

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

Behavior Levels/Staff Approaches

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

VERBAL ESCALATION

2. Refusal

- Non-compliance, slight loss of rationalization
- Set limits

VERBAL ESCALATION

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



Closer Look . . .



Non-violent/non-destructive restraint

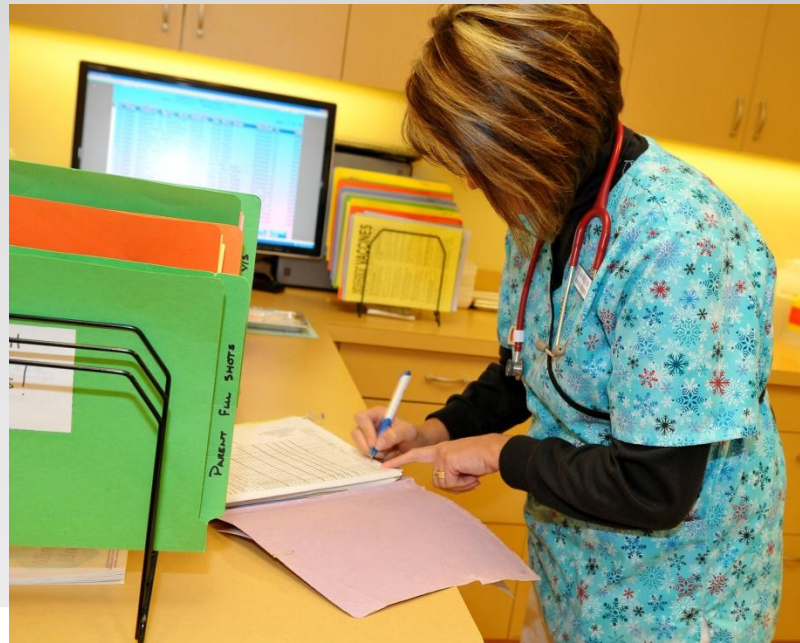
- Patient condition/behavior meets parameters:
 - Invasive line/tube in place
 - Patient attempts to pull line/tube observed
 - Patient confused/unable to redirect
 - Alternatives tried and failed
 - Ramsey score <3 24 hours post intubation or within 24 hours of weaning (CCU)

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

Restraint/seclusion may not be ordered PRN	Progress Notes
1. <input checked="" type="checkbox"/> Assessment pertaining to need for restraint/seclusion (includes precautions that place patient at greater risk)	<input type="checkbox"/> NON VIOLENT/NON SELF DESTRUCTIVE RESTRAINT assessment conducted within 24 hours of initial order
2. REASON: <input checked="" type="checkbox"/> Non-violent/Non-destructive <input type="checkbox"/> Violent/Destructive	Date 5/12/16 Time 0800
TYPE OF RESTRAINT: <input checked="" type="checkbox"/> Restraint <input type="checkbox"/> Seclusion * (Behavioral Health Unit)	Restraint indicated
3. RESTRAIN PATIENT WITH:	Patient observed pulling at tubes Is confused/unable to be re-oriented/re-directed
<input type="checkbox"/> Locked restraints Least Restrictive <input type="checkbox"/> 2-point <input type="checkbox"/> Mitts (2) <input type="checkbox"/> Freedom splints (2) <input type="checkbox"/> 4-point <input type="checkbox"/> 3-4 siderails <input type="checkbox"/> Gerichair	
<input checked="" type="checkbox"/> Soft restraints <input checked="" type="checkbox"/> (L) arm <input checked="" type="checkbox"/> (R) arm <input type="checkbox"/> Chemical <input type="checkbox"/> Drug: (Violent/destructive) Name of medication: _____	
4. RATIONALE FOR RESTRAINT/SECLUSION: <input type="checkbox"/> Danger of injury to self/others (violent/destructive) <input type="checkbox"/> High risk for causing substantial property damage (violent/destructive) <input checked="" type="checkbox"/> Attempts at removing lines, tubes, equipment observed, inability to be redirected (non-violent/non-self destructive)	Physician Signature Dr. Doolittle
<input checked="" type="checkbox"/> NON-VIOLENT/NON-SELF DESTRUCTIVE RESTRAINT <input checked="" type="checkbox"/> A face-to-face evaluation conducted by a Licensed Physician within 24 hrs of initial order <input checked="" type="checkbox"/> Renew order once each calendar day	
<input type="checkbox"/> VIOLENT/SELF DESTRUCTIVE RESTRAINTS ONLY: <input type="checkbox"/> 4 hours (Max. for behavioral conditions) Adults 18 years & older <input type="checkbox"/> 2 hours – ages 9-17 years <input type="checkbox"/> 1 hour – children under 9 years <input checked="" type="checkbox"/> Face to face exam by Physician or trained RN within 1 hour <input type="checkbox"/> RN may perform reassessment in 4 hrs up to 8 hrs <input checked="" type="checkbox"/> 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 <input type="checkbox"/> Criteria for RN to discontinue behavior restraint 1. <input type="checkbox"/> Patient verbally contracts with staff to ensure safety to self/others 2. <input type="checkbox"/> Patient is reoriented/demonstrates ability to follow direction(s) for safety <input checked="" type="checkbox"/> Notification of restraint use to the primary care physician or clinical psychologist (if he/she not ordering physician) <input checked="" type="checkbox"/> Order or contact Nutritional Services for "Behavior Tray". <input checked="" type="checkbox"/> Remove all objects in room that have potential for harm to self or others	<input type="checkbox"/> VIOLENT/SELF DESTRUCTIVE RESTRAINTS: Complete Physician/RN Assessment Criteria for 1 hr Face to Face
Date/Time	
Physician Signature	

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

Violent/Self-destructive/Chemical restraint (cont)

