RESTRAINT USE and PATIENT CARE

Orientation for Housestaff
OBJECTIVES:

Upon completion of this education program, participants will be able to:

1. Define the term ‘restraint’.
2. Identify 5 alternatives to restraint.
3. Identify the indications for restraint.
4. Describe how to order, use, monitor & remove restraints used for specific non-violent behaviors.
5. Describe how to order, use, monitor & remove restraints used for violent behaviors.
Restraint Standards, Regulations, and Policies have been developed because restraint use has often been found to be:

- Unnecessary
- Used inappropriately
- The cause of injury & death
RESTRAINTS DEFINED

<table>
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<tr>
<th>JOINT COMMISSION</th>
<th>CMS</th>
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<td>Direct application of physical force to an individual, without the individual’s permission, to restrict his or her freedom of movement. The physical force may be human, mechanical devices, or a combination thereof.</td>
<td>Any manual method or physical/mechanical device, material, or equipment attached or adjacent to the patient’s body that he/she cannot easily remove thereby restricting movement or normal access to one’s body.</td>
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KEY PRINCIPLES of RESTRAINT USE

Restraints are Medical Devices, used

- ONLY as a LAST RESORT
- when alternatives have failed;
- to prevent harm from violent & specific non-violent behaviors.
Restraints are

- Part of a standing or PRN order.
- Used based on a past history of violence.
- Used for convenience, coercion, discipline, or retaliation.
Remember

The decision to use **ANY** restraint is determined by a comprehensive assessment that concludes:

*For this patient at this time*

the use of less restrictive measures poses a greater safety risk than the risk of using restraint.
Common medical problems can lead to mental status changes, agitation & out-of-control behaviors.

ASSESS for and TREAT:

- PAIN
- OCCLUDED DRAINS
- LOW O₂ SATURATION
- INFILTRATING IV LINES
- ELECTROLYTE IMBALANCE
- ALCOHOL or DRUG WITHDRAWAL
- MEDICATION REACTIONS & SIDE EFFECTS
ALTERNATIVES to RESTRAINT

- Provide constant supervision – Direct Observation
- Engage family to remain with patient (when helpful & possible)
- Reduce environmental stimuli
- Change/eliminate bothersome treatments
- Change/Rearrange the environment
- Provide diversionary or physical activity
- Orient patient to time/place
- Speak with patient in a calm/quiet manner
- Listen attentively to patient’s concerns
- Respond to patient in ways that reduce fear & anxiety
- Use ‘sleeves’ to cover arms & ‘hide’ IV lines
### 2 CLASSIFICATIONS of RESTRAINT

<table>
<thead>
<tr>
<th>Violent Behavior</th>
<th>Non-violent Behavior</th>
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<td>Restraint is <strong>necessary to</strong> protect the patient <strong>from bodily harm</strong> due to an unanticipated violent, aggressive or destructive behavior.</td>
<td>Restraint is <strong>necessary to protect &amp; improve the patient’s well-being</strong> by preventing injury or the removal of lines/ tubes needed for treatment &amp; care.</td>
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**Restraint Devices Include**
*And may be used in either classification of restraint*

<table>
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<tr>
<th>Physical</th>
<th>Chemical</th>
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<tr>
<td>Vest</td>
<td>Anxiolytics</td>
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<tr>
<td>Soft limb holders</td>
<td>Antipsychotics</td>
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<tr>
<td>Leather or locked limb holders</td>
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<tr>
<td>Geri-chair</td>
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<td>Mitts</td>
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*When medications are used for a medical condition - such as Delirium Tremens, Schizophrenia, anxiety related disorders – they are not considered a chemical restraint.*
Indications for Non-Violent Behaviors that Require Restraint

- Intervention is necessary to improve the patient’s well-being *by preventing removal of intravenous lines, endotracheal tubes, feeding tubes, or to prevent injury of patients who are temporarily mentally incapacitated after surgery or a procedure.*
Non-Violent/Medical Restraint Procedure

1. Conduct a thorough assessment of the patient
2. Implement appropriate alternatives based on assessment
3. When alternatives are not effective an RN can initiate restraint
4. A physician order is required for restraint
5. Remove restraints when the indications for use are resolved.
6. **Order renewal** is required for **each calendar day** of use.
1. A physician’s order MUST include
   a. Clinical justification for restraint
   b. Ineffective alternatives attempted
   c. Specific time period (up to 24 hours)
   d. Type(s) of restraint used

2. A face-to-face evaluation of the patient within 12 hours of restraint application is required (& before order renewal).

3. The ordering physician MUST consult the Attending/Primary physician ASAP & document the consultation.
Non-Violent/Medical Restraint Order Documentation

On initiation or renewal of restraint orders the MD & RN will document the following:

- Assessment or behavior and/or events leading to the use of restraint
- Alternative measures tried & patient response to those measures
- Type of restraint selected
- Maximum time period for the order (not to exceed 24 hours)
Non-Violent/Medical Restraint

Nursing Assessment

- Patients are assessed at least EVERY HOUR
- Hourly assessments are documented & include
  - Patient Behavior/s
  - Restraint Alternatives Attempted
  - Interventions/Safety Measures
  - Patient Status
Non-Violent/Medical Restraint Nursing Care

