Restraint and/or Seclusion Policy and Procedure Update Sept 2012

Community Hospital of San Bernardino.
A Dignity Health Member

Purpose

This module will provide the staff with an overview of changes that will occur as a result of the 2012 Restraint and/or Seclusion policy and procedure revision.

Objectives

Upon completion of this course, the participant will be able to:

- Describe the changes included in the updated Restraint and Seclusion policy and procedure.
- Define the types of restrains
- Identify under which circumstances each type of restraint should be used.
- Describe how to assess and document care when patients are in restraints

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Definition

- **Restraint Definition per 42 CFR 482.13 (e)(1)**
  - *Any manual method, physical or mechanical device, material, or equipment that restricts, immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely that cannot be removed easily by the patient.*
  - *Per CFR 482.13 (e)(1)(i)(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 a standard treatment or dosage for the patient's condition.*
  - *If all four (4) rails are up, or if belts are being used to keep a patient in bed or from getting up, they are considered to be a restraint and all the policy/procedure and documentation guidelines apply.*

Definition

- **Seclusion Definition as per 42 CFR 482.13(e)(1)(ii)**
  - 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 (V/SD behavior) that jeopardizes the immediate physical safety of the patient, a staff member or others
    - *Staff intervenes to prevent and restrict patient to a room or gives the impression that physical intervention will occur if the patient attempts to leave.*

Definition

- **What is Face-to-Face RN Certified?**
  - *A term used to denote an RN who has completed special training and is deemed qualified and competent to conduct a comprehensive one hour face-to-face evaluation of patients in seclusion and/or restraints.*

What is NOT Considered a RESTRAINT

- Devices, such as 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, or to protect the patient from falling out of bed (including stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, crib covers, if age specific), or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Policy Change - Terminologies

Policy Change - In Terminology "Same Definition"

Old Terminology

- **Behavioral Restraint**
  - Restraint is used only in an emergency or in a crisis situation if a patient's behavior becomes violent or self-destructive presenting an immediate, serious risk to his/her safety or that of others and non-physical interventions are not effective.

New Terminology

- **Violent/Self Destructive Restraint**
  - Restraint is used only in an emergency or in a crisis situation if a patient's behavior becomes violent or self-destructive presenting an immediate, serious risk to his/her safety or that of others and non-physical interventions are not effective.

Policy Change - In Terminology "Same Definition"

Old Terminology

- **Non-Behavioral Restraint**
  - Restraint is used to limit mobility or temporarily immobilize an acute care patient for a reason specifically related to a medical, or post-surgical procedure.

New Terminology

- **Non-Violent/Non-Self Destructive Restraint**
  - Restraint is used to limit mobility or temporarily immobilize an acute care patient for a reason specifically related to a medical, or post-surgical procedure.

Physician's Order – General Provision

Physician's Order

- *A physician must conduct a clinical assessment of the patient before writing an order to use restraints and/or seclusion.*

- *In an emergency situation where restraint or seclusion is used for violent/self-destructive purposes, a competent RN may initiate the use of a restraint or seclusion.*

Physician's Order

- **Is a verbal telephone order from the physician sufficient?**
  - *Yes! A verbal order is sufficient provided it is received within **one hour**, after initiating the emergency use.*
- **Is a standing order for restraint from the physician sufficient?**
  - *No! A restraint/or seclusion is never written as a standing order or on an "as needed" basis (PRN).*

Policy Change - Physician's Order Time Limit

Old Order Time Limit

- If the initial order is NOT obtained from the patient's attending physician, consultation with the attending physician will occur **as soon as possible.**

New Order Time Limit

- If the initial order is NOT obtained from the patient's attending physician, consultation with the attending physician will occur **within one (1) hour of obtaining the order.**

When to Use Restraint:

Non-Violent/Non-Self Destructive Restraint

vs.

