Restraints
POLICY B-34

While the Board recognizes that there may be times where physical and/or chemical restraint or seclusion are necessary for the safety of the individual patients, other patients, visitors or staff:

And, in recognizing the danger inherent in restraints;

And, as a strong advocate for the respect and dignity of each individual patient;

The Board sets forth the following direction regarding the use of restraints:

1. Restraints will be used only as a last resort in managing a patient’s care.
2. Restraints will be used only when essential to protect patients from harming themselves, other patients or staff.
3. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.
4. The least restrictive method that enables care will be used.
5. The facility’s definition and usage of restraints/seclusion will meet and be monitored against all applicable laws, regulatory recommendations, and the Joint Commission standards.
What is a restraint?

- A restraint is 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
- 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.

What is seclusion?

- The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving; usually in a locked room.
- May only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.
Two Types of Restraints

NOTE:
- The type of restraint is not specific to the setting the patient is in, but to the situation the restraint is being used to address.

Violent/Self Destructive Restraint
- Used to protect the patient against any injury to self or others because of an emotional or behavior disorder.
- Sudden onset of violent aggressive behavior.

Non-Violent, Non-Destructive Restraint
- Used with patients of all ages who are hospitalized in an acute care hospital to receive medical or surgical services.
- The patient is observed attempting to remove lines, tubes and/or equipment and cannot be redirected.
- (The primary reason for use directly supports the medical healing of the patient.)
Guiding Principles for the Use of Restraint/Seclusion:

- Patients are free of restraint and/or seclusion, unless interventions are medically necessary to promote healing.
- Measures to protect the patient and others are needed due to violent/destructive behavior.
- Special care should be taken in assessing the need for restraints and seclusion in special patient populations such as children, adolescents, the elderly, the disabled, and abused patients.
  - Recognizing how age, sex, developmental level, ethnicity and history of physical and/or sexual abuse may affect the reaction of the patient to restraint/seclusion.
- The use of restraint/seclusion will be addressed in the patient’s plan of care and/or treatment plan.
Alternatives to Restraint/Seclusion Use
Alternatives to restraint must be tried prior to placing a patient in restraints:

- Speak calmly in a reassuring voice
- Treat patient in a dignified and respectful manner
- Assess comfort level
- Assess physical care needs (bathroom, hungry, thirsty . . . ?)
- Is medication intervention necessary
- Explain procedures and assess understanding
- Redirect
- Monitor patient closely to provide safety
- Play soothing music
- Place patient in hall or close to nursing station
- Utilize a safe diversional activity (folding washcloths/activity box)
- Use verbal redirection techniques and de-escalation techniques
- Decrease environmental stimuli
- Allow wandering, if possible
- Obtain a low bed/mattress
- Initiate a PT/OT referral
- Utilize a bed/chair alarm
- Use a sitter or obtain assistance from family as appropriate
Restraint Application

The following restraints are listed from least restrictive to most restrictive.

- Show of support
- Medication
- Seclusion
- 3-4 siderails
- Mitts (2)
- Freedom splints (2)
- Geri-chair
- Soft-limb restraint (2 extremities)
- Locked restraints

Patient Monitoring

- Respiratory and circulatory status
- Skin integrity
- Assessment of signs of injury
- Hygiene and elimination needs
- Nutrition and hydration needs
- RN reassessment of continued need for restraint use
Exceptions

The following are NOT governed by this policy and are NOT considered to be a restraint.

Use of weapons:
CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term “weapon” includes, but is not limited to, pepper spray, mace, nightsticks, tazers, cattle prods, stun guns, and pistols. Security staff may carry weapons as allowed by hospital policy, and State and Federal law. However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion. If a weapon is used by security or law enforcement personnel on a person in a hospital (patient, staff or visitor) to protect people or hospital property from harm, we would expect the situation to be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement.
Exceptions to Restraint

- Handcuffs/other devices applied by law enforcement
- Orthopedically prescribed devices
- Methods that involve holding or positioning patient to examine or treat them or protect them from falling
- Surgical dressings or bandages
- Situations in which timeout is used
- Use of protective equipment such as helmets
- Use of safety equipment, i.e. pediatric crib bubble, highchair belt