complete the face-to-face evaluation within one hour of application, using the Restraint or Seclusion Face-to-Face Assessment/Smart Text or (FM# 5792) in the EHR. The following aspects are evaluated and documented within one hour after restraint is applied and order for restraint is obtained, but **not** before or simultaneously.

   Components of the required documentation include specifically:

   a. Evaluation of the patient’s immediate situation,

   b. The patient’s reaction to the intervention(s),

   c. The patient’s medical and behavioral condition,

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

NOTE: "One Hour Face-To-Face Evaluation for Violent or Self-Destructive Behaviors Restraints Progress Note" (FM# 5792) can be used only if documentation using Restraint or Seclusion Face-to-Face Assessment/Smart Text is not done in the EHR. This form will be scanned into the media tab upon the patients discharge as part of the permanent medical record.

4. Administrative Supervisors who are trained to complete the face-to-face evaluation receive training during their initial orientation and at least yearly thereafter.

G. Documentation

1. Complete documentation of restraints in the EHR includes:

   - Side and site being restrained (i.e., left arm; right arm; left leg; both upper extremities, etc.)
   - Whether hard or soft restraints are used for limb restraints
   - The patient's behavior or symptoms that warranted the use of restraint or seclusion
   - The less restrictive alternatives or other interventions attempted prior to the use of restraints
   - The patient's response to the interventions used

2. Documentation should be done within the corresponding EHR flowsheets as required. An initial clinical note MUST be entered describing patient's behavior prior to the application of restraints. Post-application documentation should describe patient's behavior, interventions used, alternatives or less restrictive interventions attempted, the patient's condition or symptoms that warranted the use of restraint or seclusion, and the patient's response to the interventions used, including the rationale for continued use.

PROCEDURE:

Clinical justification for use of restraints:

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

	CATEGORY	
PATIENT BEHAVIORS	**NON VIOLENT, NON SELF-DESTRUCTIVE (MEDICAL-SURGICAL)**	**VIOLENT OR SELF-DESTRUCTIVE (BEHAVIORAL)**
Reasons for Restraints	A restraint used to promote medical / surgical healing as an adjunct to the plan of care for the protection of surgical and procedural sites and protection of lines, tubes, etc.	Any unanticipated outburst of severely violent, aggressive or self-destructive behavior that poses an imminent danger to the patient, staff or others. Limited to emergency situations.

PATIENT BEHAVIORS	NON VIOLENT, NON SELF-DESTRUCTIVE (MEDICAL-SURGICAL)	VIOLENT OR SELF-DESTRUCTIVE (BEHAVIORAL)
Rationale for Use	Use is based on a comprehensive, individualized assessment of patient need. Specific behaviors associated with need for restraint must be documented.	Immediate and serious danger to patient safety or others. Severe aggressiveness, violent and/or self-destructive behavior. Suicidal/homicidal.
Initiation	RN: 1. Attempt the use of alternatives/least restrictive measures prior to application of restraint (Addendum B). 2. RN assess patient's need for restraint and type of restraint. (Addendum A) 3. Document behaviors necessitating restraint use. 4. RN may initiate use of restraint in emergent situations when an LIP or designee is not immediately available. 5. Notify LIP or designee and obtain telephone or written order prior to application unless the situation is emergent. If the situation is emergent, the LIP or designee must be notified immediately (or within minutes of restraints being applied) 6. Initiate Plan of Care to include Physical Restraint Management. 7. Documentation on the Restraint flow sheet of Visual Checks and Safety will be performed immediately upon initial application of the restraints and every 2 hours thereafter.	RN: 1. Attempt the use of alternatives/least restrictive measures prior to application of restraint (Addendum B). 2. RN assess patient's need for restraint and type of restraint (Addendum A). 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). 4. Document violent or self-destructive behavior. 5. Notify LIP or designee and obtain the order prior to application unless the situation is emergent. If the situation is emergent, the LIP or designee must be notified immediately (within minutes of restraints being applied) 6. Initiate Plan of Care to include Physical Restraint Management. 7. Documentation on the Restraint flow sheet of Visual Checks and Safety will be performed immediately upon initial application of the restraints and every 15 minutes thereafter.
Order from LIP or Designee	1. Use EHR Restraint order set - Select Non Violent, Non Self-Destructive Behaviors (Medical / Surgical) restraint. 2. NO PRN ORDER 3. Contact LIP or designee for order prior to application or immediately (within minutes of the application of restraints 4. Patient assessed by LIP or designee and order authenticated within 24 hours of restraint application. 5. Complete LIP or designee orders include:	1. Use EHR Restraint order set - Select Violent or Self- Destructive Behaviors (Behavioral) restraint. 2. NO PRN ORDER 3. Initial order by LIP or designee obtained prior to application or immediately (within minutes of the application of restraints) 4. Maximum length of order: a. 1 hour (age 0-8) b. 2 hours (age 9-17) c. 4 hours (age 18 and older)

