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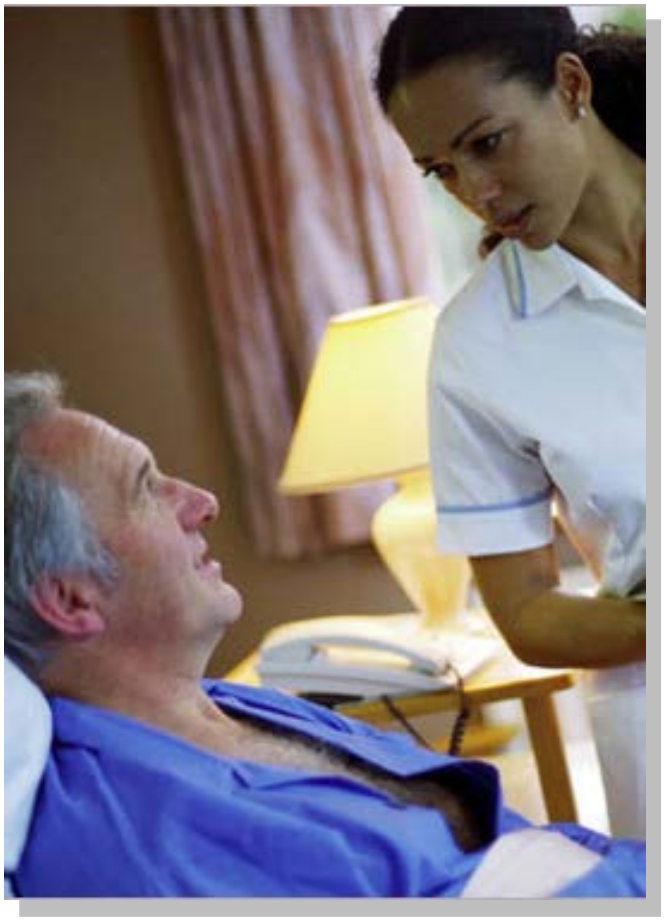
NCAL PCS

Patient Restraints for the RN

2016



Created by:
National Patient Care Services Kaiser Permanente, 2010

Revised 2013 by NCAL based on policy changes; reviewed/revised January 2016

Patient Restraints

Course Objectives

By the end of this course, you should be able to:

1. Differentiate between restraint for non-violent, non-self-destructive behavior and restraint for the management of violent, self-destructive behavior.
2. Describe Kaiser Permanente's general policy regarding restraints.
3. Identify the key steps to follow for the application of restraints.
4. Describe safe and appropriate restraint application techniques.
5. Recognize and respond to signs and symptoms of physical and/or psychological distress due to the use of restraints.
6. Indicate when to discontinue the use of restraints.
7. Identify your hospital's documentation requirements for restraints.
8. Define outside agencies' reporting criteria for restraint patients.

This course outlines Kaiser Permanente restraint policy. Be sure to familiarize yourself with the NCAL PCS Restraint Policy located through your local facility's Policy & Procedure web page.

Patient Restraints

Definition of Restraint

A restraint:

- Immobilizes or reduces the ability of a patient to freely move his or her arms, legs, body, or head.
- Can be applied manually, physically, or mechanically, with material or restraint equipment.
- Can be one of two categories of restraints:
  - restraint for *non*-violent, *non*-self-destructive behavior **or**
  - restraint for the management of violent, self-destructive behavior.
- A device or medication may or may not be considered a restraint depending on how it is used.
- Each situation in which a device or method is used to immobilize or reduce the ability of the patient to freely move his or her arms, legs, body, or head must be evaluated on a case-by-case basis to determine if the device or method is a restraint.

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Patient Restraints

Definition of Restraint

Examples of when a device is

NOT a RESTRAINT

Medical Immobilization	Adaptive Devices
• Arm board for IV stabilization • Temporarily holding patient for a consented procedure • Patient immobilized during MRI, surgery, or procedure	• Torso support belt • Orthopedic devices • Table top chair

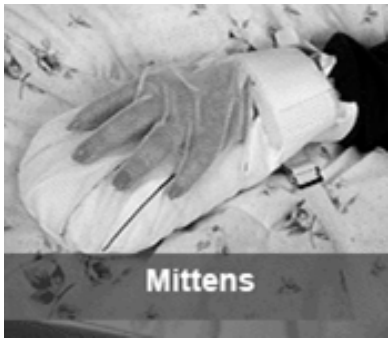
Protective Devices
• Side rails used to prevent a patient from sliding or falling out of bed e.g. recovering from anesthesia, specialty bed that constantly moves to improve circulation • Gurney rails or wheelchair belt used during transport • Crib used for an infant or toddler and age appropriate • Net over crib for active toddler • Helmet • Velcro belt in chair used as a reminder and patient can remove it

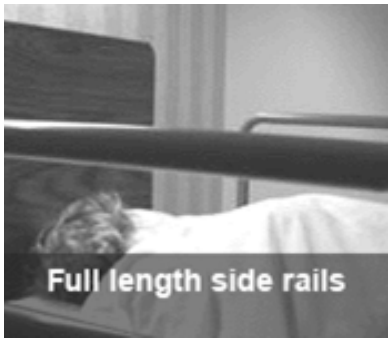
Corrections Restrictions	Pediatric Applications
Law enforcement devices for security purposes (e.g. handcuffs)	Therapeutic holding, comforting

Types of Restraints

Restraint for Non-Violent, Non-Self-Destructive Behavior:

- Used to ensure the physical safety of the non-violent, non-destructive patient who is interfering with necessary medical and/or nursing care (pulling needed lines/tubes) or compromising safety (high fall risk), when alternative interventions are unsuccessful.





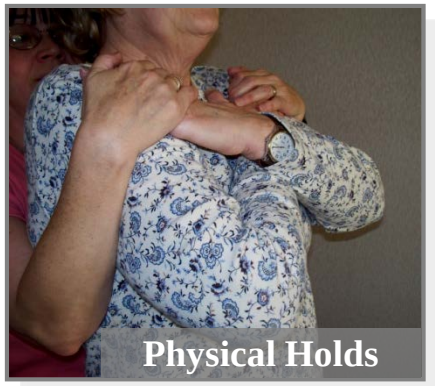
Examples of Devices Used as Restraint for Non-Violent, Non-Self-Destructive Behavior

Patient Restraints

Types of Restraints

Restraint for the management of violent, self-destructive behavior:

- Used to manage violent or destructive behavior that jeopardizes the immediate physical safety of the **patient**, **staff**, or **others**.
- Includes physical devices, physical holds, and **medication**.


Physical Holds


Limb Holders


Medication

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Restraint for the Management of Violent, Self-destructive Behavior

Drug Used as Restraint

A medication used solely to manage the patient's behavior or restrict the freedom of movement, and which is NOT a standard treatment or dosage for the patient's condition, is considered a ***form of restraint***.

Patient Restraints

Restraint Use

Situation	Example of Restraints
Restraint for Violent, Self-Destructive Behavior	
Patient presents with severely agitated or paranoid behavior, threatening to harm self	Soft limb holder Medications: Haloperidol & other antipsychotics
Restraint for Non-Violent, Non-Self-Destructive Behavior	
Immobilization to keep confused or sedated patient from removing Medical devices (e.g., IV, endotracheal tube, catheter, etc.) or climbing out of bed	Mittens, elbow extenders, or soft limb holder **Note:** indwelling catheters/tubes can cause a patient to be agitated. On a daily basis, evaluate for medical necessity and remove when possible.
Device used to prevent an unreliable patient from getting out of bed and falling: Patient with memory loss/dementia and has an unsteady gait or impulsive behavior.	Roll / lap belt or full side rails

Restraint Policy

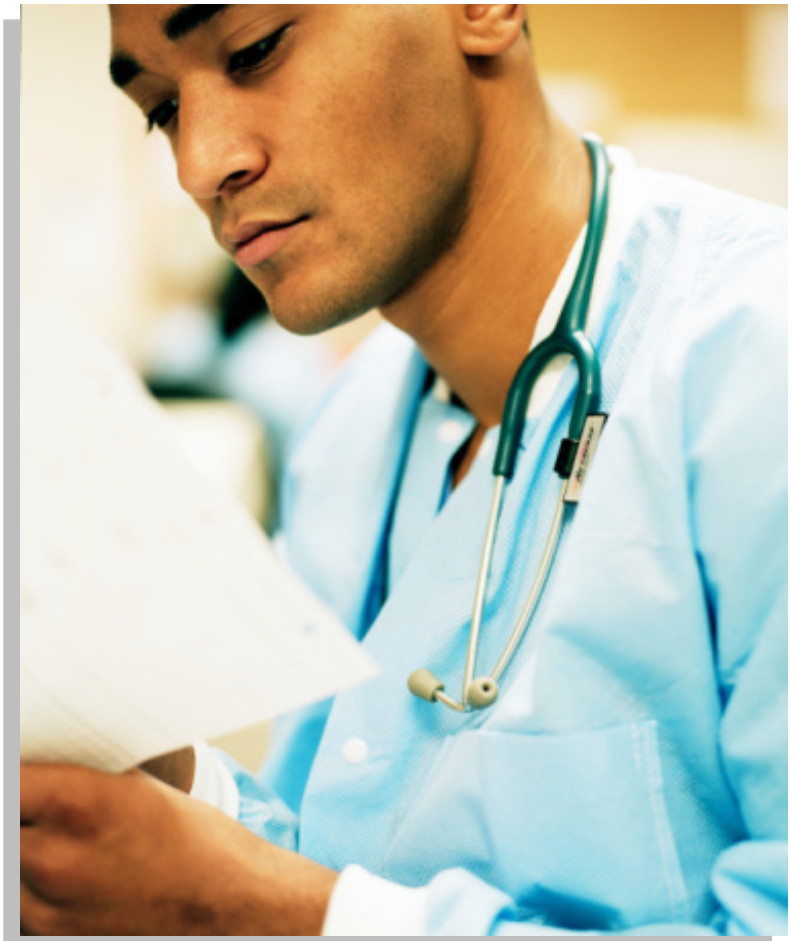
It is the policy of Kaiser Permanente that restraint(s):

- Will never be used **unless medically necessary**, and only if needed to improve the patient's and/or other person's safety.
- Will not be used until alternatives to restraint are utilized and deemed ineffective.
- Must be the **least restrictive** possible for the shortest period of time.
- Do not cause unnecessary physical discomfort, harm, or pain, and are **easily removable** in an emergency.
- Will never be used for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.
- **Will not** be used based on an individual's history or solely on a history of dangerous behavior.
- When used, will be employed by the nurse so as to ensure that the patient's rights, dignity, and well-being are protected.

Patient Restraints

Restraint Policy

Kaiser Permanente policy (con't):



Depending on why they are used, many devices or methods may be considered a restraint at some times but not at other times. It is the ***intent*** of the restraint, and not the device itself, that dictates whether or not it is a restraint, and what type of restraint it is.

Step 1

Comprehensive Individual Assessment

Every episode of a restraint must be triggered by a **comprehensive individualized assessment**, and never based on history.

This assessment includes a full assessment to identify medical, psychiatric, or other problems that may be causing behavior changes that if addressed, would eliminate or minimize the need for restraints.

Documentation includes:

- A description of the patient's behavior (documented in row "Clinical Justification")
- **Alternatives** to restraints that have been attempted (documented in row "Less Restrictive Alternative").
- When restraint is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, (Restraint for Violent, Self-destructive Behavior), the assessment will include relevant clinical and social information that places the patient at greater physical or psychosocial risk during restraint (document in row "Risk Factors"). If needed, pertinent information is obtained from family or significant others.

Patient Restraints

Step 1: Initial Assessment

1 **Patient Observation**

A. Observe & describe the patient's current behavior, condition or, symptom that warrants the use of restraint, for example:

- Unsafe exits from bed/chair
- Interfering with needed medical therapies
- Danger to self or others
  - Besides a violent, self-destructive patient, this also includes the **cognitively-impaired** patient who wanders or desires to leave the hospital against medical advice.

B. Identify and assess the patient's medical & socio-cultural factors:

- Identify, then eliminate or correct factors that cause delirium (for example, review medications, correct metabolic abnormalities, treat infection or pain)
- Ensure that the patient can see and hear you
- Administer medication to control pain, hallucinations, delusions, paranoia, anxiety, or sleep disruption
- Consider clinical and social information that may increase physical, emotional and/or psychological risk during restraint, such as **a phobia of being tied down, history of child abuse or post-traumatic stress disorder.**

Step 1: Initial Assessment

2 **Potential Triggers**

Comprehensive Individual Assessment

It is critical that triggers that might ***eliminate or minimize*** the need for restraints be evaluated and addressed first if possible. These triggers include **patient**, **caregiver**, and **environmental** factors.

Patient triggers can include:

- Medical factors such as stroke, head trauma, brain tumor, delirium, dementia, or epilepsy
- Psychiatric conditions
- Physical discomfort in a patient with difficulty expressing needs, due to language or sensory impairment

Caregiver triggers can include:

- Overlooking the patient's physical and cognitive needs
- Not realizing the patient speaks a foreign language
- Placing excessive demands on the patient
- Rushing or appearing impatient
- Appearing to be angry or uncaring
- Forgetting to explain procedures
- Talking too fast

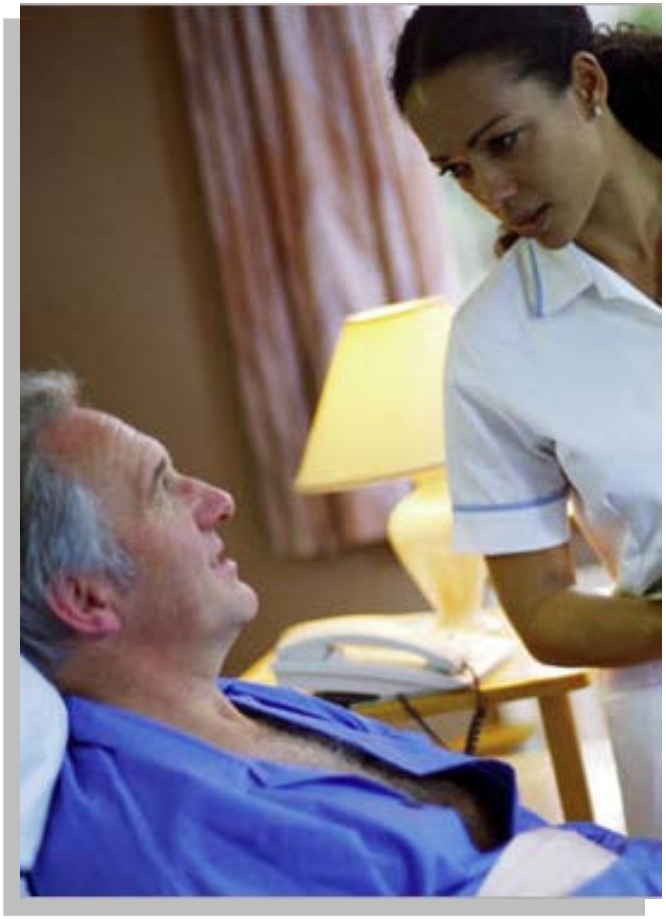
Environmental triggers can include:

- Excessive noise
- Sensory overload
- Change of environment, routine, or caregiver, especially for cognitively impaired patient
- Lack of stimulation

Step 1: Initial Assessment

Comprehensive Individual Assessment

3 **Identify Alternatives**



After reviewing and identifying the patient's behaviors, and addressing potential triggers, what **alternatives to a restraint and/or less restrictive interventions** would you suggest?

See – Examples of Alternative Interventions & Less Restrictive Restraint Devices (located in Restraint Policy, Appendix C)

Patient Restraints

Step 1: Initial Assessment

Comprehensive Individual Assessment

4

Least Restrictive Restraints

Wedge Cushion

Self-Releasing Belt

Side Rails

Lap buddy

Kaiser Permanente policy specifies that staff must choose the **least restrictive restraint possible** for safety and **discontinue its use as soon as possible**.

The **least restrictive** restraint necessary varies from patient to patient, and is <u>always</u> based on:

- The individual patient assessment
- The effectiveness of previously tried non-restraint interventions

A restraint can never be used for any other purpose, such as coercion or retaliation, by staff. It also cannot be used based solely on an individual's history of dangerous behavior.

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Patient Restraints

Step 2: Obtain MD order for Restraint

Physician order must be obtained

- Restraint may only be initiated or continued upon the order of a physician or authorized licensed independent practitioner (LIP) primarily responsible for patient's ongoing care.
- In a situation requiring the emergency application of restraint (i.e., a situation when the need for a restraint intervention occurs so quickly that a physician order cannot be obtained prior to the application of restraint), a registered nurse may initiate restraint use.
- After the patient's and/or staff's safety is ensured, an order for restraint must be obtained from the physician/LIP either during the emergency application of the restraint, or immediately **(within a few minutes)** after the restraint has been applied.
- If an order is **not** obtained immediately, it would be considered ***application of restraint without an order***.

Contents of physician order

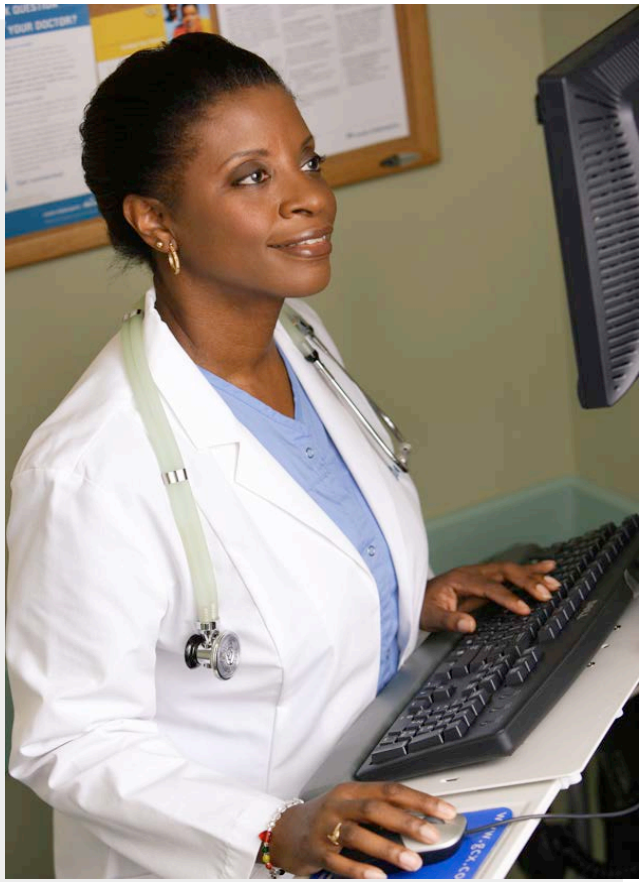
The order for restraint must be based on the specific behaviors that indicate the need for restraint and must:

1. Include the specific type and location (if applicable) of the restraint
2. Reflect the least restrictive manner possible
3. Include the behavior justifying the restraint
4. Specify the duration of restraint and renew it within appropriate time frames

Patient Restraints

Step 2: Obtain MD order for Restraint

Restraint Order Special Considerations:



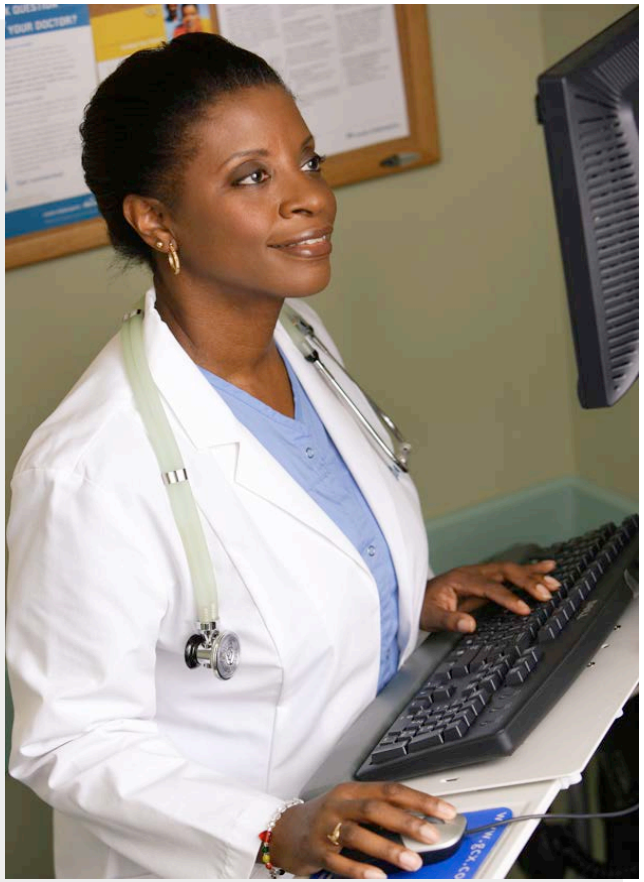
1. If the order is given by an on-call or after-hours non-treating physician, the ordering physician or RN must consult with the treating physician (who has primary responsibility for patient care/management) ASAP. The consultation may occur by telephone.

