CH USE OF RESTRAINTS

Summary:
Policy that defines the use of physical restraints for violent or self destructive behavior and non-violent behavior.

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<th>Effective Date:</th>
<th>2/20/2001</th>
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<td>Revision History:</td>
<td>7/20/2011, 5/1/2011;12/8/2010;5/31/10;8/22/07;3/20/06;2/22/06;3/10/05;2/20/05;8/05/04;3/08/04;2/09/03</td>
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<td>Facilities:</td>
<td>SJMC, SMMC</td>
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<td>Approved By:</td>
<td>SJ CNO; SM CNO</td>
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<td>Policy Impacts:</td>
<td>All Direct Patient Care Providers</td>
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Purpose

1. To protect the dignity and safety of inpatients, outpatients, staff, and visitors through safe restraint processes.
2. To identify patients at risk for restraint and provide alternatives to restraint use.
3. To provide guidelines for use of least restrictive interventions to avoid restraint use. To define the procedure to be followed when all alternatives have been exhausted and proven ineffective, and restraints are necessary to maintain patient safety.
4. To define staff training requirements related to safe processes. See appendix A.

Scope

This policy applies to all staff members, physicians, physician assistants and licensed independent practitioners involved in ordering, applying, and monitoring, assessing, and providing care for any patient in a restraint.

Responsibility

It is the responsibility of the hospital CNO or designee to disseminate this policy and its contents to all appropriate hospital employees and licensed independent practitioners and to ensure compliance.

Policy
1. This hospital strives to be a restraint free environment.
2. Seclusion will not be used at this hospital.
3. This hospital recognizes that all patients have the right to be free from physical or mental abuse, and corporal punishment.
4. Restraint use, of any form, will never be used as a means of coercion, discipline, convenience, or retaliation by staff.
5. Staff will ensure that patients are treated with dignity and privacy during periods of restraint.
6. Staffing levels and assignments shall be set to minimize circumstances that give rise to restraint use and to maximize safety when restraints are used.
7. Restraint use will not be based on an individual’s restraint history or solely on a history of dangerous behavior.
8. Restraints will only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member or others.
9. Restraint use will only be imposed upon receipt of appropriate physician orders, when needed to ensure the immediate physical safety of the patient, a staff member, or others and will be discontinued at the earliest time possible, regardless of the length of time identified in the order.
10. A protocol will not serve as a substitute for obtaining a physician’s or other Licensed Independent providers (LIP) order prior to initiating each episode of restraint.
11. Restraint use within the hospital is limited to those situations for acute medical and surgical care as a measure to prevent patient injury as well as to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.
12. The type or technique of restraint used will be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
13. Restraint orders will not be written or accepted as a PRN or standing order.

Exceptions:

**Raised Side Rails** – If a patient’s status required that all bed rails be raised, while the patient is in bed, a standing or PRN order is permitted. It is not necessary to obtain a new order each time the patient is returned to bed after being out of bed. Please see “Definitions” section below to determine whether the use of side rails is determined to be a restraint.

Definitions

**A restraint** is:

1. 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.

This restraint definition applies to **ALL** uses of restraint in **ALL** hospital care settings. Under this definition, commonly used hospital devices and other practices could meet the definition of restraint, such as:
A. Tucking a patient’s sheets in so tightly that the patient cannot move
B. Use of a “net bed” or an “enclosed bed” that prevents the patient from freely exiting the bed. EXCEPTION: Placement of a toddler in an “enclosed” or “domed” crib.
C. Use of “Freedom” splints that immobilize a patient’s limb
D. Using side rails to prevent a patient from voluntarily getting out of bed; or
E. Geri chairs or recliners, if the patient cannot easily remove the restraint appliance and get out of the chair on his/her own.

NOTE: Generally, if a patient can easily remove a device, the device would not be considered a restraint. In this context, “easily remove” means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff (e.g. side rails are put down, not climbed over; buckles are intentionally unbuckled; tied or knots are intentionally untied, etc.) considering the patient’s physical condition and ability to accomplish objective (e.g. transfer to a chair, get to the bathroom on time, etc.)

1. 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.

Drugs or medications that are used as part of a patient’s standard medical or psychiatric treatment, and are administered within the standard dosage for the patient’s condition, would not be subject to the requirements of this standard.

Criteria used to determine whether the use of a drug or medication, or combination of drugs or medications is a standard treatment or dosage for the patient’s medical condition includes all of the following:

A. The drug or medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters;
B. The use of the drug or medication follows national practice standards established or recognized by the medical community, or professional medical associations or organizations; and,
C. The use of the drug or medication to treat a specific patient’s clinical condition is based on that patient’s symptoms, overall clinical situation, and on the physician’s or other licensed independent practitioner’s (LIP) knowledge of that patient’s expected or actual response

Another component of “standard treatment or dosage” for a drug or medication is the expectation that the standard use of a drug or medication to treat the patient’s condition enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of the drug or medication.

A restraint does NOT include:
1. Orthopedically prescribed devices
2. Surgical dressings or bandages
3. Protective helmets
4. Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests
5. Methods that protect the patient from falling out of bed.

Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of the bed. When a patient is on a bed that constantly moves to improve circulation or prevents skin breakdown, raised side rails are a safety intervention to prevent the patient from falling out of bed and are not viewed as restraint.

The use of side rails in these situations protects the patient from falling out of bed and, therefore, would not be subject to the restraint requirements.

6. Methods that permit the patient to participate in activities without the risk of physical harm.
7. Devices used for postural support.
8. Adaptive devices or mechanical supports used to achieve proper body position, balance, or alignment to allow greater freedom of mobility.
9. Devices utilized for forensic or correction restrictions for security purposes (i.e. prisoner shackles such as leg-irons, handcuffs, etc.). Restraint use, related to the clinical care of a person under forensic or corrective restrictions does apply (i.e. prisoner patient requiring related to acute medical and surgical care as a measure to prevent patient injury as well as the use of restraint to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others).
10. Supportive/protective devices used during transportation via wheelchair or cart.

**Raised Side Rails**

1. When side rails are not used as a method to prevent the patient from falling out of bed, but instead, used to restrict the patient’s freedom to exit the bed, the use of side rails to prevent the patient from exiting the bed would be considered a restraint.
2. When the clinician raises all four side rails in order to restrain a patient, defined as immobilizing or reducing the ability of a patient to move his or her arms, legs, body, or head freely to ensure the immediate physical safety of the patient, the requirements of this policy apply.
3. If a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails for this patient would not be considered restraint because the side rails have no impact on the patient’s freedom of movement. In this example, the use of all four side rails would not be considered restraint. Therefore, the requirements of this policy would not apply.
4. When a patient is on a bed that constantly moves to improve circulation or prevents skin breakdown, raised side rails are a safety intervention to prevent the patient from falling out of bed and are not viewed as restraint.
5. When a patient is placed on **seizure precautions** and all side rails are raised, the use of side rails would not be considered restraint. The use of padded side rails in this situation should protect the patient from harm; including falling out of bed should the patient have a seizure.

**Procedure**

1. Restraint use in acute medical and surgical care as a measure to prevent patient injury (i.e.: non-violent/non-self destructive behaviors)

   **A. Indications:** Prior to the initiation and/or continued use of a restraint in acute medical and surgical care as a measure to prevent patient injury, the patient must be assessed in order to prevent interference with his or her treatment plan.

   1) Assessment for Risk for restraint:
      a. Does the patient have a medical device?
      b. Does the patient understand the need to not remove the device?
      c. Is the patient required to be immobile?
      d. Is the patient exhibiting aggressive, combative, or destructive behavior?
      e. Does this behavior place the patient/staff/others in immediate danger?

   **B. Consideration of less restrictive means:** Prior to the initiation and/or continued of a restraint, alternative means of protecting the patient will be considered and documented.

   1) Alternatives to Restraint
      a. Patients that are determined to be at risk for restraint will have alternatives initiated promptly. Appendix B contains a listing of alternatives to restraints.