PATIENT BEHAVIORS	NON VIOLENT, NON SELF-DESTRUCTIVE (MEDICAL-SURGICAL)	VIOLENT OR SELF-DESTRUCTIVE (BEHAVIORAL)
Order from LIP or Designee	a. Type of restraint (choose only one per order set) b. Criteria/rational for restraint (choose only one) c. Duration of restraint d. Electronic signature, date & time 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. 7. If the attending physician did not order the restraint, the attending physician must be notified as soon as possible, but consult should occur prior to the expiration of the order.	5. Complete LIP or designee orders include: a. Type of restraint (choose only one per order set) b. Criteria / rational for restraint (choose only one) c. Duration of restraint d. Electronic signature, date & time 6. If four-point restraint is used, must designate “soft” or “hard” restraint. 7. 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-to-face assessment. 8. If the attending physician did not order the restraint, the attending physician must be notified as soon as possible, but consult should occur prior to the expiration of the order. 9. Orders may be renewed for a period NOT to exceed 24 hours.
Educate Patient / Family	Use Information on Restraints (Addendum C)	Use Information on Restraints (Addendum C)
Initial Evaluation by LIP or Designee	LIP or designee evaluates patient within 24 hours of initiation of the order (in person).	In person face-to-face evaluation by LIP or designee or RN with current competency within 1 hour after restraint application and order for restraint is received. The RN or PA 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.
LIP or Designee Re-evaluation	LIP or designee reassessment and a new restraint order are to be obtained before the end of the following day.	Face-to-face evaluation is required with the initiation of the order; e.g., if a patient remains in restraints after 24 hours, a new order is required and a new face-to-face evaluation must be performed. Order must be renewed in the following time frames and for a period of 24 hours only 1. every 1 hour (age 0-8) 2. every 2 hours (age 9-17) 3. every 4 hours (age 18 and older) If four point restraint is used, must designate “soft” or “hard” restraint.

PATIENT BEHAVIORS	NON VIOLENT, NON SELF-DESTRUCTIVE (MEDICAL-SURGICAL)	VIOLENT OR SELF-DESTRUCTIVE (BEHAVIORAL)
Assessment by RN	Assess every 2 hours – 1. Circulation check 2. Comfort and safety 3. Skin integrity 4. Nutritional needs / hydration 5. Range of motion 6. Elimination needs/Hygiene 7. Rights and Dignity 8. Readiness for release of restraint	Assess every 15 minutes – 1. Vital signs 2. Circulation check 3. Comfort and safety 4. Skin integrity 5. Nutritional needs / hydration 6. Range of motion 7. Elimination needs / hygiene 8. Rights and dignity 9. Readiness for release of restraint
Documentation	1. Narrative Notes prior to initiation of restraints and with all changes in behavior. 2. Restraint Flow Sheet. 3. Patient Plan of Care/treatment plan. 4. Narrative note prior to initiation of restraint describing behaviors necessitating restraint use.	1. One Hour Face-to-Face Evaluation for Behavioral Restraints Progress Note (FM #5792) or SMART text note in the EHR 2. Restraint Flow Sheet. 3. Patient Plan of Care/Treatment Plan. 4. Narrative Notes prior to initiation of restraints
Criteria for Release and Discontinuation of Restraint	1. Restraints should be discontinued at the earliest possible time, regardless of the length of time identified in the order. 2. Restraints must be removed when an alternative to restraints is available and effective and or the patient no longer meets criteria for restraints. 3. 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 prior to application and an assessment completed by LIP or designee within 24 hours of reapplication.	1. Restraints must be removed when patient is no longer violent or self-destructive. 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. 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 violent restraints, a new order must be obtained as soon as the patient is safe and the situation is under control and a face-to-face assessment completed by the LIP or designee within one hour of restraint application.

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 use of less restrictive alternatives attempted should be documented in the EHR flowsheet column before the initiation of the restraint.

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.

   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. The restraint order should be obtained prior to application or in the event of an emergency, immediately after the application of restraints (within minutes).

4. If a patient requires violent / self-destructive (behavioral) restraint while on a medical-surgical or PCU unit, and the nursing care needs of that patient exceed the capacity that is able to be provided on that unit, the patient may need to be moved to a higher level of care setting until such time as the monitoring requirements change.

5. 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.

6. 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.

7. 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.

