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Restraint Use, 630.00.00

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PHILOSOPHY:

Kadlec Regional Medical Center's believes and supports that all patients have the right to be free from restraint except in emergencies in which there is an imminent risk of the patient physically harming themselves or others including staff. Kadlec Regional Medical Center is committed to the prevention, reduction, and limitation of restraint use. Non physical interventions as listed in this policy are preferred interventions. The decision to use a restraint is not driven by diagnosis, but by a comprehensive multidisciplinary patient assessment. Restraints will only be used when least restrictive interventions are ineffective. Restraints are used as the last alternative to protect the immediate physical safety of the patient, staff and others and will be discontinued at the earliest time possible.

PURPOSE:

To provide a hospital-wide policy and procedure for the consistent utilization, assessment, application, and evaluation of patients in restraints.

POLICY:

- This policy applies to ALL locations within the hospital and ALL hospitalized patients regardless of age, who are restrained.
- Establishes procedures for documenting, reporting, and monitoring the use of restraints.
- Maintaining that patient's rights, dignity, modesty, comfort, and wellbeing are preserved during restraint use.
- Permitting, as appropriate, the participation of patients, and/or families in decisions regarding the use of and alternatives to restraint use.
- Outlines levels of restraints authorized by Kadlec Medical Center.
- The hospital does not permit restraint or seclusion for any purpose such as coercion, discipline, convenience, or retaliation by the staff.
- Kadlec Medical Center utilizes and approves chemical, mittens, soft wrist restraints, and Neoprene restraints. Mittens and chemical restraints are considered least restrictive and should be utilized first.

SCOPE:

Physicians, ARNPs, and PAs may order and discontinue restraint use.

RNs may initiate, apply, assess, manage, document, and discontinue restraints per policy.

Licensed Practical Nurses (LPN), Certified Nurse Assistants (CNA), Nurse Techs, Patient Sitters, Rehab techs, PT/OT/ST and unit secretaries may make patient observations and assist the RN during restraint use.

Qualified personnel may discontinue restraints based on patient assessment and defined criteria.

Competency of the staff involved with restraint use must be documented during unit orientation and/or assigned Health-Stream. This includes temporary staff (e.g. agency and travelers).

DEFINITIONS:

Restraints: Any method that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

Physical: Any manual method, physical holding, or mechanical device that restricts freedom of movement or normal access to one's body; any material or equipment attached or adjacent to the patient's body that he/she cannot easily remove.

Chemical: A drug or medication used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement in a given situation and is not a standard treatment or dosage for the patient's medical or psychiatric condition.

Mittens: A least restrictive form of restraint that can be utilized for a patient that poses a threat to invasive lines necessary for his/her hospital course. **ORDER REQUIRED**

Non-Violent Restraints (Formerly know as Medical Restraint): Physical or chemical restraint used to maintain safe medical therapy after alternatives to restraint have failed. **ORDER REQUIRED**

Violent Self-Destructive Restraints (Formerly known as Behavioral Restraint): Physical or chemical restraints applied in an emergent situation where the patient is exhibiting **violent** and **aggressive** behavior and there is imminent risk of the patient physically harming self, staff, or others. **Patients in Behavioral Restraints must be under direct observation at all times. ORDER REQUIRED.**

Procedural Restraints: Restraints that are usual, customary, and inherent parts of medical, dental, and surgical procedures, i.e. securing a patient to an operating room table, IV arm-board. **NO ORDER REQUIRED.**

Seclusion: Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. **Seclusion is not used in this facility.**

Forensic/Correctional Constraints: The use of handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons are not governed by this rule. The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. The hospital is still responsible for an appropriate patient assessment and provision of safe, appropriate care to these patients. **NO ORDER REQUIRED.**

Adaptive Devices: Voluntary devices 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 a mechanical support, i.e. postural support, orthopedic appliance devices, leg braces. **NO ORDER REQUIRED.**

Protective Devices: Devices intended to provide safety (not related to cognitive function) or to compensate for a physical deficit, i.e. protective helmets, side rails, tabletop chairs, seatbelt in high chairs, support seats. Devices that protect the patient from falling out of bed are not considered a restraint. **NO ORDER REQUIRED.**

Use of Side Rails: Side Rails will not be used as restraint

A side rail is considered a restraint when it is used as a method to restrict a patient's freedom. Example:

- Raising all four side rails in an effort to prevent the patient from voluntarily exiting a bed, etc.

