Restraints
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.
What is a Chemical Restraint?

- A drug or medication used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement
- Used to control or inhibit onset of violent or destructive behavior
- It is not a standard treatment or dosage used for the patient’s condition
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.
Two Types of Restraints (cont)

- **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 that presents imminent risk of harm to self and/or others.
Two Types of Restraints (cont)

- **Non-Violent, Non-Destructive Restraint**
  - Patient condition/behavior meets parameters:
    - Invasive line/tube in place
    - Patient attempts to pull line/tube observed
    - Patient confused/unable to be redirected
    - Alternatives tried and failed
Two Types of Restraints (cont)

- **Non-Violent, Non-Destructive Restraint**
  - The primary reason for use directly supports the medical healing of the patient
  - *The patient’s behavior is non-violent and non-aggressive*
Guiding Principles for the Use of Restraint/Seclusion:

- Patients are free of restraint and/or seclusion, unless these interventions are medically necessary to promote healing.
- Measures to protect the patient and others are needed due to violent/destructive behavior.
Guiding Principles for the Use of Restraint/Seclusion (cont):

- 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.
- 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
Alternatives to Restraints (cont).

- 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
Alternatives to Restraints (cont).

- 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
Behavior Levels/Staff Approaches

1. Anxiety

- Noticeable increase or change in behavior
  - Pacing
  - Finger drumming
  - Wringing of the hands
  - Staring

1. Supportive

- Use a non-judgmental approach attempting to alleviate anxiety
De-escalation Techniques

- Be aware of not only what is said to patient but how it is said
  - Tone – avoid inflections of impatience
  - Volume – keep to the volume appropriate for distance/situations
  - Cadence – deliver message using an even rate and rhythm
Behavior Levels/Staff Approaches

2. Defensive

- Beginning stage of loss of rationality
  - At this stage, an individual often becomes belligerent and challenges authority

2. Directive

- Take control of the situation by setting limits
3. Acting Out Person

- The total loss of control, which results in a physical acting out episode

3. Non-violent Physical Crisis Intervention

- Safe, non-harmful control and restraint positions used until the patient can regain control of their behavior
- Used as a last resort
Behavior Levels/Staff Approaches

4. Tension Reduction

- A decrease in emotional and physical energy
- Regaining rationality

4. Debriefing

- Used to re-establish communication
- Better able to build relationships with our patients
VERBAL ESCALATION

1. Questioning

- Information seeking
  - A rational question seeking a rational response
- Challenging
  - Questioning authority or being evasive, attempting to draw staff into power struggle

- Give a rational answer
- Stick to the topic
- Redirect
2. Refusal

- Non-compliance, slight loss of rationalization
- Set limits
3. Release

- Acting out, emotional outburst, blowing off steam, screaming, swearing
- Allow them to let off steam, if possible
- Use an understanding, reasonable approach
- Remove audience or acting out individual from the area
VERBAL ESCALATION

4. Intimidation

- Individual is verbally or non-verbally threatening staff in some manner
- Hands-on approach at this time may trigger acting-out behavior
- Seek assistance and wait for team to intervene
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
Exceptions

The following are NOT governed by the restraint 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 Restraints

- 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
Exceptions to Restraints (cont)

- Situations in which timeout is used
- Use of protective equipment such as helmets
- Use of safety equipment, i.e. pediatric crib bubble, highchair belt
Non-violent/non-destructive restraint

- Patient condition/behavior meets parameters:
  - Invasive line/tube in place
  - Patient attempts to pull line/tube observed
  - Patient confused/unable to redirect
  - Alternatives tried and failed
  - Ramsey score <3 24 hours post intubation or within 24 hours of weaning (CCU)
Non-violent/non-destructive restraint (cont)

- Methods for choosing the least restrictive intervention based on assessment of medical condition/behavior status
  - Re-direction techniques
  - Use of freedom splint or mitt
Non-violent/non-destructive restraint (cont)

- Initiation/revisions to the plan of care appropriate to restraint use to be entered in clinical documentation plan of care section.
Non-violent/non-destructive restraint (cont)

- Every 2 hour monitoring of the physical/psychological well-being of the patient who is restrained
  - Respiratory and circulatory status
  - Range of motion
  - Skin integrity
  - Assessment of signs of injury
  - Hygiene and elimination needs
  - Nutrition and hydration needs
  - Continued need for restraint use
Non-violent/non-destructive restraint (cont)

- Ensure parameters of hospitalwide procedure met
  - Orders never written as prn
  - Time limit for orders - to be renewed each calendar day
  - Physician notified as soon as possible of initiation and written or phone order obtained
  - Immediate notification of the physician if restraint initiated due to significant changes in patient’s condition
Non-violent/non-destructive restraint (cont)

- Ensure parameters of hospitalwide procedure met (continued)
  - Face to face evaluation by licensed physician within 24 hours of initial order must be completed
  - Renewal of order once each calendar day
  - Face to face re-evaluation by licensed independent practitioner at least each calendar day
Non-violent/non-destructive restraint (cont)

- Document record of restraint use on unit/department restraint log
  - Patient and family education provided
  - Report to QMS via Hotline #4199 and Incident Reporting System and document on unit/department restraint log
    - Any death while in restraints, or
    - Within 24 hours of being removed from these restraints
    - Within 1 week after restraint or seclusion where it is reasonable to assume death was a direct or indirect result of restraint/seclusion use
Non-Violent/Non-Destructive Restraint

PHYSICIAN RESTRAINT/SECLUSION ORDER SHEET

Page 1 of 2

<table>
<thead>
<tr>
<th>Restraint/seclusion may not be ordered PROT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assessment pertaining to need for restraint/seclusion</td>
</tr>
<tr>
<td>(includes precautions that place patient at greater risk)</td>
</tr>
<tr>
<td>2. REASON</td>
</tr>
<tr>
<td>☐ Non-violent/Non-destructive</td>
</tr>
<tr>
<td>☐ Violent/Destructive</td>
</tr>
<tr>
<td>TYPE OF RESTRAINT</td>
</tr>
<tr>
<td>☐ Restraint</td>
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<tr>
<td>☐ Restraint * (Behavioral Health Unit)</td>
</tr>
<tr>
<td>Date 5/12/16</td>
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<tr>
<td>3. RESTRAIN PATIENT WITH:</td>
</tr>
<tr>
<td>☐ Locked restraints</td>
</tr>
<tr>
<td>☐ 2-point</td>
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<td>☐ 4-point</td>
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<tr>
<td>☐ 8-4 sidereals</td>
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<tr>
<td>☐ Soft restraints</td>
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<tr>
<td>☐ (l) arm</td>
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<tr>
<td>☐ (r) arm</td>
</tr>
<tr>
<td>☐ Chemical</td>
</tr>
<tr>
<td>☐ Drug: (violent/destructive)</td>
</tr>
<tr>
<td>Name of medication:</td>
</tr>
<tr>
<td>4. RATIONALE FOR RESTRAINT/SECLUSION:</td>
</tr>
<tr>
<td>☐ Danger of injury to self/others (violent/destructive)</td>
</tr>
<tr>
<td>☐ High risk for causing substantial property damage (violent/destructive)</td>
</tr>
<tr>
<td>☐ Attempts at removing lines, tubes, equipment observed, inability to be redirected (non-violent/non-self destructive)</td>
</tr>
<tr>
<td>☐ NON-VIOLENT/NON-SELF DESTRUCTIVE RESTRAINT</td>
</tr>
<tr>
<td>☐ Face-to-face evaluation conducted by a licensed physician within 24 hrs of initial order</td>
</tr>
<tr>
<td>☐ Renew order once each calendar day</td>
</tr>
<tr>
<td>☐ VIOLENT/SELF-DESTRUCTIVE RESTRAINTS ONLY:</td>
</tr>
<tr>
<td>☐ 4 hours (Max. for behavioral conditions) Adults 11 years &amp; older</td>
</tr>
<tr>
<td>☐ 2 hours - ages 5-17 years</td>
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<tr>
<td>☐ 1 hour - children under 5 years</td>
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<tr>
<td>☐ Face to face exam by Physician or trained RN within 1 hour</td>
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<tr>
<td>☐ RN may perform assessment in 4 hrs up to 8 hrs</td>
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<tr>
<td>☐ The physician then conducts an in-person re-evaluation at least every 8 hrs for patients 18 and older and every 4 hrs for patients under 17</td>
</tr>
<tr>
<td>☐ Criteria for RN to discontinue behavior restraint</td>
</tr>
<tr>
<td>1. ☐ Patient verbally contracts with staff to ensure safety to self/others</td>
</tr>
<tr>
<td>2. ☐ Patient is reoriented/demonstrates ability to follow direction(s) for safety</td>
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<tr>
<td>☐ Notification of restraint use to the primary care physician or clinical psychologist (if he/she is not ordering physician)</td>
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<tr>
<td>☐ Order or contact Nutritional Services for &quot;Behavior Tray&quot;</td>
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<tr>
<td>Date/Time</td>
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<tr>
<td>Physician Signature</td>
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</tbody>
</table>

Please remember to date, time and sign all orders
Closer Look (cont) . . .

Violent/Self-destructive/Chemical restraint

- Strategies to identify staff and patient behaviors, events and environmental factors that may trigger the need for restraint/seclusion
Use of non-physical intervention skills, i.e. verbal redirection techniques, de-escalation, use of diversion activities, decreasing of stimuli, show of support and other alternatives attempted and failed
Use of non-physical intervention skills, i.e. methods for choosing the least restrictive intervention based on assessment of medical condition/behavior status and use of last resort.
Violent/Self-destructive/Chemical restraint (cont)

- Initiation/revisions to the plan of care appropriate to restraint use to be entered in clinical documentation plan of care section.
Every 15 minutes, monitoring the physical/psychological well-being of the patient who is restrained/secluded to include

- Respiratory and circulatory status
- Range of motion
- Skin integrity
- Assessment of signs of injury
- Hygiene and elimination needs
- Nutrition and hydration needs
- Continued need for restraints
Violent/Self-destructive/Chemical restraint (cont)

- Ensure parameters of hospitalwide procedure met
  - Orders never written as prn or standing order
  - Requirement of face to face exam by physician, trained registered nurse within 1 hour of initial order
  - If the restraints are ordered by a consultant, attending physician is notified within 8 hours of application
Violent/Self-destructive/Chemical restraint (cont)

- Ensure parameters of hospitalwide procedure met (continued)
  - The patient is monitored 1:1 by staff during the first hour of restraint/seclusion
    - Video and audio monitoring for the first hour with patient’s permission (Behavioral Health Dept)
  - Time limit for restraint/seclusion order
    - Up to 4 hours adults 18 or older
    - Up to 2 hours ages 9-17
    - Up to 1 hour children < 9
Ensure parameters of hospitalwide procedure met (continued)

- In person re-evaluation by physician
  - Every 8 hours patients 18 or older
  - Every 4 hours patients 17 or younger
- Completion of all documentation forms/flow sheets
- Patient and family education provided
- Notify clinical leadership restraint episode >12 hours or 2 or more separate episodes
Violent/Self-destructive/Chemical restraint (cont)

- Removal of restraints
  - Identification of specific behavior changes/behavior criteria needed to discontinue restraint use at the earliest time possible
    - Patient verbally contracts with staff to ensure safety of self/others
    - Patient demonstrates ability to follow directions for safety
Violent/Self-destructive/Chemical restraint (cont)

- Removal of restraints (cont)
  - Or, ended immediately at first sign of physical, psychological or physiological distress
Debriefing
  ◦ Occurs with patient and individuals involved within 24 hours of end of episode
Document record of restraint use on unit/department restraint log

- Patient and family education provided

**Violent/Self-destructive/Chemical restraint (cont)**

<table>
<thead>
<tr>
<th>Restraint Type</th>
<th>Violent / Self-Destructive Restraint Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Patient behaviors exhibited are a danger to self or others.</td>
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</table>

**JAMESON HEALTH SYSTEM**

**VIOLENT / SELF-DESTRUCTIVE RESTRAINT MONITOR**

(For ward to D. Neurohr, South Administration by the 6th of each month)