Violent/Self Destructive Restraint

When to Use a Restraint

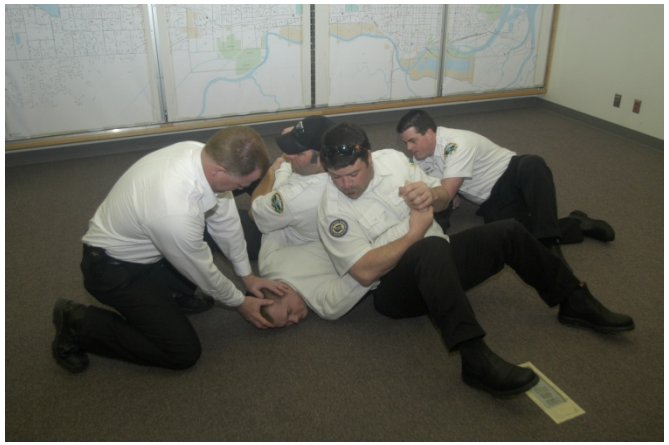
- The hospital uses restraint and/or seclusion only to protect the immediate physical safety of the patient, staff or others.
- The hospital does not use restraint and/or seclusion as means of coercion, discipline, convenience, or staff retaliation.
- The hospital uses restraint and/or seclusion only when less restrictive interventions are ineffective.
- The hospital uses the least restrictive form of restraint and/or seclusion that protects the physical safety of the patient, staff, or others.
- The hospital discontinues restraint and/or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.

Non-Violent /Non-Self Destructive Restraint

- Restraint is used to limit mobility or temporarily immobilize an acute care patient for a reason specifically related to a medical, or post-surgical procedure.
  - Example:
    - This includes the need to ensure that a tube will not be removed or that an acute care patient will not perform activity before it is medically appropriate and the acute care patient is attempting to dislodge the tube or trying to get out of bed.

Violent /Self Destructive Restraint

- Restraint is used only in an emergency or in a crisis situation if a patient's behavior becomes violent or self-destructive presenting an immediate, serious risk to his/her safety or that of others and non-physical interventions are not effective.
  - Example:
    - The use of restraint and/or seclusion for violent/self-destructive behavior must be limited to the duration of the emergency safety situation regardless of the length of the order.
    - Patient is danger to self or to others



Policy Change - Non-Violent /Non-Self Destructive Restraint

Policy Change - Physician's Order in Non-Violent /Non-Self Destructive Restraint

Old Physician's Order

- The attending physician will be notified **immediately** and a restraint and/or seclusion order obtained within 12 hours of restraint initiation.
- The attending physician will perform an **face-to-face assessment of the patient** within 24 hours of the initiation of the restraint, at which time the restraint will either be re-ordered or discontinued as indicated.

New Physician's Order

- The attending physician will be notified **within an hour** and a restraint and/or seclusion order obtained within 12 hours of restraint initiation
- The attending physician will perform an **in-person assessment of the restraint patient** within 24 hours of the initiation of the restraint **and at least once every calendar day**, at which time the restraint will either be re-ordered or discontinued as indicated.

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Policy Change - Monitoring for Non-Violent /Non-Self Destructive Restraint

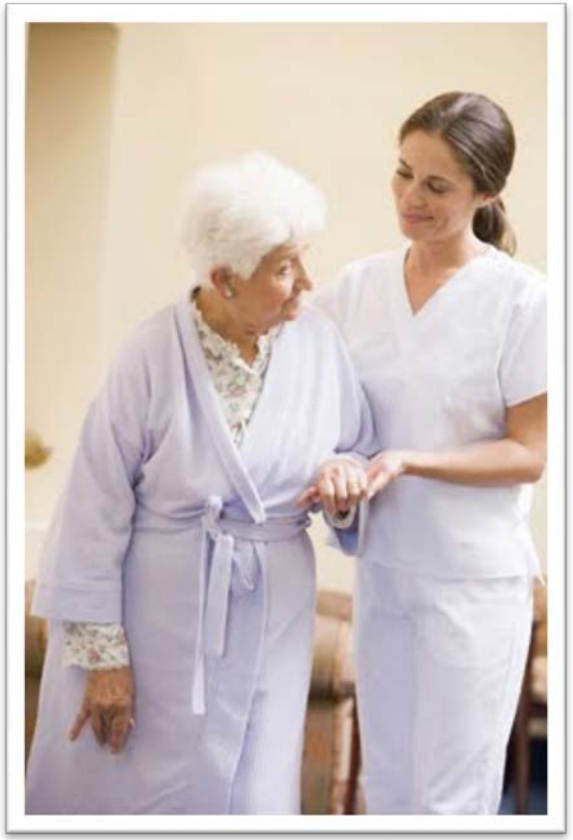
Old Monitoring Parameter

- The reason and rationale for restraint (observed condition or behavior) will be assessed on an ongoing basis and documented at least once per-day.

New Monitoring Parameter

- The reason and rationale for restraint (observed condition or behavior) will be assessed on an ongoing basis and documented at least once per-day.
  - **The patient's response to the intervention will be documented at least once per day.**
  - **The need for continued restraint or discontinuation of restraint will be documented at least once per day.**

Monitoring for Non-Violent /Non-Self Destructive Restraint – con't



New Monitoring Parameter

- Alternatives- alternatives and less restrictive forms of restraint considered by the caregiver will be documented at least once per day.

Monitoring for Non-Violent /Non-Self Destructive Restraint – con't

New Monitoring Parameter

- Other monitoring activities will be completed every 2 hours including but not limited to :
  - **Readiness for discontinuation of restraint**
  - **Injury**
  - **Level of distress or agitation, mental status and neurological status.**

Policy Change - In Violent /Self -Destructive Restraint

Policy Change - Requirements for Violent /Self Destructive Restraint

Old Requirements

- As soon as possible, but no longer than one hour after the initiation of restraint and/or seclusion, the RN will consult with the physician about the patient's physical and psychological status and obtain an order for the restraint and/or seclusion.

New Requirements

- **In an emergency application situation, the RN will obtain an order from the physician either during the emergency application of the restraint and/or seclusion, or within a few minutes of the application.**

Policy Change - Requirements for Violent /Self Destructive Restraint – *con't*

Old Requirements

- One hour face-to-face assessment. The physician or an appropriately trained RN or Physician Assistant will perform a face-to-face assessment of the patient's physical and psychological status within one hour of the initiation of the restraint and/or seclusion.

New Requirements

- One hour face-to-face assessment **will be done by a physician, LIP or an RN who has successfully completed the competency for performing a face-to-face assessment. This assessment of the patient's physical and psychological status will be done within one hour of the restraint and/or seclusion.**

Requirements for Violent /Self Destructive Restraint – *con't*

New Requirements

- In-person evaluation will include:
  - **A complete review of systems assessment and behavioral assessment, including identification of the specific reason for the restraint and/or seclusion and type of restraint and/or seclusion.**
  - **Review and assessment of the patient's history, drugs, medications and diagnostic test results.**
  - **A determination of other factors, such as drugs or medications, interactions, electrolyte imbalances, hypoxia, sepsis, etc. that are contributing to the exhibiting behavior.**

Requirements for Violent /Self Destructive Restraint – *con't*

New Requirements

- In-person evaluation will include:
  - **The patient's reaction to the intervention**
  - **The need to continue or terminate the restraint and/or seclusion**

- **The patient who is simultaneously restrained and secluded will be continually monitored by and RN at the bedside**

Monitoring for Violent /Self Destructive Restraint

New Monitoring Parameter

- Assessment will be completed as specified on the currently approved restraint documentation form. The assessment shall include the following, unless it is inappropriate for the type of restraint employed:

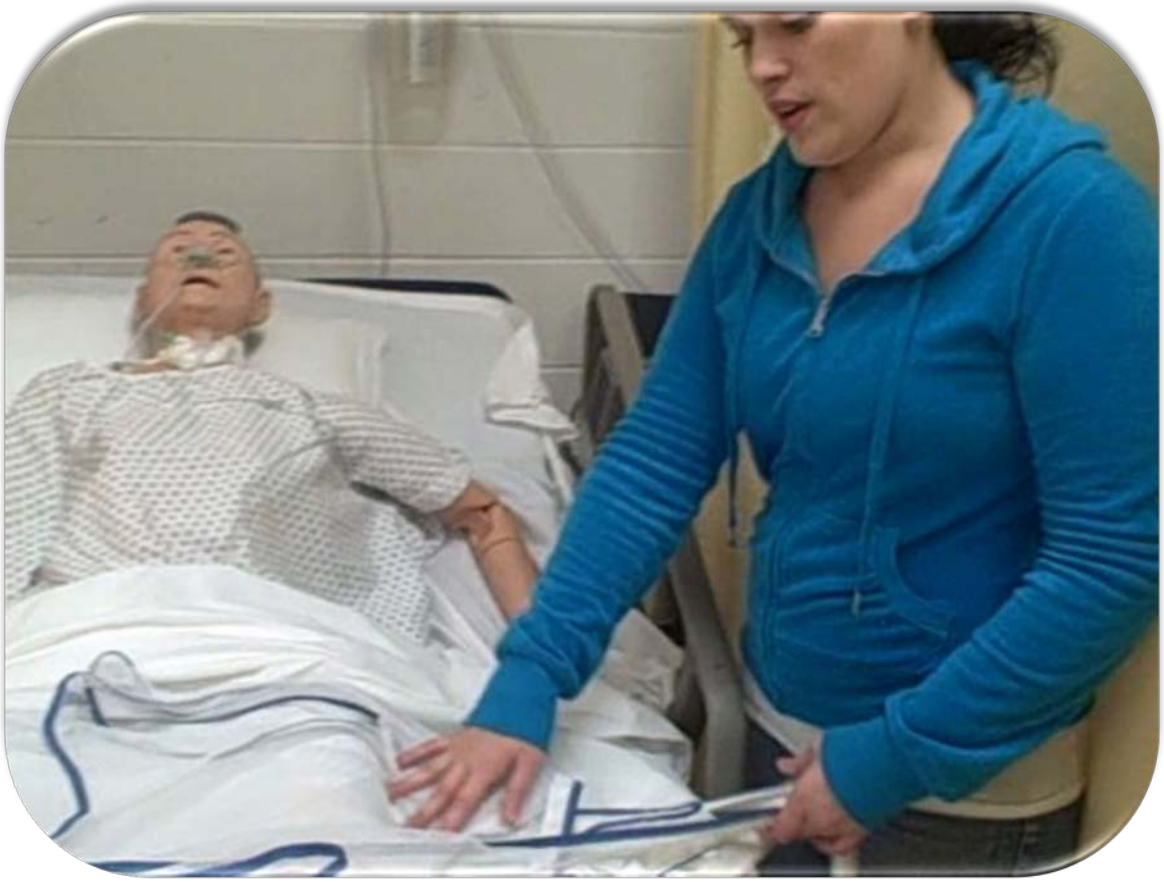
1. **Respiratory and cardiac status**
2. **Visual/Safety observation**
3. **Skin integrity**
4. **Vital signs**
5. **Circulation , Motion Sensation including systematic release of the restraint and completion of ROM**
6. **Level of consciousness**

Monitoring for Violent /Self Destructive Restraint *con't*

New Monitoring Parameter

7. **Toileting offered**
8. **Fluid/Nourishment offered**
9. **Readiness for discontinuation of restraint and/or seclusion**
10. **Injury**
11. **Level of distress or agitation, mental status and neurological status.**

Education and Training for Staff



Education and Competency Training of Staff (Include 5 Elements "Per New Policy")

Education and Competency Training "per policy"

1. **Education will include the technical skill aspects of application, re-application and removal of restraints, and the care of the patient in restraints for Certified Medical Imaging Staff, Emergency Medical Technicians (EMTs), Certified Nursing Assistants (CNAs), Mental Health Workers (MHWs), Respiratory Care Practitioners (RCPs), and Public Safety Officers.**

Training for Certified Medical Imaging Staff, EMTs, CNAs, MHWs, RCPs, and Public Safety Officers will include but not limited to:

a. Proper application of restraint
b. Checking for tightness of restraint around extremities
c. Properly securing restraint strap using the "Quick-Release" knot

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Application of Soft Limb Restraint

A. Apply soft limb restraints one limb at a time. Wrap the padded portion of the wrist restraint around the wrist of the patient. Pass the strap through the slot at the other end of the restraint and tie the restraint to the bed frame in a manner in which you can easily and quickly remove them in the event of a fire or other emergency.

B. Restraints are to be positioned snugly at the narrowest points of limb. Restraints should not be so tight that they restrict circulation in the limb. Ensure that you can slip two to three fingers underneath between the patient's wrist and the restraint to maintain adequate circulation and prevent skin breakdown.

C. **DO NOT** secure restraint ties in bedrails. Secure ties to bed frame or to portion of bed frame that moves with patient.

Application of Soft Limb Restraint

D. Assess the patient every 15 minutes while the restraints are still in use. Observe the nail beds on the patient's fingers and look to see if they return to their normal pink color after gently pinching them. If they do not, the restraints may be applied too tight. Ensure that circulation is normal in the patient's hands and fingers. Look for reddened areas around the restraints, which may be a sign of skin breakdown.

Quick-Release Tie

How to Tie the Posey Quick-Release Tie

1. Wrap the strap once around a movable part of the bed frame leaving at least an 8″ (20 cm) tail. Fold the loose end in half to create a loop and cross it over the other end.
2. Insert the folded strap where the straps cross over each other, as if tying a shoelace. Pull on the loop to tighten.
3. Fold the loose end in half to create a second loop.
4. Insert the second loop into the first loop.
5. Pull on the loop to tighten. Test to make sure strap is secure and will not slide in any direction.
6. Repeat on other side. Practice quick-release ties to ensure the knot releases with one pull on the loose end of the strap.

Education and Competency Training of Staff

Education and Competency Training "per policy" *con't*

2. **Documented educational, instructional training program will include the proper and safe application and use of: soft limb, waist belt, side rails, locking restraints, emergency medication, seclusion and, techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of restraint and/or seclusion, ongoing monitoring, signs of physical and psychological distress in a person in restraint and/or seclusion, and discontinuation procedures for RN's and Licensed Vocational Nurse/Licensed Psychiatric Technicians (LVN/LPT).**

Proper Selection of Restraint

Selection of Restraint:

Select type of restraint based upon patient needs and clinical status. Consider level of control required to maintain safe and effective restraint.

Consideration for Selection of Soft Individual Limb Restraints:

- a) Allows greater selectivity of restraint placement and patient positioning.
- b) Allows increased options for freedom of movement.

Education and Competency Training of Staff

3. **Education and training will include: the need for specific individualized assessment/interventions dependent on the patient's condition, behaviors, history and environmental factors, emergency application of restraint and on-going re-evaluation**

   A. Education will also include safe alternatives to the use of restraints

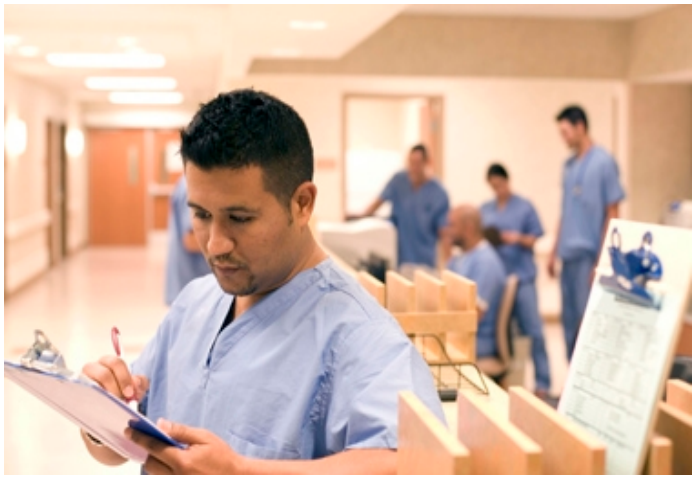
   B. Clinical identification of specific behavioral changes that indicate that restraints and/or seclusion are no longer necessary will be included in the training.