- Care is given & documented at least every 2 hours
- Key components of this care include:
  ✓ Hydration
  ✓ Toileting
  ✓ Range of Motion
  ✓ Skin checks to assess for breakdown
  ✓ Extremity checks to assess circulation

- Patients who need their hand(s) to communicate must have their hand(s) released for a brief period (5 min) hourly, and as needed, to permit communication – unless unsafe to do so.
Non-Violent/Medical Restraint Transfer Requirements

For transfer of a patient from one location to another:

- Reassess the need for continued restraint & document
- The transfer report will include the plan of care for restraint use
- The receiving team will note that assessment as re-initiation or discontinuation of restraint, dependent upon patient’s behavior
- Restraints must be *re-ordered* (according to Policy) after the transfer is completed.
Non-Violent/Medical Restraint Discontinuation

Remove restraints as soon as possible & document:

- The change in patient’s behavior since application of restraint
- The patient’s condition & current behavior

A Physician/LIP order is needed for removal of restraints.

Following removal of restraint the patient’s behavior shall be assessed & documented by nursing at least every thirty (30) minutes for one (1) hour.

Patients who have been restrained during their hospitalization are to be discharged only after a complete assessment (with documentation) by an RN and MD.
Indications for restraint use in the management of violent behavior

Restraint may only be applied in emergency situations or as a last resort in order to ensure the patient’s, another patient’s, or staff’s safety and;

NEVER

Ordered as ‘PRN’ or used as a means of coercion, discipline, convenience, or retaliation.
1. Conduct a rapid assessment for least restrictive interventions(s).

2. If less restrictive interventions are **NOT** effective or feasible ... Restraint is applied by a trained staff member in an emergency.

3. **A Physician must order restraints within one hour of restraint initiation** & conduct a face-to-face examination of the patient.

4. The ordering **physician MUST consult** with the Attending physician **within 2 hours of the order**.

5. **Physician & nursing staff collaborate** to identify ways to help the patient gain control
1. The order MUST include:
   a. Behavior leading to restraints
   b. Clinical justification for the use of restraints
   c. Less restrictive measures implemented and not effective
   d. Type of restraint
   e. Time limit for use of restraint

2. A renewal order may be authorized by the physician up to a maximum of 8 hours.

3. A face-to-face evaluation must be conducted by the Attending/Primary physician before the end of the 8 hour period.
A Physician’s order is limited to the following time frames:

- 4 hours: adults
- 2 hours: age 9 to 17
- 1 hour: under age 9

A Physician may authorize a renewal of the restraint order up to a maximum of 8 hours

And

Before the end of the 8 hour period a face-to-face Physician evaluation must be conducted by the patient’s Primary Physician
Nurses & Physicians MUST document
- patient behavior & events leading to the use of restraints
- less restrictive measures tried prior to restraint
- patient response to less restrictive measures
- clinical justification for use (prevention of bodily harm)
- type of restraint used

For Inpatients:
identify use of restraint on the Problem List & Care Plan.
Patients who use their hands to communicate (through sign language or writing) must have their hand/hands released hourly (for a short time – 5 minutes or so) to permit communication unless unsafe to do so.
Patients are assessed with documentation every 15 minutes.

The assessment & documentation includes:
- Patient Behavior/s
- Restraint Alternatives Attempted
- Interventions/Safety Measures
- Patient Status
Violent Behavioral Restraint Nursing Care

Care is given & documented at least every 2 hours

Key components of the care includes:

- Toileting
- Hydration
- Range of Motion
- Skin checks to assess for breakdown
- Extremity checks to assess circulation
Violent Behavioral Restraint
TRANSFER REQUIREMENTS

When patients are transferred from one location to another:

- Reassess prior to transfer
- Note restraints on the transfer report & plan of care
- Restraints are then be re-ordered per policy as soon as the transfer is completed.
Violent Behavioral Restraint

DISCONTINUATION

Restraints are removed when the patient’s behavior indicates it is safe to do so.

This requires

1. Collaboration between Nursing staff & the Physician
2. The Physician’s order
Restraint Discontinuation:

Once restraints are removed, a new order is required to re-initiate restraint.

Following restraint removal:
the patient’s behavior shall be assessed at least every thirty (30) minutes for one (1) hour with documentation on the flow sheet.

Patients who have been restrained while hospitalized must have a documented assessment done by a nurse & physician prior to discharge.
Violent Behavioral Restraint
Documentation for Discontinuation

On removal of restraints document:

- The change in patient’s behavior since the application of restraint
- Any alternative interventions currently effective
- On-going reassessments of the patient’s condition to ensure safety
Electronic Restraint Aids

- **Restraint Re-Order Alert**: One hour before a restraint order expires an alert will populate to the in-box of the Physician/LIP who entered the order and to the in-box of the Attending Physician.

- **Restraint Order Tab**: On each unit in the vicinity of ‘Patient List’ there will be a ‘Restraint’ tab which will list the names of the patients who have had restraints ordered.

- **Restraint Order Report**: This will list the names of all patients who have had restraints ordered within the five (5) day period. This will assist with auditing for staff compliance with the restraint Policy.
SHACKLES

- Shackles applied by the Department of Corrections are **NOT** included in the definition of restraints.

- A Physician/LIP may request the shackles be replaced with a soft restraint for medical reasons, such as in Critical Care areas where resuscitation may be needed.

- Q2H Nursing Care is required & must be documented.