8. The physician’s order must specify:

   a. The type of restraint device.

      Note: For violent / self-destructive (behavioral) restraint, if four- point restraint is ordered, delineation of “soft” or “hard” restraint is required.

   b. Category of restraint:

      1) Non-violent / non self-destructive (medical surgical)

         or

      2) Violent / self-destructive (behavioral)

   c. The behaviors exhibited to justify use for the restraint

   d. Date and time ordered

e. Duration

f. Behavior-based criteria for release

9. Discontinuing Restraint Prior to Expiration of the Order:

a. Restraints should be discontinued at the earliest possible time, regardless of the length of time identified in the order.

b. 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.

c. 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.

d. The RN will assess and document the behaviors exhibited and 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.

10. 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.

11. Special considerations for use of the bed enclosure bed:

a. The bed enclosure bed is considered a non-violent and non-destructive restraint and requires a physician order, with a renewal order, in alignment with non-violent, non-self-destructive restraint guidelines.

b. The bed enclosure bed is not indicated for:

- violent self-destructive patients

- patients who weigh less than 46 pounds or who are shorter than 46 inches
- patients in wrist restraints
- patients who weigh 300 pounds or more
- patients who rub excessively
- patients with an extensive PICA disorder
- patients who are, or who become, claustrophobic
- patients with multiple tubes in place such as chest tubes

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, or as close as possible to the actual time due. Documentation should reflect the time that the actual assessment was performed. For example, documentation of a 1200 assessment that is being entered at 1225 should generate an assessment column in the EHR of 1200.

2. Every 15 minutes for violent restraints, or as close as possible to the actual time due. Documentation should reflect the time that the actual assessment was performed. For example, documentation of a 1200 assessment that is being entered at 1205 should generate an assessment column in the EHR of 1200. 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.

3. Each time a restraint is ordered or is renewed, the following needs to be documented in the appropriate area of the EHR:

    a. Circumstances and specific behaviors that led to restraint use.

    b. Consideration or failure of non-physical interventions.

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

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

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

    f. Each in-person evaluation and reevaluation of the patient.

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

h. Monitoring and patient assessments are documented as per policy guidelines.

i. Update of 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 safety 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. **Plan of Care / Treatment Plan:**

1. The plan of care should clearly reflect a loop of assessment, intervention, evaluation and re-intervention.

2. A plan of care for restraint use must be initiated and include the identified problem, outcome oriented goals, and the planned interventions

3. Patient and family education should be ongoing. The Patient/Family Information on Restraints form (FM# 2965) is available in forms management and within the EHR so that it can be provided to the patient or family at any time.

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 (g) 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.

Refer to policy S24 01 776 Reporting Deaths Associated with Restraints or Seclusion for reporting requirements and procedure.

O. **Performance Improvement:**

Restraint usage is reviewed by all appropriate disciplines both concurrently and retrospectively.

Prolonged restraint use is analyzed and for each day of prolonged use beyond policy definitions, the appropriateness of continued use will be done by nursing leadership.

Prolonged restraint use is defined as use of restraint:

1. For greater than 5 days for a medical/surgical restraint, excluding patients with high risk for compromised airway (i.e., intubated, tracheostomy), 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 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 #2939 Progress Notes

FM #2939-A Progress Notes – Restraint Log

FM# 2965 Patient / Family Information on Restraints

FM #2965-TCH Patient / Family Information on Pediatric Restraints

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

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 01 067 BiPAP Non-Invasive Ventilation – Care of Patient

M03 01 714 Patient Transport Intra-Hospital

M03 03 922 Verbal Orders

M03 07 706 Patient Leaving Against Medical Advice (AMA)

M05 00 054 Baker Act Transfer

S06 00 133 Corrective Action of Nonconformities

M14 03 116 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 00 823 Safety Management of Serious Safety Events and Precursor Events

REFERENCES:

Federal Statue 42 CFR part 482

NIAHO Accreditation Requirements PR.7 Restraint or Seclusion; Revision 18-2

Medical Staff Rules & Regulations: http://www.leehealth.org/physicianpub/ms-bylaws.asp

Bed Enclosure Bed Posey Company Model 8070 User Manual - 2014

Addendum A

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. **Specialty Chair (Lap Hugger)**

3. **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.

4. **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. Assure that mitt is not restricting patient circulation to hand.

5. **Limb and Vest Restraints**

   Secure 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 the attached clips. Secure the strap out of the patient's reach.

6. **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.

7. **Bed Enclosure Bed**

   See Addendum E.

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 anticholinergic 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 HEALTH

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 Health.

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.