   C. Education on use of restraint for violent/self destructive behavior management will include use of de-escalation techniques, mediation and self-protection.

Alternatives to Use of Restraint

Examples of Alternatives to Restraints but not limited to:

1. Redirect the patient's attention like activity apron
2. Engage the patient in constructive discussion or activity
3. Assist the patient to maintain self control and prevent escalation
4. Provide companionship like family and friends
5. Use of bed alarms
6. Meeting identified physical needs such as toileting, hunger or thirst
7. Individualizing plan of care



Discontinuation of Restraint

- Discontinuation of the use of restraint is based on the determination that need for restraint is no longer present or that the patient's needs can be met with less restrictive methods.
  - *After careful assessment, the criteria for removal of restraints or seclusion is **based on the absence of the behavior that caused the restraints and/or seclusion to be applied.***
    - ***Example:*** Patient is no longer pulling lines or tubes
      Patient verbalizes not to harm self or others
  - *The patient **must be released from restraints at the earliest possible time** based on the patient's ability to meet release criteria.*

Things to Consider for Violent/Self Destructive Restraint

- Patient is posing aggressive behaviors
  - posing danger to self
  - posing danger to others
- Violent and self-destructive
  - appropriate for protecting against threat of harm to self and others

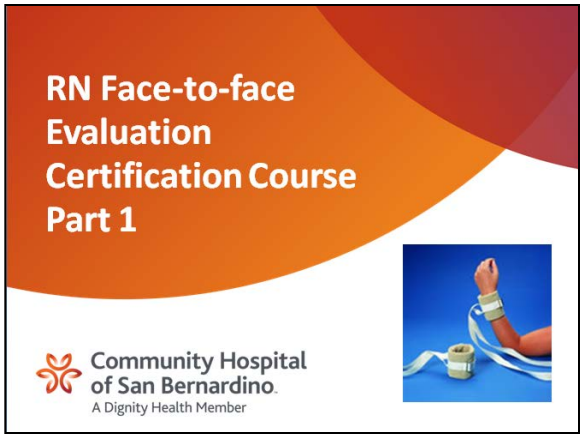
Education and Competency Training of Staff

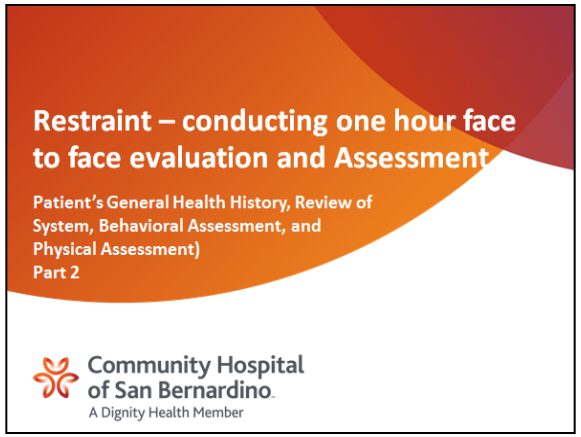
4. **All levels of staff that has any element of responsibility for restraint must have a current "Basic Life Support" course completion card from American Heart Association**

Education and Competency Training of Staff

5. **RN's who are deemed competent to conduct face-to-face evaluations will complete documented training that demonstrates they are qualified to conduct a physical and behavioral assessment of the patient that addresses: the patient's immediate situation, the patient's medical and behavioral condition, and the need to continue or terminate the restraint and/or seclusion.**

*****To be a "Certified Face-to-Face RN", the RN must complete Part 1 and Part 2 of the RN-Face-to-Face Evaluation Certification Course, successfully pass and score at least 90% of the post test and successfully complete 3 face-to-face competencies.*****





Desired Outcome

- **The goals when using restraints are:**
  - Use the least restrictive devices
  - Discontinue use as soon as goals are accomplished
  - Prevent harm to the patient or others
  - Implement and complete required treatments without delay or disruption
  - Maintain the patient's skin integrity
  - Meet fluid and nutritional needs
  - Meet elimination needs
  - Prevent damage to the physical environment
  - Maintain the patient's dignity

Thank You

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