<table>
<thead>
<tr>
<th>Affix Patient Label</th>
<th>(One label per patient)</th>
<th>Type of Restraint</th>
<th>Date-Time Initial Order &amp; MD Ordering</th>
<th>Use of Psych Medication</th>
<th>Date-Time 1st Assessment &amp; MD Review</th>
<th>Use of Physician or RN</th>
<th>Date-Time 2nd Assessment &amp; MD Review</th>
<th>Use of RN</th>
<th>Date-Time 3rd Assessment &amp; MD Review</th>
<th>Use of MD</th>
<th>Date-Time 4th Assessment &amp; MD Review</th>
<th>Use of RN</th>
<th>Date-Time 5th Assessment &amp; MD Review</th>
<th>Use of MD</th>
<th>Date-Time 6th Assessment &amp; MD Review</th>
<th>Use of RN</th>
<th>Date-Time 7th Assessment &amp; MD Review</th>
<th>Use of MD</th>
<th>Date-Time 8th Assessment &amp; MD Review</th>
<th>Use of RN</th>
<th>Date-Time 9th Assessment &amp; MD Review</th>
<th>Use of MD</th>
<th>Date-Time 10th Assessment &amp; MD Review</th>
<th>Use of RN</th>
<th>Date-Time 11th Assessment &amp; MD Review</th>
<th>Use of MD</th>
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</table>

**Injuries Sustained by Pt. or Staff While Pt. Restrained**

**Name of RN Who Initiated**

**Day of Restraint Initiated**

**Name of MD Who Initiated**

**Patient Care Manager Signature**

**REVIEW**

**03/11/99 03/12/99**
Document record of restraint use on unit/department restraint log (cont)

- Report to QMS via Hotline #4199 and Incident Reporting System and document on unit/department log:
  - Any death while in restraints, or
  - Within 24 hours of being removed from these restraints, or
  - Within 1 week after restraint or seclusion where it is reasonable to assume death was a direct or indirect result of restraint/seclusion use
**PHYSICIAN RESTRAINT/SECLUSION ORDER SHEET**

**Page 1 of 2**

<table>
<thead>
<tr>
<th>Violent/Self Destructive/Chemical Restraint (Behavior Restraint)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Restraint/seclusion may not be ordered PPN</strong></td>
</tr>
<tr>
<td><strong>Progress Notes</strong></td>
</tr>
</tbody>
</table>

1. **Assessment pertaining to need for restraint/seclusion**
   (includes precautions that place patient at greater risk):

2. **REASON**
   - [ ] Non-violent/non-destructive
   - [ ] Violent/Destructive

3. **TOP UP RESTRAINT**
   - [ ] Restraint
   - [ ] Seclusion *(Behavioral Health Unit)*

4. **RESTRAIN PATIENT WITH**
   - [ ] Locked restraint
   - [ ] Least Restrictive
     - [ ] 2-point
     - [ ] 4-point
     - [ ] 4-siders
     - [ ] Geri chair
   - [ ] Soft restraints
     - [ ] (1) arm
     - [ ] (1) leg
   - [ ] Chemical
   - [ ] Drug (Violent/destructive)

5. **As Appropriate**

6. **RATIONALE FOR RESTRAINT/SECLUSION**
   - [ ] Danger of injury to self/others (violent/destructive)
   - [ ] Risk for causing substantial property damage (violent/destructive)
   - [ ] Physician Signature

7. **A face-to-face evaluation conducted by a Licensed Physician within 24 hrs of initial order**

8. **Renew order once each calendar day**

9. **VIOLENT/SELF DESTRUCTIVE RERAINTS ONLY**
   - [ ] 4-hour (with behavioral conditions)
   - [ ] Adult 18 yrs & older
   - [ ] Child 0-17 yrs
   - [ ] 1 hour - children under 9 yrs

10. **Face to face exam by Physician or trained RN within 1 hour**
    - [ ] RN may perform reassessment in 4 hrs up to 8 hrs
    - [ ] The physician then conducts an in-person re-evaluation at least every 8 hrs for patients 18 and older and every 4 hrs for patients under 17

11. **Criteria for RN to discontinue behavior restraint**
    - [ ] Patient verbally contacts with staff to ensure safety to self/others
    - [ ] Patient is oriented/demonstrates ability to follow direction(s) for safety

12. **Notification of restraint use to the primary care physician or clinical psychologist**
    (if he/she not ordering physician)

13. **Order or contact Nutritional services for “Behavior Tray”**

14. **Removal of all objects in room that have potential for harm to self or others**

**Date/Time**

Physician Signature

EDU-1100 04/05/16

**Please remember to date, time and sign all orders**