Addendum E

BED ENCLOSURE BED

1. When it is determined that a patient meets the criteria for the bed enclosure bed and a physician order has been obtained, the bed can be ordered through Central Supply as a specialty bed. If Central Supply is closed, contact the Administrative Supervisor. If the patient has respiratory issues and will require the head of the bed to be elevated greater than 15 degrees, order "bed enclosure bed with filler cushions". The enclosure will fit over any of the Lee Health beds, except the Stryker III.

2. The company can have the bed enclosure bed delivered to Lee Health in approximately 4 hours. In the meantime, a safety attendant may need to stay with the patient until the bed enclosure bed arrives.

3. Once the bed arrives, the delivery person will set the bed up for the staff.

4. Once the patient is placed in the bed enclosure bed, the following "Quick Check" items are recommended by the company:

    a. **Canopy and Netting** – Make sure there are no tears, holes, or abrasions in the nylon panels or netting; that the canopy and frame are securely attached to the hospital bed; and that the six foam pads that cover the frame are in place and in good condition.

    b. **Mattress** – The mattress must be fully zippered into the mattress compartment. NEVER put a mattress inside the patient area.

    c. **Clutter and Cleanliness** – Make sure the bed is clean and free of clutter or any objects.

    d. **Bed Height and Bed Control** – Make sure the bed is at the lowest height (16 or 17 inches from the floor to the deck of the bed). This will help reduce the risk of entrapment or suffocation from excess canopy material in the patient compartment and reduce the risk of tipping the bed if the patient becomes agitated or aggressive. NEVER leave the bed control inside the patient area when the patient is unattended.

    e. **Head Elevation** – Leave the mattress flat, with the head of the bed down. If you need to raise the patient's head or torso, use a filler cushion to help reduce the risk of entrapment. Monitor at least hourly to ensure that the cushions stay in place.

    f. **Side Rails** – Always make sure all side rails are in the fully down position. This will help reduce the risk of serious injury or death from entrapment.

    g. **Locking Casters –** To help reduce the risk of unwanted bed movement, the casters of the hospital bed must be fully locked when the patient is in the bed.

    h. **Zippers and Quick-Release Buckles** – Test that all zippers open easily and close securely. Always use the zipper pull-tabs and clip the quick-release buckles (white to white or black to black) on all access panels. Test all zipper closures by pressing against the access panel or canopy material near each zipper to make sure they are secure.

i. **Drainage and Tube Ports** – Make sure zippers are fully closed when ports are not in use. If in use, check that the flow is not impeded.

j. **Nurse Call Button** – If permitted by the patient's care plan, make sure the nurse call button is easily accessible to the patient.

k. **Linens** – It is recommended that only a flat sheet and pillow be under the patient and sheet and blanket over the patient. Incontinence pads, diapers, etc., will be evaluated and used as necessary. Every extra item placed inside the enclosure increases a risk to the patient.

l. **Patient Attire** – The patient must be dressed in a hospital gown or personal sleepwear (without drawstrings). The patient is not to wear street clothing. Any clothing worn in the bed enclosure bed is to be checked for safety and all objects removed from the pockets. No patient belongings are allowed in the bed enclosure. Unsecured mittens can be used in the bed.

DISCHARGE / BED NOT NEEDED

When the patient is discharged or the bed is no longer needed, immediately notify Central Supply that bed has been discontinued and have Housekeeping wipe down the bed. The vendor will pick the bed up directly from the unit and do a thorough cleaning.

ACUTE CARE NON-VIOLENT RESTRAINTS: Restraint Use & Orders

	Initiation	Physician Order	Plan of Care	Monitoring	Discontinuation	Reinitiation
PATIENT	Patient exhibits medical reasons for restraints		Alternative measures unsuccessful		Patient Cooperative	Patient exhibits medical reasons for restraints Alternative measures unsuccessful
NURSE		Attempt use of alternative measures and document Head to Toe Assmt. Psycho Social Nurse obtains VO from LIP as soon as the patient is safe and the situation is under control	Apply appropriate type of restraint Initiate Q2H monitoring Document Flowsheet Non-violent restraint tab Initiate Plan of Care to include physical restraint mgmt. Plan of Care	Continue Q2H monitoring and document Update POC	Restraints removed Order is discontinued Orders Mgmt Documentation discontinued Document flowsheet Revise Care Plan Plan of Care Note: No trial release of restraints once a restraint is removed, a new order is required	Obtain order Apply app. type of restraint Initiate Q2H monitoring Revise care plan to include physical restraint mgt.
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	STOP	

* Red text indicates EPIC Documentation

Standards & Quality Work Product 5/31/18

ACUTE CARE -VIOLENT/DESTRUCTIVE RESTRAINTS-ADULT: