CH RERAINTS: PHYSICAL/BEHAVIORAL

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

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<tr>
<th>Effective Date:</th>
<th>2/21/2001</th>
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<tbody>
<tr>
<td>Revision History:</td>
<td>6/01/10, 8/22/07;3/20/06;2/22/06;3/10/07;8/05/07;11/08/04;9/21/04;8/05/04;3/08/04;2/09/03</td>
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<tr>
<td>Facilities:</td>
<td>SJMC, SMMC</td>
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<tr>
<td>Approved By:</td>
<td>SJMC CEO; SMMC CEO; VP Clinical Excellence</td>
</tr>
<tr>
<td>Policy Impacts:</td>
<td>All Direct Patient Care Providers</td>
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</tbody>
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POLICY:

Carondelet Health seeks to provide an environment that reduces or eliminates the use of restraints. Alternatives are used, if possible, prior to the use of physical restraint. If physical restraints are necessary, clinical justification is documented and restraints are removed at the earliest possible time. Periodic assessment of the patient in restraints is made to reassess the clinical reason for the continued use of the restraint, if applicable and to protect and preserve the patient’s health, safety, dignity, and well being. Risks associated with vulnerable patient populations, such as; patients with a history of sexual or physical abuse, patient’s with possible ethnic, gender or age issues, and emergency, pediatric, cognitively impaired or physically limited patients, are assessed as well.

Education of staff regarding the organization’s approach to restraint use, policies, procedures and application of restraints is provided during the orientation process. Annual education is provided to maintain staff awareness and competency.

CH does not permit the use of seclusion which is the involuntary confinement of a patient alone in a room or area from where the person is physically prevented from leaving.

Definition: A restraint is defined as 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. Any drug 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 such as Ativan included in the Alcohol Withdrawal protocol, is 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 exams or tests are not restraints. Devices used to protect the patient from falling out of bed are not considered restraints. Devices used to permit the patient to participate in activities without the risk of physical harm are not considered restraints.

PROCEDURE:

1. Prior to using physical restraint, an attempt must be made and documented to use an alternative method to physical restraint. If physical restraints are determined to be necessary, because alternative measures to restraint are inapplicable, unsuccessful and/or the patient’s safety cannot be maintained, the least restrictive method of effective restraint should be used, based on the clinical judgment of the licensed healthcare provider. The method of restraint will be determined by assessment and monitoring of the patient, the patient’s prior experience with restraints and by the need for patient and staff safety. The hospital does not permit restraint or seclusion for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.

2. Appropriate physical restraint shall be initiated by a nurse, as determined by patient action or behavior, after receiving a physician’s written or verbal order. If restraint is applied prior to notification of physician, the RN must contact attending physician as soon as possible to obtain the order. The reason for the use of restraints, and an explanation of alternative measures to restraint, should be explained to the patient and, if possible or applicable, family members or significant others. The verbal or written order must indicate the reason for restraint, the type of restraint and the time limit for restraining the patient. The attending physician must be notified as soon as possible if the attending physician did not order the restraint. A physician order is not required when a patient is in disciplinary restraints under police custody.

Restraints used for nonviolent behavior

3. A restraint order is applicable and must be reordered every calendar day after an evaluation by the physician using the approved restraint order form. (See the “Physical Restraint Order Sheet”, attached to this policy, or print it from the CNET Standing Orders.)

4. The restrained patient will be monitored, assessed and re-evaluated by direct observation every two (2) hours. Evaluation of the patient will include assessing circulation as appropriate, providing for hydration and toileting needs and assessing overall safety. This includes the patient in disciplinary restraints under police custody. Patients in disciplinary restraints must have a law enforcement officer present at all times. Assessments are documented in the “Restraint Documentation Interventions” (which is located on the Meditech Intervention Screen).
Such documentation shall include observations of the patient and care given to meet his/her physical needs. Those areas that are not computerized shall use approved documentation forms. This includes the patient in disciplinary restraints under police custody.

6. An improvement in patient behavior or actions may indicate that the patient may be released from the physical or chemical restraint. The patient’s behavior must be assessed and documented. A nurse or physician will make the decision to release the patient from physical restraints. (If reapplication of restraints is necessary, based on patient behavior or safety concerns, a new restraint order is required.) A law enforcement officer is the only individual authorized to remove/release the restraints of a patient being held in police custody. If the restraints interfere with the care of a patient being held in police custody, the nursing staff will address the issue to the responsible law enforcement officer.

