Origination:	*2/5/2016*
Last Approved:	*9/21/2021*
Last Revised:	*9/21/2021*
Next Review:	*9/20/2024*
Owner:	*Emily Goolsby: Hendrick Health Director, Education*
Policy Area:	*Patient Care*
Standards & Regulations:	
References:	

Restraint Use, 3.1083

PURPOSE:

Hendrick Medical Center will establish minimum standards for the care of patients requiring restraint use at Hendrick Medical Center.

DEFINITIONS:

Restraint:

a. 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 or,

b. a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not standard treatment or dosage for the patient's condition.

Non-Violent/Non-Self Destructive Restraint (Non-Psychiatric) is restraint used to manage non-violent, non-self-destructive behavior, for non-behavioral health care reasons. It is used to assist with the provision of medical or surgical care, including symptoms of withdrawal. NOTE: If the main goal is to maintain medical treatment such as ET tube, IVs, or other lines, this type of restraint should be used.

Violent or Self-Destructive Restraint (Behavorial/ Psychiatric) is the restriction of patient movement in response to severely aggressive, destructive, violent or suicidal behaviors that jeopardizes the immediate physical safety of the patient, staff, or others by placing the patient or others in imminent danger. **Violent or Self-Destructive Restraint (Behavioral/ Psychiatric)** rules may apply to restraint use regardless of the setting (unit or department) in which it is applied. NOTE: This type of restraint is usually limited to patients with a primary psychiatric diagnosis such as Bi-Polar disorder, Schizophrenia, Manic Depressive or Psychotic Episode disorder.

Exclusions:

- orthopedically prescribed devices,
- surgical dressings or bandages,
- protective helmets, or
- other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests,
- a device to protect the patient from falling out of bed*,
- a device to permit the patient to participate in activities without the risk of physical harm (this does not include physical escort)

- finger control mitts that do not restrict movement of the arms and are used as a safety device

*Guidelines for side rail use: Side rails are NOT generally considered a restraint IF the patient is able to raise/lower on their own. However, IF full length side rails are in use and the patient can NOT raise/lower them by him or herself, for any reason, the rails may meet the definition of a restraint. The unit/department supervisor or designee should be consulted to ensure proper use of side rails. If side rails are used to prevent falls, they are not considered restraints, as long as they are documented as such.

ALTERNATIVES TO RESTRAINT include, but are not limited to:

- cover device
- decreasing stimulation in environment
- diversional activity
- frequent observation
- moving to room close to desk
- medication for pain/anxiety
- use of sitter/family
- wrap device
- other methods – distraction, moving equipment, etc., as appropriate

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

GENERAL RULES:

APPLICABLE TO NON-VIOLENT/NON-SELF DESTRUCTIVE RESTRAINTS (NON-PSYCHIATRIC), VIOLENT OR SELF-DESTRUCTIVE RESTRAINTS (BEHAVIORAL RESTRAINT) AND SECLUSION

1. Use of restraint will occur only if it is:
    a. medically necessary to promote healing,
    b. required to ensure the immediate physical safety of the patient, a staff member, and/or others,
    c. when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member and/or others from harm, and
    d. will be discontinued at the earliest possible time.
2. Least restrictive means:
    a. restraint or seclusion shall not be used when less restrictive interventions would be effective
    b. when restraint or seclusion is indicated, least restrictive methods shall be chosen
3. Jacket (vest) restraints will not be used.
4. Patient's dignity, rights and well-being are protected at all times.
5. Discontinuation of Restraint: Restraint shall be discontinued when the registered nurse or licensed practitioner assesses that the behavior or condition that was the basis for the restraint order is resolved, regardless of the duration of the enabling order.
6. Restraints shall only be applied and removed by hospital personnel with demonstrated competence in the application and removal of the type of restraint being used.
7. Efforts shall be made to discuss the issue of restraint, when practical, with the patient and the family

around the time of use. Inclusion of the family or others in these discussions is governed by overriding policies related to patient privacy and confidentiality.

8. The patient's care plan will be modified to address restraint or seclusion.
9. Death Reporting and Documentation
    a. Deaths will be reported as outlined in the CMS or other applicable regulation.
    b. Reporting documentation will be in accordance with CMS or other applicable regulation.
    c. Clinical staff is responsible for reporting any patient deaths while in restraints or within 24 hours of discontinuation of restraints. Deaths shall be reported to the Quality Department.

INDICATIONS

1. Restraints may be initiated only when:
    a. less-restrictive alternatives have been attempted or otherwise determined to be ineffective or inappropriate;
    b. deemed appropriate in the clinical conditions, medical-surgical therapies, life-support therapies, and devices such as the following. These are examples, not an all-inclusive list:
        i. to maintain airway support, ventilation and oxygenation;
        ii. to maintain surgical site integrity;
        iii. to foster a safe environment for a patient with decreased ability to follow verbal direction.
        iv. to protect an endotracheal tube;
        v. to protect a tracheostomy tube if patient dependent on mechanical ventilation arterial lines / femoral sheaths;

LICENSED PRACTITIONER RESPONSIBILITIES

1. Restraint shall be ordered by a licensed practitioner and used only when clinically indicated. PRN restraint orders are not accepted.
2. If the attending or responsible licensed practitioner is unavailable, a registered nurse may initiate restraint in advance of a licensed practitioner's order.
3. As soon as possible after meeting the immediate safety needs of the patient, the attending or responsible licensed practitioner will be contacted for an order.
4. The attending or responsible licensed practitioner shall perform a face-to-face assessment of the patient within 24 hours of the initiation of the restraint, at which time he or she shall either discontinue or, if giving an individual order, write an order for continuation of the restraint. (For patients on protocol, a new order is not needed.)
5. The attending or responsible licensed practitioner shall perform an in-person assessment of the restrained patient at least once every calendar day.
6. The licensed practitioner may order initiation of the Non-Violent/Non-Self Destructive Restraint (Non-Psychiatric) Protocol. Use of this Restraint Protocol does not require a daily order.

PATIENT MONITORING AND

DOCUMENTATION:

1. An RN must assess the patient prior to restraint application.
2. A licensed nurse reassesses the patient on an ongoing basis. The assessment/reassessments includes clinical justification, type of restraint to apply, alternative measures implemented prior to decision to restraint, education to patient and/or family regarding restraints, including clinical justification and patient rights as well as address the physical and psychological well-being of the patient.
3. A licensed nurse must document the following each shift (or more often if indicated below):
    a. Type and location of restraint device(s)
    b. Necessity of continued restraint
    c. If less restrictive methods are appropriate
    d. Care plan updates as indicated
    e. A written licensed practitioner's order has been obtained per episode of care (e.g. while IV or tubes are utilized; while on ventilator)
        i. For Violent/Self-Destructive Restraint (Behavioral) refer to specific Violent/Self-Destructive Restraint order guidelines.
    f. Restraints have been released and reapplied every two hours
    g. Food and fluid have been offered every two hours
    h. Toileting has been offered every two hours
    i. Range of Motion or freedom of movement has been provided every two hours
4. Prior to release/discontinuation of restraints, the RN must document the patient meets criteria.
5. All nursing documentation will be completed in the electronic medical record (EMR). When the computer is down and the downtime procedures are in place, the appropriate downtime form(s) are utilized.

RELEASE AND REAPPLICATION

1. Criteria for release/discontinuation includes:
    a. Calm
    b. Quiet
    c. Follows instructions
    d. Absence of impulsive behavior
    e. Alert
    f. Removal of E-T Tube/drains/dressings, etc.
    g. Alternative not previously available becomes available (example: family)
2. Based on RN assessment, the patient will be released when release/discontinuation criteria met. Time and Date of actual release (not just that criteria have been met) must be documented.
3. Should alternative or less restrictive interventions become ineffective or not applicable, restraint may be reapplied as long as the enabling restraint order or order for protocol remains in effect.
4. A new order to initiate the protocol will be obtained if restraint use is reinstated after a documented

discontinuation.