Raising of all side rails may lead to entrapment, entanglement, and the possibility of increased severity of a fall and or injury.

A side rail is not considered a restraint when it is used to protect the patient from injury. Examples:

- Use of side rails to prevent a patient who is on a bed that constantly moves to improve circulation, side rails may be neccessary to prevent the patient from falling out of the bed as it moves.
- The use of padded side rails to prevent harm in patients who are on seizure precautions
- Infants and toddlers placed in cribs
- Prevention of a fall and subsequent injury from a patient rolling off of a stretcher (a narrow, elevated, highly mobile cart). There is increased risk of falling and increased risk of severity of injury from a stretcher due to its narrow width, mobility and elevated platform.
- When a patient is not physically able to get out of bed, side rails have no impact on the patient's freedom of movement, and therefore would not be considered a restraint.

PROCEDURE PRIOR TO INITIATING RESTRAINTS:

Attempt alternative measure prior to initiating restraints.

A. Alternative measures should be attempted with the help of the patient and family. These alternative measures include the following but are not limited to:
    - Provide companionship and supervision
    - Move patient closer to nursing station
    - Explain the use of equipment and procedures to the patient and family
    - Encourage family support individuals to stay with patient
    - Increase observation of patient/increase frequency of nursing rounds
    - Reduce the stimulation and noise in the environment
    - Change the appearance of equipment/re-evaluate need for equipment
    - Offer diversion/physical activities, appropriate to development and preferences
    - 1:1 Patient care
    - Sitter/Family in room
    - Reorientation to surroundings
    - Repositioning and/or Pain management
    - Bed Alarm

1. Once patient assessment warrants the need for restraints additional information should be collected, including:
    - Techniques, methods, or tools that would help the patient control his or her behavior. When appropriate, the patient and/or family assists in the identification of such techniques;
    - Pre-existing medical conditions or any physical disabilities and limitations that would place the

patient at greater risk during restraint; and any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint.

2. After failure of alternatives, determine/assess the reason a restraint is needed. There are two distinct reasons for the application of restraint: 1) medical management (Non-Violent) and 2) aggressive and/or violent behavior management (Violent or Self-Destructive).
3. The **reason** for restraint application will determine physician order and patient management criteria.

Non-Violent Restraint

1. Non-Violent restraint may be initiated for:
   Interfering with treatment including, but not limited to:
   - Pulling on IV, NG, Foley, ET tube.
   - Reaching for IV, NG, Foley, ET tube.
   - Pulling on or removing dressings.
   - patient's diagnosis or condition is such that he or she may unpredictably and suddenly awaken and harm him or herself
2. Prior to initiating non-violent restraint
   1. RN attempts and documents least restrictive alternatives to physical or chemical restraints (i.e. frequent rounding, bed alarm, etc). If ineffective:
   2. RN notifies the physician and receives orders for restraint
   3. If patient is in immediate danger of discontinuing necessary medical treatment, a qualified, competent RN may initiate the least restrictive restraint (ie: mittens).
   4. The RN who applied the restraint must notify the physician within 15 minutes to obtain an order for restraint. An initial telephone verbal order is acceptable for non-violent restraint.
   5. In the cases in which the patient has agreed to participate in Kadlec's care partner program, the primary RN will contact the care partner to update and educate them on the restraint usage.
   6. The Non-violent Restraint Order is completed when the restraint order is initiated.
      Physician Orders will be placed in EPIC and must include:
      - Date
      - Start and stop time (order will automatically discontinue in 24hrs)
      - Reason for restraint
      - Type of restraint used, and number of extremities involved, as appropriate
      - Signature of physician with date and time
      - In case of a telephone order, the name of the individual taking the order must place order in EPIC and the appropriate physician must be listed for co-sign.

      Orders for the use of restraint must never be written as a standing order or on an "as needed" basis (PRN).
3. Physician Assessment: The physician must make a face-to-face assessment of the patient within 24 hours of the initiation of restraints and document current condition of the patient, including whether or not the actions causing the individual to be restrained remain.
   - The physician must assess the patient for use of restraint on a daily basis, criteria for the

discontiunation of restraints should be discussed among the care team, and the physician must reorder the restraints if indicated every 24hours.