7. The use of side rails for the purpose of preventing patient falls is not considered a restraint. Four side rails up on patient beds with mattresses that move to prevent pressure ulcers and used to keep patient from falling out of bed is not considered a restraint.

The use of all four side rails up to prevent the patient from exiting the bed and not meeting conditions outlined above is considered a restraint and requires a physician order for restraint.

RESTRAINTS FOR VIOLENT OR SELF DESTRUCTIVE BEHAVIOR

1. Restraints ordered for violent or self destructive behavior require an order within one hour of initiation of the restraint with an assessment by a physician, Licensed Independent Practitioner or RN trained to assess and order restraints.(RN who has completed education program for restraint ordering) See Attachment A – Restraint Designated RN Competency Checklist.

2. If trained RN will be completing the initial assessment within the 1st hour, the following procedure will be followed:
   - RN or security officer will notify the house supervisor/nursing office that restraints are being applied for violent/self destructive behavior.
   - Supervisor will identify a restraint trained RN on duty to perform the initial one hour assessment.
   - RN designated to complete initial restraint assessment will document the following information in the physician progress note:
     - Patient behavior exhibited, alternative measures attempted, type of restraint applied (must be least restrictive per policy)
   - Restraint designated RN will coordinate with patient’s attending nurse – regarding who will notify physician and obtain the telephone order for restraint.

2. Restraints applied for violent or self destructive behavior are limited to a four (4) hour time limit for adults 18 years of age or older and a two (2) hour limit for children and adolescents 9-17 years of age, and a one (1) hour for patients under nine years of age.
3. A restraint order must be renewed by physician written order or telephone order every four (4) hours for adults 18 years of age or older and every two (2) hours for children/adolescents 9-17 years of age and one (1) hour for patients under nine (9) years of age.

4. The physician shall conduct an in-person re-evaluation of the patient’s physical and psychological status and need for continued restraint every 24 hours (must occur within 24 hours).

5. The patient restrained for violent or self-destructive behavior will be monitored, assessed and evaluated by continuous observation with documented assessments every 15 minutes.

6. When a restraint is removed or released before the time-limited order expires, a new order is required if there is a need to reapply the restraint.

RESPONSIBLE PERSONS:
All physical restraints must be applied, monitored and removed by competent, trained staff. Forensic staff (Security Officers) may assist in the application of restraints.

Note: Restraint devices will be secured to the bed, or chair, so as not to cause excessive stress or pressure on the patient. If knots are used they will be tied so as to permit quick release; the use of quick release devices is also permitted.

NURSING ALERT:

- If the patient must be restrained in supine (lying down, face up) position, the patient’s head must be free to rotate to the side and, when possible the head of the bed should be elevated to minimize the risk of aspiration.
- If the patient must be restrained in a prone (lying down, face down) position, the airway must remain unobstructed at all times.
- Never place towel, bag or other cover over patient’s face as part of therapeutic hold process.

RESTRAINT DEATH REPORTING
In the event that a patient dies while in restraint (including physical or chemical restraint), CMS will be notified according to CMS death reporting guidelines. Reportable deaths include patients who died while in restraints, were restrained any time during the 24 hours immediately preceding death, or were restrained within one week prior to death and where it is reasonable to assume that use of restraint contributed directly or indirectly to the patient’s death.

Procedure:

1. The RN caring for patient at time of death will review the patient medical record to determine if restraints were used at any time in the 7 days prior to death and answer restraint question on death report form accordingly.
2. If restraints were in use according to the criteria on the CH death report form, the Nursing Supervisor/RN will complete the Hospital Restraint Death Report Worksheet. If death was a result of restraints, notify immediate supervisor/house supervisor who will in turn notify risk management as needed based on event review (see Sentinel Event policy).

3. The Nursing Supervisor/RN will fax the worksheet to CMS immediately after the time of death. The CMS fax number is located on the worksheet.

4. The form will be faxed no later then the close of business the day after the patient’s death. For a death occurring on a weekend, the close of the next business day is Monday, unless that day is a holiday, then the following business day.

5. The Nursing Supervisor or designee will print fax verification, staple it to original worksheet, and place both on the chart with a copy being placed in the Nurse Manager/Director mailbox.

6. The Nurse Manager/Director will verify that worksheet was completed and faxed to CMS.

7. The Nurse Manager/Director will submit copy of the CMS reporting tool to the CH Risk Department and complete an incident report if patient died while in restraints or if patient was in restraints within seven (7) days prior to death and restraints are thought to have contributed to the death.

**ALTERNATIVE MEASURES TO RESTRAINT**

**Providing companionship and supervision**
Family, friends or volunteers should be asked to stay with the patient. Determine when the patient needs one-to-one attention (typically at night) and intervene accordingly.

**Changing or eliminating bothersome treatments.**
Initiate oral (as opposed to IV or NG) feedings, when possible.
Remove catheters and drains as soon as possible.

**Modifying the Environment.**
Increase or decrease the amount of light in the room, depending on glare and the patient’s preference or needs.
Activate bed alarms.
Reduce environmental noise.
Keep the call button accessible.

**Reality Orientation and Psychosocial Interventions.**
Involve the patient in conversation.
Explain procedures to reduce fear and convey a sense of calm.
Provide reality links when appropriate (TV, radio, calendar, clock).
Use relaxation techniques (therapeutic touch, massage, and warm baths).
Use active listening to elicit the patient’s feelings.

**Offering Diversionary and Physical Activities.**

Use TV, radio, and music for diversion (depending on the patient’s
cognitive capacity and individual preferences)
Provide exercise and ambulation whenever possible.
Involve in activities of daily living.
Use physical and occupational therapists to help the patient increase his
strength and endurance and feel a sense of accomplishment.
Use music chosen specifically for the patient to reduce agitation or
to provide diversion.

**APPROVED BY: CH STANDARD POLICY SIGNATURES**

See Attachments that follow

**ATTACHMENT A: RESTRAI NT RN COMPETENCY CHECKLIST**
**Restraint-designated RN Competency Checklist:**
**Restraints for Violent/Self-destructive Behavior**

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<thead>
<tr>
<th>Requirements</th>
<th>Original Completion Date</th>
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<tr>
<td><strong>Current BCLS</strong> (Renew every 2 years)</td>
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<tr>
<td><strong>Current Competency Cruise</strong> (Renew annually)</td>
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<tr>
<td><strong>Crisis Prevention &amp; Intervention Training (CPI)</strong> (Update every 2 years)</td>
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<tr>
<td><strong>Dealing with Difficult Patient Behavior Training</strong> (Review every 2 years)</td>
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<tr>
<td><strong>CH Restraint Policy</strong> (Review annually)</td>
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<tr>
<td><strong>Restraint Documentation Training</strong> (One time only, update if changes)</td>
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Name: _________________________________ Title: __________________

Signature: ___________________________ Date: ________________

**Attachment B: RESTRAINT STANDING ORDER**

- Initial application of restraint
Continuation of current restraint (renewal required each calendar day for nonviolent restraints; renewal required within 24 hrs for violent and/or self destructive patient)

### Non-Violent (Physician face to face assessment / renew each calendar day)

1. **Reason for Restraint (Non-Violent):**
   - Apply restraints for: (check all that apply)
   - Compromised medical treatment
   - Physical safety of patient, staff or others
   - Patient confused
   - Attempted alternatives to restraint use are unsuccessful

### Violent (Physician face to face assessment renew every 24 hours)

1. **Reason for Restraint (Violent or Self-destructive):**
   - Patient exhibiting violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.
   - Per guidelines, physician will be called every four hours for renewal (to be signed, dated, and timed below).

### 2. Patient Behavior/Assessment

- (Check all that applies): Patient has been assessed as a potential injury to self for the following reasons: patient confused or otherwise unable to follow instructions, AND one or more of the following (check all that apply):
  - Patient persists in efforts to disconnect medical equipment
  - Patient is combative, agitated, or thrashing in a manner and setting that could result in injury
  - Patient picking at surgical/wound dressings in a manner that could compromise healing
  - Movements are compromising alignment, lines, or essential therapies/treatments
  - Other (specify)

### 3. Nursing to utilize most effective, least restrictive type of restraint after attempting alternative methods.

### 4. If restraint initiated by RN prior to physician face to face evaluation, notify the primary physician as soon as possible if the primary physician did not order/sign the restraint order.

I have examined the patient and have determined that the use of restraint is clinically justified. **Designated RNs may assess/order restraints for violent/self destructive behavior within 1st hour only. Additional orders require physician order.**

**RENEWAL ONLY FOR VIOLENT/SELF Destructive Behavior ONLY**

Orders for restraints for violent and/or self-destructive behavior must be renewed every 4 hrs.

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<th>Every 4 Hour Order:</th>
<th>Date/Time:</th>
<th>Physician:</th>
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Physician must co-sign each telephone order taken by RN.