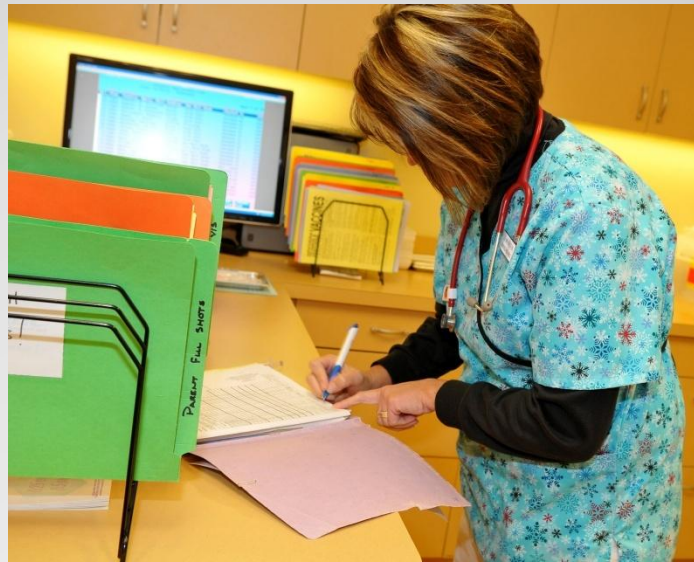
- Use of non-physical intervention skills, i.e. verbal redirection techniques, de-escalation, use of diversion activities, decreasing of stimuli, show of support and other alternatives attempted and failed

Violent/Self-destructive/Chemical restraint (cont)

- 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.



Violent/Self-destructive/Chemical restraint (cont)

- 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

Violent/Self-destructive/Chemical restraint (cont)

- 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

Violent/Self-destructive/Chemical restraint (cont)

- Debriefing
 - Occurs with patient and individuals involved within 24 hours of end of episode

Violent/Self-destructive/Chemical restraint (cont)

- Document record of restraint use on unit/department restraint log
 - Patient and family education provided

**JAMESON HEALTH SYSTEM
VIOLENT / SELF-DESTRUCTIVE RESTRAINT MONITOR
(Forward to D. Neurohr, South Administration by the 5th of each month)**

Affix Patient Label (One sheet per patient)	Type of Restraint	Date/Time Initial Order and MD Ordering	Date/Time Face to Face Evaluation Conducted by MD or trained RII within 1 st of initial order	Date/Time q 8 ^h reassessment by MD	Use of Psych Med as an alternative or to enable d/c	Notification of Family (Yes, No or N/A)	Pt. Family Education (Yes, No or N/A)	Care Plan Reflects Restraint Use	Initial RN Assessment and Monitoring Documentation Complete	Date/Time of Notification to Clinical Leadership if Episodes > 12 ^h	Date/Time notification of clinical leadership if 2 or more episodes	Date & Time of Restraint Removal	Debriefing Conducted ASAP but within 24 ^h of Episode	Death while in Restraints or within 24 ^h of Restraint episode / use	Day of Week Restraint Initiated	Name of RII Who Initiated	Injuries Sustained by Pt. or Staff while Pt. Restrained

RESTRAINT TYPE:
4L = Limbs/Locked
C = Chemical
S = Seclusion

VIOLENT /SELF-DESTRUCTIVE RESTRAINT USED:
To protect the patient against any injury to self or others because of emotional or behavioral disorder.
Patient behaviors exhibited are a danger to self or others.

Violent/Self-destructive/Chemical restraint (cont)

- 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

Violent/Self Destructive/Chemical Restraint (Behavior Restraint)

PHYSICIAN RESTRAINT/SECLUSION ORDER SHEET
Page 1 of 2

Restraint/seclusion may not be ordered P/N	Progress Notes
1. <input checked="" type="checkbox"/> Assessment pertaining to need for restraint/seclusion (includes precautions that place patient at greater risk).	<input type="checkbox"/> NON VIOLENT/NON SELF DESTRUCTIVE RESTRAINT assessment conducted within 24 hours of initial order
2. REASON: <input type="checkbox"/> Non-violent/Non-destructive <input checked="" type="checkbox"/> Violent/Destructive	Date _____ Time _____
TYPE OF RESTRAINT: <input checked="" type="checkbox"/> Restraint * <input type="checkbox"/> Seclusion * (Behavioral Health Unit)	
3. RESTRAIN PATIENT WITH: <input checked="" type="checkbox"/> Locked restraints Least Restrictive <input type="checkbox"/> 2-point <input type="checkbox"/> Mitts (2) <input type="checkbox"/> Freedom splints (2) <input checked="" type="checkbox"/> 4-point <input type="checkbox"/> 3-4 siderails <input type="checkbox"/> Gerichair <input type="checkbox"/> Soft restraints <input type="checkbox"/> (L) arm <input type="checkbox"/> (R) arm <input type="checkbox"/> Chemical <input type="checkbox"/> Drug: (violent/destructive) As Appropriate	
Name of medication _____	
4. RATIONALE FOR RESTRAINT/SECLUSION: <input checked="" type="checkbox"/> Danger of injury to self/others (violent/destructive) <input checked="" type="checkbox"/> High risk for causing substantial property damage (violent/destructive) <input type="checkbox"/> Attempts at removing lines, tubes, equipment observed, inability to be redirected (non-violent/non-self destructive)	Physician Signature _____
<input type="checkbox"/> NON-VIOLENT/NON-SELF DESTRUCTIVE RESTRAINT <input checked="" type="checkbox"/> A face-to-face evaluation conducted by a Licensed Physician within 24 hrs of initial order <input checked="" type="checkbox"/> Renew order once each calendar day	
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Date/Time _____	
Physician Signature _____	

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