4. When restraints are applied, the least restrictive method is used. Listed in order of least to most restrictive:
    1. 1 point Mitt
    2. 2 point Mitt
    3. Chemical restraint
    4. 1 point soft restraint
    5. 2 point soft restraint
    6. 3 point soft restraint
    7. 4 point soft restraint
5. Patient Observation and Documentation:
    A. The patient assessments should be individualized based upon the patient's needs. Patients are observed at minimum every 2 hours to determine that:
        1. Patient is safely restrained
        2. Restraint device is intact
        3. Restraint device is secured appropriately
        4. Maximum movement/range of motion is available or performed (as appopriate)
        5. Call light is within patient's reach (as appropriate)
        6. Comfort needs are being met (repositioning, toileting, temperature regulation, etc.)
        7. Dignity and wellbeing will be maintained
    B. Documentation includes:
        1. Placement of restraint site or sites and least restrictive measures tried.
        2. Reason restraint continues, including current action
        3. Safety and comfort needs of the patient met, including nutritional and toileting needs as assessed
        4. Time of release, repositioning and removal of restraints (range of motion performed)
        5. Appearance of skin and limb where restraint is used
        6. Vascular checks including circulation and perfusion
        7. Effectiveness of restraint, improvement/deterioration of actions
        8. Documentation of patient/family notification and education must occur after initiation of restraints and then PRN as indicated.
6. Plan of Care: The plan of care should reflect assessment, reassessment and identify the criteria for the discontinuation of the restraint and alternative methods to use when the restraints are removed.
7. Restraint Discontinuation: The use of restraints will be evaluated during all nurse patient interactions and as specified in this policy, restraints will be discontinued as soon as criteria identified by the care team is met, regardless of the time specified in the order. **If restraints are discontinued and reapplication**

becomes necessary, a new order is required. A temporary removal that occurs for the purpose of caring for a patient's needs (toileting, feeding, and range of motion) is not considered a discontinuation of restraint.

8. Reportable Conditions: Report to the physician immediately the following conditions:
    1. Ineffectiveness of restraint in controlling behavior or increasing agitation
    2. Extremity or respiratory complication resulting from being restrained
    3. Significant change in patient's condition.

Violent or Self-Destructive Restraint

1. A patient is a candidate for violent or self-destructive restraint if they are exhibiting **aggressive** or **violent** behavior with Imminent risk of harm to self and or others. This may be a physical and/or chemical restraint. Violent or Self-Destructive restraints are selected only when less restrictive measures have been found to be ineffective to protect the patient or others from harm.
2. In an emergent situation, where the patient's actions are violent or aggressive and leading to harm to self or others, in the absence of a physician, the following must occur:
    1. RN attempts at least one alternative to restraint. If that fails, RN calls a code gray
    2. RN initiates the least restrictive devices (i.e. medication, restraints)
    3. RN calls physician within 15 minutes; notifies of condition, and receives time-specific, age-appropriate restraint orders (see below for restraint order parameters).
    4. In the cases in which the patient has agreed to participate in Kadlec's care partner program, the primary RN will contact the care partner to update and educate them on the restraint usage
3. A Violent or Self-Destructive Restraint Order is completed when restraint is initiated. Physician Orders must include:
    - Date
    - Start and stop time (order will automatically discontinue based on maxium duration)
    - Reason for restraint
    - Type of restraint used, and number of extremities involved, as appropriate
    - Signature of physician with date and time
    - In the case of a telephone order, the name of the individual taking the order must place order in EPIC and the appropriate physician must be listed for co-sign.
      Orders for the use of restraint must never be written as a standing order or on an "as needed" basis (PRN).

The maximum duration of violent self-destructive restraint is strictly limited to:

A. Four (4) hours for adults 18 years and over
B. Two (2) hours for children and adolescents 9 to 17 years
C. One (1) hour for children 0 to 8 years
D. Orders may be renewed according to the time limits for a maximum of **24 consecutive** hours.

4. Physician Assessment: A physician or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care must evaluate and assess the patient within one hour of the initiation

of restraint and every 24 hours, thereafter. After the original order expires, a physician or other LIP assess the patient behavior before issuing a new order. Assessment should include:

- The physical and psychological status of the patient
- The patient's reaction to the intervention
- The patient's medical and behavioral condition
- Review and assessment of patient history, drugs and medications taken prior to admit
- Most recent lab results
- Identify criteria for discontinuation of restraints with the care team

Document in the medical record.
****This is required even if the patient is in restraints for less than 1 hour**