   **C. Orders:** Restraint use will be initiated upon the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraints. The order for restraint will include the type of and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. The attending physician will be consulted as soon as possible if the attending physician did not order the restraint. When a LIP/physician is not available to issue a restraint order, an RN with demonstrated competence may initiate restraint use based upon face-to-face assessment of the patient. In these emergency situations, the order must be obtained during the emergency application or immediately (within minutes) after the restraint is applied.

   **D. Conversation with patient and/or the patient’s legal representative:** To the extent practical, the issue of restraint will be discussed with the patient and/or his/her legal representative around the time of its use. This education will be documented in the patient’s medical record.

   **E. Care Plan:** The patient’s care plan will be modified to reflect the need for restraint.
F. **Continuation of restraint orders:** The attending physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint will perform in-person assessments of a restrained patient at least once every calendar day, at which time restraint will either be reordered or discontinued as indicated. A restraint order must not exceed twenty-four (24) hours, and must specify clinical justification for the restraint. The physician order may be for a time period shorter than twenty-four hours.

G. **Early discontinuation of restraint:** Restraint will be discontinued as soon as it is no longer indicated by the patient’s actions or the nature of the patient’s treatment plan. Restraint may NOT be reapplied without a new order if the patient again meets the indications that justified the original restraint order. A “trial release” constitutes a PRN use of restraint and therefore is not permitted.

H. **Patient monitoring:** Patients in restraint will be monitored as often as necessary to assure safety and dignity and to attend to comfort needs. Patients will be assessed immediately after restraints are applied to assure safe application and will be observed at least every two hours to assure that restraint remains indicated, that restraining devices remain safely applied, and that the patient remains as comfortable as possible. Monitoring will be conducted by a physician, other licensed independent practitioner or a trained staff member that has completed restraint competencies.

I. **Documentation:** The following will be documented in the medical record whenever medical restraint is applied:

1) A description of the patient’s actions or condition that indicated the initial and/or continued use of restraint
2) The alternative or less restrictive interventions attempted
3) Physician orders for restraint
4) Physician orders for interventions used
5) Patient monitoring
6) Significant changes in the patient’s condition
7) An updated restraint care plan
8) Discussions and education with the patient and/or his/her legal representative (as appropriate) regarding restraint
9) Patient’s response to the interventions used, including without limitation, the rationale for continued use (if applicable)

2. **Restraint Use for the Management of Violent or Self-destructive Behavior that Jeopardizes the Immediate Physical Safety of the Patient, a Staff Member or Others**

   A. **Consideration of less restrictive means:** Prior to the initiation and/or continued use of restraint, alternative means of protecting the patient and others will be considered.

   B. **Orders:** Restraint use will be initiated upon the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized
to order restraints. The order for restraint will include the type of and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. If the need for restraint occurs so quickly that an order cannot be obtained prior to the application of restraint (emergency application situation), the order for restraint must be obtained either during the emergency application of the restraint, or immediately (within a few minutes) after the restraint has been applied. The restraint may only be renewed, with the following limits, for up to a total of 24 hours:

1) 4 hours for adults 18 years of age and older
2) 2 hours for patients between nine and 17 years of age; or
3) 1 hour for children under 9 years of age

J. **Conversation with patient and/or his/her legal representative**: To the extent practical, the issue of restraint will be discussed with the patient and/or his/her legal representative around the time of its use. This education will be documented, as appropriate.

K. **Care Plan**: The patient’s care plan will be modified to reflect the need for restraints.

L. **Discontinuation of restraint**: The restraint used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others will be discontinued as soon as it is no longer indicated by the patient’s behavior or the nature of the patient’s treatment plan, regardless of the length of time identified in the order. If restraint is discontinued prior to the expiration of the original order, a NEW order must be obtained prior to reinitiating the use of restraint or seclusion.

M. **Renewal of restraint orders**: After 24 hours, before writing a new order for the use of restraint for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint must see and assess the patient.

