RESTRAINT/SECLUSION OF PATIENTS

ADMINISTRATIVE POLICY I-14

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RESTRAINT/SECLUSION OF PATIENTS
PATIENT CARE SERVICES

I. PURPOSE: The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. The decision to use a restraint is driven by a comprehensive individual assessment. This document is used to provide consistent guidelines for the safe use of chemical and physical restraints and seclusion, if alternatives have proven to be clinically ineffective to provide a safe environment for the patient. Guidelines for patient/family education and staff training/competency are included.

II. DEFINITIONS:

A. Physical Restraints: Any manual method or physical/mechanical device that restricts freedom of movement or normal access to one's body, material, or equipment that the patient cannot easily remove. Side rails are considered a physical restraint unless specifically requested for use by the patient or when used in the process of transporting the patient from one location to another either by stretcher or by bed.
B. Chemical Restraints: Drug used as a restraint; a medicine used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.
C. Positioning or Securing Devices: Used to maintain the position and/or immobility of a patient during invasive procedures; not considered restraints. Items used during diagnostic, or therapeutic treatment that intentionally restrict freedom of movement, under direct observation by the clinician are not considered restraint.
D. Voluntary Mechanical Support: Used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support, not generally considered restraints.
E. Restrictive Devices Applied by Correction Authority: Handcuffs and other restrictive devices applied by correction authority for custody, detention, and public safety reasons and is not involved in the provision of health care; not considered restraint/seclusions.
F. Seclusion: Involuntary confinement of a person in a room or an area where the person is physically prevented from leaving and is separated from others.

III. GENERAL PROCEDURES:

A. Assessment of risk factors, interventions and alternatives to restraint and/or seclusion use
    1. A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint/seclusion are outweighed by the risk of not using it. The use of an anatomical, physiological, and psychological assessment for risk factors by the RN and/or the physician facilitates the limited, justified use of restraint/seclusion and/or seclusion. Planning for, that is, being

proactive rather than reacting to, the patient's behavior protects the patient's health and safety and allows for the implementation of preventive strategies that would be of the greatest benefit to the patient.

2. Prevention of Physical Restraint/seclusion--Preliminary efforts should be directed to assessing the source of the behavior and take steps to alleviate the problem. Do not overlook simple solutions. Often a patient's behavior can be subdued by addressing their needs.
3. Possible physiological sources of behavior:
   a. Medication changes/drug interactions
   b. Oxygenation levels
   c. BUN/creatinine levels
   d. Sedation/anesthesia effects
   e. Abnormal laboratory values
   f. Uncontrolled pain
   g. Alcohol and/or drug withdrawal
   h. History of anxiety or mental health issues
4. Possible reasons for behavior:
   a. Comfort level
   b. Loss of control in hospital
   c. Fears and anxieties
   d. Level of satisfaction with care
   e. Environment
5. Factors to consider as part of the assessment include, but are not limited to:
   a. Disorientation to person, place, or time
   b. Memory disturbances
   c. Fluctuating levels of awareness
   d. Alteration in sleep/wake cycle
   e. Perceptual disturbance
   f. History of sexual/physical abuse
6. The following causative factors also should be considered as part of the assessment:
   a. Pain or other physical discomfort
   b. Types and/or combinations of medications to determine if any may be contributing to the behavior
   c. Types and/or combinations of treatment modalities
   d. Physiological changes that may be causing or contributing to the altered behavior patterns such as oxygen perfusion, blood glucose changes, blood chemistry, etc.
7. Attempts should be made to evaluate and use the following interventions/ alternatives when possible and in response to the patient’s assessed needs:
   a. Monitoring
      Companionship; staff or family stay with patient
      1) Room near or visible from nursing station
      2) Close, frequent observation
   b. Environmental measures

1) Decrease stimulation; quiet surroundings, appropriate lighting, relaxing music
2) Call light accessible at all times
3) Orientation of patient to surroundings
4) Occupied bed in low position with brakes locked
5) Room/halls clear of obstacles such as excess equipment
6) Use of bed check alarm device
7) Availability of bedside commode
8) Familiar possessions, photographs, etc.

c. Comfort measures
1) Address pain management or other sources of physical discomfort
2) Comfortable positioning and clothing, keeping patient clean and dry
3) Reduce noise and avoid waking up patient during periods of sleep, if possible
4) Gentle touch, soothing voice

d. Interpersonal skills
1) Pleasant, consistent interaction with patient and family
2) Actively listen to patient, calm reassurance
3) Verbal de-escalation by redirecting the focus

e. Diversional activities
1) Distract patient with videos, TV, photographs, reading materials; engage in conversation
2) Purposeful activity i.e. puzzles or sorting
3) Provide alternative activity for hands i.e. rubber ball, squeezing devices, etc.
4) Sensory Aides: Be sure patient has and is using eyeglasses, hearing aides as appropriate
5) Provide alternative system for sensory deficiencies, if needed

f. Medication/nutritional
1) Implement any interventions necessary to assist in adjustment of treatment to stabilize physiological changes by notifying the physician
2) Discontinue all lines that may no longer be medically necessary and initiate oral as opposed to IV or NG feedings