5. Patient Observation:

A. The patient must be monitored by continuous in person observation by an assigned staff member who is competent and trained to call for assistance for any item listed:
    1. Signs of any injury associated with applying the restraint
    2. Restraint device is intactt and secured appropriately
    3. Maximum movement/range of motion is available or performed (as appopriate)
    4. Readiness for discontinuation of restraint

6. Documentation of the above is required at the initiation of restraint and **every 15 minutes** thereafter.

7. Additional documentation every 2 hours (minimum) must include:

A. Placement of restraint and site

B. Reason restraint continues, including current action

C. Safety and comfort needs of the patient met, including nutritional and toileting needs as assessed

D. Repositioning, range of motion, and removal of restraints

E. Effectiveness of restraint, improvement/deterioration of actions

F. Documentation of patient/family notification and education must occur after initiation of restraints and then PRN as indicated.

8. As early as feasible in the restraint process, the patient is made aware of the rationale for restraint and the behavior criteria for its discontinuation. Restraint is discontinued when the patient meets his or her behavior criteria.

9. Plan of Care: The plan of care should reflect assessment, reassessment and identify the criteria for discontinuation of the restraint and alternative methods to use when the restraints are removed.

10. Restraint Discontinuation:The use of restraints will be evaluated during all nurse patient interactions and as specified in this policy, restraints will be discontinued as soon as criteria identified by the care team is met, regardless of the time specified in the order. **If restraints are discontinued and reapplication becomes necessary, a new order is required.** A temporary removal that occurs for the purpose of caring for a patient's needs (toileting, feeding, and range of motion) is not considered a discontinuation of restraint.

11. Reportable Conditions: Report to the physician immediately the following conditions:

- Ineffectiveness of restraint in controlling behavior or increasing agitation

- Extremity or respiratory complication resulting from being restrained
- Significant change in patient's condition.

12. Multiple Episodes of Violent or Self-Destructive Restraint- The need for violent restraints lasting longer than 24 consecutive hours will be reported to the Patient Care Supervisor or Unit Manager. The Patient Care Supervisor or Unit Manager will report to Chief Nursing Officer if appropriate. Once reported initially, leadership is notified at least every 24 hours that the situation continues.

13. Reporting:

A. The following will be reported to CMS:
    - A death that occurs while a patient is in restraint or seclusion
    - A death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
    - A death known to the hospital that occurs within 1 week after a restraint or seclusion where it is reasonable to assume that the use of a restraint or placement of seclusion contributed directly or indirectly to the patient's death regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing of asphyxiation.

B. If any of the above conditions occur, immediately notify Risk/or Quality Care Management who have the responsibility to report to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.

C. Risk/Quality staff will document in the patient's medical record the date and time the death was reported to CMS.

STAFF COMPETENCY AND TRAINING:

Competency of the staff involved with restraint use must be documented during unit orientation and/or assigned Health-Stream. This includes temporary staff (e.g. agency and travelers).

- KMRC's commitment to prevent, reduce and strive to eliminate restraints
- Review of policy
- Emphasis on minimizing use of restraints and use of alternative measures
- Least restrictive alternatives
- Safe application of restraints
- Monitoring, reassessment, and documentation
- Raising awareness about how restraints may be experienced by the patient
- Preserving the patient's safety and dignity when restraints are used
- How staff behaviors can affect the behaviors of the patients
- De-escalation, mediation, self-protection, and other techniques such as time-out
- The use of non-physical intervention skills
- How to recognize signs of physical distress inpatients who are being held or restrained
- Assisting patients in meeting behavior criteria for discontinuing restraints
- Recognizing signs of any incorrect application of restraints
- Recognizing when to contact a physician to evaluate and/or treat the patient's physical status
- Use of First Aid techniques and certification in the use of cardiopulmonary resuscitation, including periodic recertification.

Physician training includes the review of the hospital restraint policy and procedure; including assessment

criteria,initial order, reordering, restraint use, and documentation required. This will occur and be documented during orientation.

REFERENCES:

Comprehensive Accreditation Manual for Hospitals (2011). The Joint Commission on Accreditation of Health Care Organization, Oakbrook Terrace, IL.
CMS Rules and Regulations 42 CFR Part 482 Patients' Rights; Final Rule

Attachments

Flow Diagram

Approval Signatures

Approver	Date
Kirk Harper: VP, Nursing & CNO	08/2019
Heather Shipman: Executive Assistant	08/2019
Darcy Dixon: Registered Nurse	07/2019

Applicability

WA - Kadlec Regional Medical Center