N. **Face to face assessment/evaluation**: Within 1 hour of application of a restraint for a patient who is exhibiting violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others, the patient must be seen face-to-face by a

1) Physician or other licensed independent practitioner, or
2) Registered nurse or physician assistant who has been trained in restraint use

During the face-to-face evaluation of the patient within 1 hour of initiation of restraint, the following will be evaluated:

1) The patient’s immediate situation
2) The patient’s reaction to the intervention
3) The patient’s medical and behavioral condition
4) The need to continue or terminate the restraint
If the face-to-face evaluation is conducted by a trained registered nurse or physician assistant, that individual will consult the attending physician or licensed independent practitioner who is responsible for the care of the patient as soon as possible after the completion of the evaluation.

O. **Patient Monitoring:** Appropriately trained staff will continuously observe patients in restraint due to violent or self-destructive behavior. Such monitoring will be documented at least every 15 minutes.

P. **Documentation:** The following will be documented in the patient’s medical record whenever restraints are applied for violent or self-destructive behavior:

1) A description of the patient’s actions or condition that prompted the initial and/or continued use of restraint
2) The alternative or less restrictive interventions attempted
3) Physician orders for restraint
4) Physician orders for interventions used
5) Patient Monitoring
6) Significant changes in the patient’s condition
7) An updated restraint care plan
8) Discussions and education with the patient and/or his/her legal representative (as appropriate) regarding restraint
9) Patient’s response to the interventions used, including without limitation, the rationale for continued use (if applicable).
10) The one hour face-to-face evaluation

2. **Staff Training Requirements**

All staff that has direct patient contact shall receive education and training in the proper and safe use of restraints during orientation and on an annual basis thereafter. Staff members shall receive training and demonstrate competency prior to applying restraints, performing associated monitoring and assessment of the restrained patient or providing care for a restrained patient. The patient shall be informed of the purpose of the restraint and the criteria for restraint removal. The patient’s family to the extent practical will be informed of restraint use and the criteria for removal.

A. In order to minimize to use of restraint, all direct care staff as well as any other staff involved in the use of restraints will receive ongoing training and demonstrate an understanding of:

1) When a device is considered a restraint and when it is considered part of a procedure
2) The possible alternatives to the use of restraint
3) Observed actions or behaviors that may warrant the need for restraint
4) Techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of a restraint
5) The use of non-physical intervention skills
6) The undesired and desired outcomes of restraint use
7) The patient’s rights in regard to restraint use
8) The safe application of restraint devices

B. Additional training is required for staff who apply, monitor, assess, and evaluate the patient in restraint and includes demonstrated competency and understanding of:

1) The physician orders and assessments requirements for patients in restraint
2) Choosing the least restrictive intervention based on an individualized assessment of the patient’s medical or behavioral status or condition
3) The documentation of the care and monitoring of the patient
4) Assessing respiratory status
5) Assessing skin integrity
6) Taking vital signs and interpreting their relevance to the physical safety of the patient
7) Recognizing nutrition/hydration needs
8) Checking circulation and range of motion in the extremities
9) Addressing hygiene and elimination
10) Addressing physical and psychological status and comfort, including recognizing and responding to signs of physical and psychological distress
11) Identification of specific behavioral changes that indicate that restraint is not longer necessary
12) Assisting patients in meeting criteria for the discontinuation of restraint
13) Recognition of the need to contact a physician to evaluate/treat the patient’s physical status.

C. Additional training is required for staff who care for, apply, monitor and evaluate patients in restraints because of violent, self-destructive behavior that jeopardizes the patient, staff members or others, including and understanding of:

1) The underlying causes of threatening behaviors exhibited by the patients they serve
2) Violent or self-destructive behavior that may be related to the patient’s medical condition
3) How their own behavior can affect the behaviors of the patients they serve
4) Recognizing readiness for the discontinuation of restraint

D. Training in First Aid and CPR

Staff will be trained and able to demonstrate competency in first aid techniques for patients in restraint who are in distress or injured. The patient populations will be assessed to identify potential scenarios and develop training to address those scenarios. For example, for patients who are found hanging in restraints, or a restrained patient choking? Staff will be trained and certified in the use of CPR.