Additional Rules for VIOLENT/SELF-DESTRUCTIVE RESTRAINT (BEHAVIORAL)

1. REQUIREMENTS FOR ALL SETTINGS
    a. INITIATION OF RESTRAINT: An RN may initiate restraint in advance of a licensed practitioner's order.
        i. As soon as possible after the initiation of restraint or seclusion, the registered nurse shall consult with a responsible licensed practitioner about the patient's physical and psychological status and obtain an order (verbal or written).
        ii. The initial and all subsequent restraint orders shall expire in:
            - 1-hour or less for patients 8 years of age or younger,
            - 2-hours for patients from 9 to 17 years, and
            - 4-hours for patients 18 years of age and older
    b. **One-hour face-to-face assessment**: The physician or licensed practitioner or an appropriately trained registered nurse shall perform a face-to-face assessment of the patient's physical and psychological status within one (1) hour of the initiation of the restraint.
    c. **Ongoing face-to-face assessment**: A responsible licensed practitioner shall conduct an in-person reevaluation at least every
        i. 8 hours for patients 18 years of age or older and
        ii. 4 hours for patients17 years of age or younger
    d. **Continuous in-person observation:**
        i. Monitoring of patients in restraint is accomplished through continuous in-person observation by a competent staff member.
        ii. If a staff member is physically holding the patient as the method of restraint, a second staff person shall be assigned to observe the patient.
    e. **Monitoring**:
        i. An RN or licensed practitioner shall assess the patient at the initiation of the restraint.
        ii. A licensed nurse or licensed practitioner shall assess the patient every 15 minutes thereafter.
        iii. The assessment shall include the following unless it is inappropriate for the type of restraint employed:
            i. Every 15 minutes:
                - Signs of any injury associated with applying restraint or seclusion
                - Respiratory effort and circulatory status
            ii. Every 2 hours:
                - Nutrition and hydration
                - Circulation and range of motion in the extremities

- Vital signs
- Hygiene and elimination
- Physical and psychological status and comfort
- Readiness for discontinuation of restraint or seclusion

TRAINING OF STAFF INCLUDING MEDICAL STAFF FOR NON-VIOLENT/NON-SELF DESTRUCTIVE RESTRAINT (NON-PSYCHIATRIC) and VIOLENT/SELF DESTRUCTIVE RESTRAINT (BEHAVIORAL) USE:

The hospital and medical staff members shall receive training in the following subjects as it relates to duties performed under this policy. Such training shall take place before the new staff member is asked to implement the provisions of this policy and shall be repeated periodically as indicated in the department/unit training plan, which shall be based on the results of quality monitoring activities.

1. **Licensed Practitioners who order restraint** shall have a working knowledge of the requirements of this policy as demonstrated through ongoing compliance.
2. **Hospital staff members who assess patients for restraint or who apply restraint** shall receive training in the following:
    a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint.
    b. The use of nonphysical intervention skills.
    c. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition.
    d. The safe application and use of all types of restraint or seclusion used by the staff member, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).
    e. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary.
    f. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the one-hour face-to-face evaluation.
    g. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
3. Hospital staff will receive training on the restraint policy and application of restraints during unit-specific orientation (if applicable), licensed nurse orientation, and as part of the ongoing reeducation and clinical staff competency assessments.
4. Documentation of staff training and demonstration of competency will be placed in the employee's unit

personnel file.

Attachments

No Attachments

Approval Signatures

Approver	Date
Susan Greenwood: Abilene Market CNO / Hendrick Health VP, Nursing	9/21/2021
Emily Goolsby: Hendrick Health Director, Education	9/8/2021
Tracee Robinson: Hendrick Health Director, Quality	9/8/2021
Michelle Rutherford: Senior Risk Manager	8/31/2021