B. Least Restrictive Restraint/Seclusion/Safe Application (listed in the order of the least restrictive): Assessment and reassessment processes should include the appropriateness of the choice of restraint/seclusion and/or seclusion. Physical restraint/seclusions will be loosened at least every two hours to evaluate skin integrity and circulation. The types of restraint/seclusion devices available within this facility, in the order of less restrictive to more restrictive, and how to apply safely is as follows:

1. Side Rails (least restrictive): All 4 side rails or 2 full-length rails = restraint/seclusion; 2 half rails are not considered restraint/seclusion; side rails on specialty beds are not considered restraint/seclusion as they relate to positioning
2. Roll or Soft Belt: Lay the belt horizontally across the bed, the soft flannel side up and the back pad in the middle. Secure the short strap to the movable part of

the bed frame, with quick release ties at waist level, out of the patient's reach. Bring the long strap over and around the patient's waist and back behind the patient through the slot in the back pad. Secure the long strap to the movable part of the bed frame out of the patient's reach with quick-release knots. In order to ensure that the straps do not interfere with breathing, you should be able to slide your open flat hand between the device and the patient.

3. Mittens (1-2 mitts): Slide the restraint mitt over the patient's hands with the ties on the posterior side of the hand. Secure the strap around the wrist to hold the unit in position on hand. After the hand has been secured in the mitt, the strap ends must be secured to the bed frame, wheelchair frame, or secure part of the appliance on which the patient has been placed, out of patient's reach with a quick release knot.
4. Limb Restraint (1-, 2-, 3-, 4-point): Place the strap ends through the open slot in the wrist or ankle restraint/seclusion cuff and pull snug around the wrist or ankle. Tie the straps to the bed frame, wheelchair frame, or any secure part of the appliance on which the patient has been placed. The straps must be secured out of the patient's ability to reach the ties.
5. Vest Restraint: Place vest with slits in back. The vest restraint/seclusion should always be crisscrossed in back. Pass strap through slit/or loop to secure. When the patient is fitted correctly, the restraint’s side seam will not move more than two inches forward or backward. Depending on the style, either: secure waist straps to the bed frame, or, if the bed is adjustable, secure the straps to the wheelchair, secure straps to kick spurs.
6. Chemical Restraint: A drug used as a restraint is a medication used to restrict the patient's freedom of movement in medical-post surgical situations or for the emergency control of behavior and is not a standard treatment for the patient's medical or psychiatric condition.
7. Leather Restraint (most restrictive): Leather restraints are utilized for the shortest possible duration in situations where patients are exhibiting extremely violent behavior. Lesser alternatives should be immediately evaluated in conjunction with other interventions to assist in keeping the patient from harming themselves or others.
    a. Leather cuff restraint/seclusion (also called tough cuff): Place cuff snugly around wrists or legs. Apply padding as needed. Put strap through metal hook on cuff. Secure strap to bed frame.
    b. Leather arm and leg restraint: (1 piece). Assemble equipment. Place restraint on bed, at level of patient's wrists and legs. Secure leather strap to bed. Apply cuffs snugly around wrists and legs. Apply extra padding, if indicated. Put straps through metal hook on cuff and secure.
8. Seclusion: Seclusion is the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving. As appropriate, change the patient into a hospital gown, search area where patient will be confined looking for possible points of injury, etc. Remove all jewelry and process as noted in the Patient Belongings policy and procedure. Remove eyeglasses, dentures, contacts, etc. Secure safely.

C. Introduction to Behavioral and Non-Behavioral

Behavioral Health

1. Acts of, or imminent potential for, violence to self or others, documented by:
2. Physical threats of harm to self/others
3. Suicidal or homicidal behavior
4. Already restrained pts. Resisting restraints, posing potential injury to self or others
5. May include acting out behavior or secondary dementia complicated by a mood disorder or psychosis, or delirium

Non-Behavioral Health

1. Medical indication with patient lacking decision-making capacity.
2. Any other conditions where safety/well- being is in jeopardy.
   * Disorientation to person, place or time
   * Memory disturbances
   * Fluctuating levels of awareness
   * Alteration in sleep/wake cycle
   * Perceptual disturbance
3. May include detoxification (known ETOH or drug use), CVA, ventilator management, invasive tubes or lines, electrolyte imbalance, Alzheimer's, OBS, seizure (post-ictal).

Traumatic Brain Injury

1. Does patient have known documented traumatic brain injury?
2. Has patient been involved in recent traumatic event (e.g., MVA)?
3. Does patient display signs/symptoms consistent with post concussive syndrome (agitation, confusion, or posing injury to self)?

D. Procedure for Behavioral Use of Restraint/Seclusion

1. Authorization and ordering of restraint/seclusion
   a. The physician gives the order only when less restrictive measures have been found to be ineffective to protect the patient or others from harm
   b. In an emergency situation, hospitals may authorize a qualified registered nurse trained in the use of seclusion/restraint to initiate the seclusion/restraint. As soon as possible, and not to exceed one (1) hour, an order must be secured from a physician or licensed independent practitioner
   c. Verbal or written orders for seclusion or restraint are limited to:
      1) 4 hours for adults > than 18 years
      2) 2 hours for children and adolescents ages 9 to 17
      3) 1 hour for children under age 9
   d. The patient is re-evaluated as follows:
      1) Every 4 hours for adults ages 18 and over
      2) Every 2 hours for children and youth ages 9 to 17
      3) Every 1 hour for children under age 9
   e. Staff must use the behavioral criteria for release from seclusion or restraint stated in the order to ensure the seclusion/restraint is ended at the earliest possible time

2. Observation/Monitoring of the Patient
    a. The intent of monitoring the patient is two-fold. First, monitoring evaluates the well being of the patient and the continued protection of their rights and dignity
    b. Examples would include monitoring whether the patient is comfortable, too warm or cold, needs fluids, and whether his/her circulation is constricted. Second, monitoring evaluates the behaviors that precipitated the use of seclusion/restraint to determine whether the behavior is still present. This evaluation is used to decide whether restraint/seclusion is still required to protect the patient or others or whether the behavior has subsided and early release or a less restrictive method is now appropriate.
    c. A patient in seclusion OR restraint must be continually assessed, monitored, and reevaluated, with the goal being the release of the patient at the earliest possible time. Monitoring is defined as observation, and direct, face-to-face interaction with the patient. Patients will be monitored every 15 minutes by a qualified staff member and assessed by an RN at least every one hour
    d. As appropriate to the type of restraint/seclusion, physical monitoring of the patient includes the following: monitoring of circulation, color, and temperature of the extremities, nutrition/hydration, vital signs, hygiene/elimination, physical/psychological comfort, readiness for discontinuance and proper application of the device used.
    e. Relief periods for patients in seclusion or restraint/seclusions must occur, except when precluded for safety reasons (in which case the reason must be documented). Patients must be given relief periods every two hours at which time they should be offered the use of the bathroom, fluids, and/or nourishment. Relief periods must also be documented. If relief periods are not given, document why; i.e., "Patient asleep".

E. Non-Behavioral Use of Restraint/Seclusion

1. Procedure for authorization and ordering of restraint/seclusions
    a. Restraint/seclusion is used upon the order of a physician. If a physician is not available to issue such an order, restraint/seclusion use is initiated by a registered nurse based on an appropriate assessment of the patient. In that case, a physician is notified within 12 hours of the initiation of restraint/seclusion and a verbal or written order is obtained from that physician and entered into the patient's medical record. If the initiation of restraint/seclusion is based on a significant change in the patient's condition, the registered nurse immediately notifies the physician. A written order, based on an examination of the patient by the physician, is entered into the patient's medical record within 24 hours of the initiation of restraint/seclusion
    b. Continued use of restraint/seclusion beyond the first 24 hours is authorized by the physician renewing the original order or issuing a new order if restraint/seclusion use continues to be clinically justified. Such renewal or

new order is issued no less often than once each calendar day and is based upon an examination of the patient by the physician.

2. Patient needs/monitoring: All restrained patients are to be monitored by qualified staff at least every 2 hours or more frequently as warranted by patient condition for the following:
   a. Signs of injury associated with the restraint/seclusions or seclusion
   b. Nutrition/hydration
   c. Circulation and range of motion in the extremities
   d. Hygiene and elimination
   e. Physical and psychological status and comfort i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well-being
   f. Readiness for release from restraint/seclusions

E. Early release:

The patient will be assessed for possible early discontinuation of restraint/seclusion use.

a. If the individual is given a trial release period and the clinical justification that required the use of restraint/seclusion reoccurs within the time period of the order, the restraint/seclusions can be reapplied without obtaining a new order.
b. The behavior that is present and the ineffective alternatives that were attempted is documented in the patient care record.
c. The time limit of the original order remains unchanged
d. At the completion of the time limit for the order, the guidelines for the continuation of the use of restraint/seclusions will be followed
e. Documentation will include the criteria present for release.