E. Death Reporting Requirements
The hospital will report all deaths that occur under the following circumstances to CMS.

1) While a patient is in restraint
2) Within 24 hours after the patient has been removed from restraint
3) Within 1 week after restraint where it is reasonable to assume that use of restraint contributed directly or indirectly to a patient’s death.

“Reasonable to Assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

F. The CNO or designee will be notified of all deaths that occur under the circumstances listed above.

G. Each death referenced above will be reported to the CMS Regional Office, Division of Survey and Certification, by telephone no later than the close of business the next business day following knowledge of the patient’s death.

H. Staff will document the date and time the death was reported to CMS in the patient’s medical record.

CMS Regional Office

Region 7 – Kansas City

Richard Bolling Federal Building
601 E. 12th Street
Kansas City, MO 64106
Phone: Division of Survey and Certification (816) 426-2011

APPROVAL SIGNATURES: CH Standard Nursing Policy Signatures

See Appendix A&B That Follow
APPENDIX A: TRAINING REQUIREMENTS

A. **Direct Care Staff**
   Staff will demonstrate competency in the application of restraints. Training will be provided to all staff designated as having direct patient care responsibilities (the facility to list), including contract or agency personnel. In addition, if the hospital security guards or other non-healthcare staff (the facility to list) assist direct care staff, when requested in the application of restraint or seclusion, the security guards, or other non-healthcare staff (as defined by the facility) are also expected to be trained and able to demonstrate competency in the safe application of restraint. Training will occur:
   1) Before performing restraint application, monitoring, assessment and providing care for a patient in restraint or seclusion,
   2) As part of orientation, and
   3) On an annual basis to ensure staff possess requisite knowledge and skills to safely care for restrained patients.
   4) The results of skills and knowledge assessment, new equipment, or QAPI data may indicate a need for targeted training or more frequent or revised training.

B. **Staff who conduct the one hour face-to-face evaluation**
The purpose of the 1 hour face-to-face evaluation is to complete a comprehensive review of the Patient’s condition and determine if other factors such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis etc. are contributing to the patient’s violent or self-destructive behavior. Training for the RN or PA who conduct the 1 hour face-to-face will include:
   1) Application of restraints.
   2) Monitoring, assessment and providing care for a patient in restraint; including:
      a. The patient’s immediate situation
      b. The patient’s reaction to the intervention
      c. The patient’s medical and behavioral condition
      d. The need to continue or terminate the restraint

C. **Physicians and other LIPs authorized to order restraint**
   Physicians and other LIPs authorized to order restraint will receive a copy of the CH restraint policy and be expected to comply with the requirements on the use of restraints. Physicians will receive a copy of the policy and orders upon new and reappointment applications.

D. **Individuals providing training** will be qualified as evidenced by education, training, and experience in techniques used to address patients’ behaviors for the populations served. In addition these individuals will demonstrate a high knowledge regarding all the requirements as set forth in this policy and procedure. There will be documentation to ensure that the individuals providing education and training have the appropriate qualification required.

APPENDIX B: ALTERNATIVES TO RESTRAINT
A. **Psychosocial Alternatives**
   - Diversion
   - Family interaction
   - Orientation
   - Pastoral visit
   - Reassurance
   - Reading
   - Relaxation techniques
   - Interpreter services
   - Personal possessions available
   - Quiet area
   - One-on-one discussion
   - Decreased stimulation
   - Change in environment
   - Re-establishing communication
   - Setting Limits

B. **Environmental Alternatives**
   - Commode at bedside
   - Decreased noise
   - Music/TV
   - Night light
   - Room close to nursing station
   - Call light within reach
   - Bed alarm in use
   - Specialty low bed
   - Sensory aids available (glasses, hearing aid)
   - Decreased stimulation
   - Providing a quiet area
   - Physical activity
   - Orientation

C. **Physiological Alternatives**
   - Toileting
   - Fluids/nutrition/snack
   - Positional devices
   - Pain intervention
   - Assisted ambulation
   - Re-positioning
   - Rest/Sleep
   - Providing assistance
   - Additional warmth
   - Decreased temperature
   - Check lab values