2. If the behavior is due to an unanticipated change in the patient's condition, the physician must be notified immediately. The physician must see and assess the patient as soon as possible.

Patient Restraints

Step 2: Obtain MD order for Restraint

Exceptions to Restraint Orders:

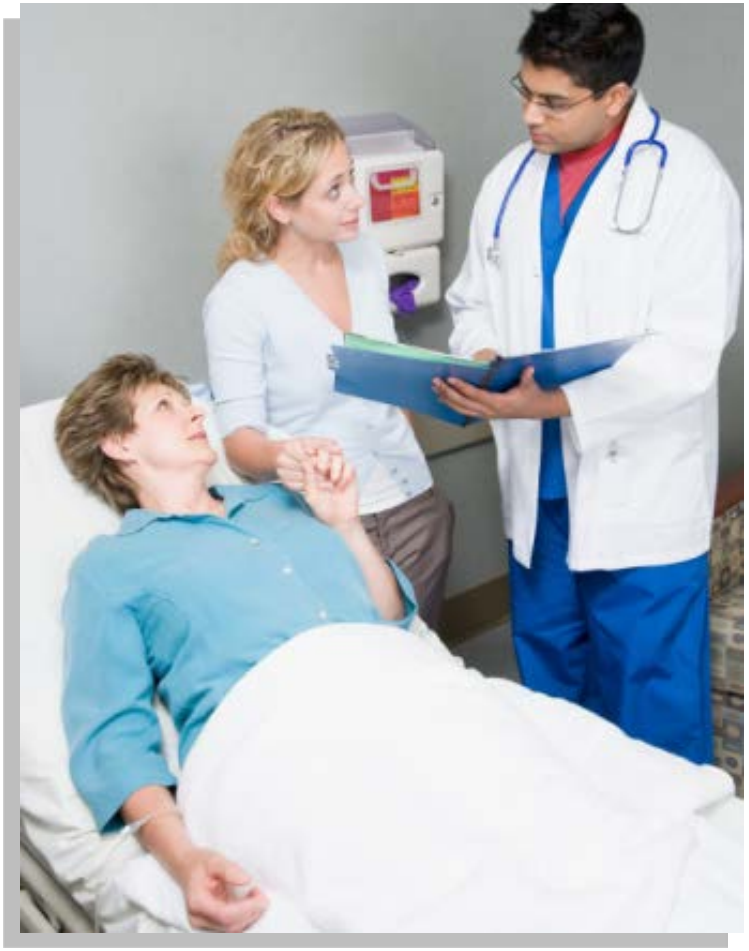


Physicians **cannot** write a restraint order as a standing order or on a PRN basis, except in the following situations:

1. Patient consistently requires use of a Geri chair for the patient to safely be out of bed.
2. Patient's status requires that all bedrails be raised (restraint) while in bed, a standing or PRN order is permitted when the patient is out of bed. It is not necessary to obtain a new order each time the patient is returned to bed after being out of bed.
3. Patient demonstrates repetitive self-mutilating behavior related to a chronic medical or psychiatric condition. Specific parameters must be established and documented in the treatment plan.

Patient Restraints

Step 3: Notifying Patient & Family



- For the patient in restraint for the management of violent, self-destructive behavior, the family *must* be notified in accordance with the patient's wishes. For the patient in restraint for *non*-violent, *non*-self-destructive behavior, the family *should* be notified.
- **Educate the patient / family** on the rationale, purpose, risks, and benefits of using a restraint and when it will be discontinued.
- Relay this information in a compassionate tone, reassuring that comfort and care needs for the patient will be continually monitored.

Patient Restraints

Step 4: Safe Application of Restraint

The safety of the patient is always a consideration when applying restraints.

A restraint can be applied **only** if it does not cause unnecessary physical discomfort, harm, or pain, and is easily removable in an emergency. Patient's rights, dignity, and well-being must be protected during restraint.

Choice

Choose the most appropriate, least restrictive device possible.

Ensure the correct size, as applicable.

Sizing for elbow restraints and lap belt is critical to ensure effectiveness and patient safety.

Comfort

Place patient in an anatomically correct position, with skin & bony prominences assessed and padded as needed.

Avoid restraining patient in prone or fully supine position & use with caution in anyone who is a current smoker to prevent death from suffocation or strangulation.

Never use a belt on a pregnant patient or a patient who has had recent abdominal surgery.

Respect

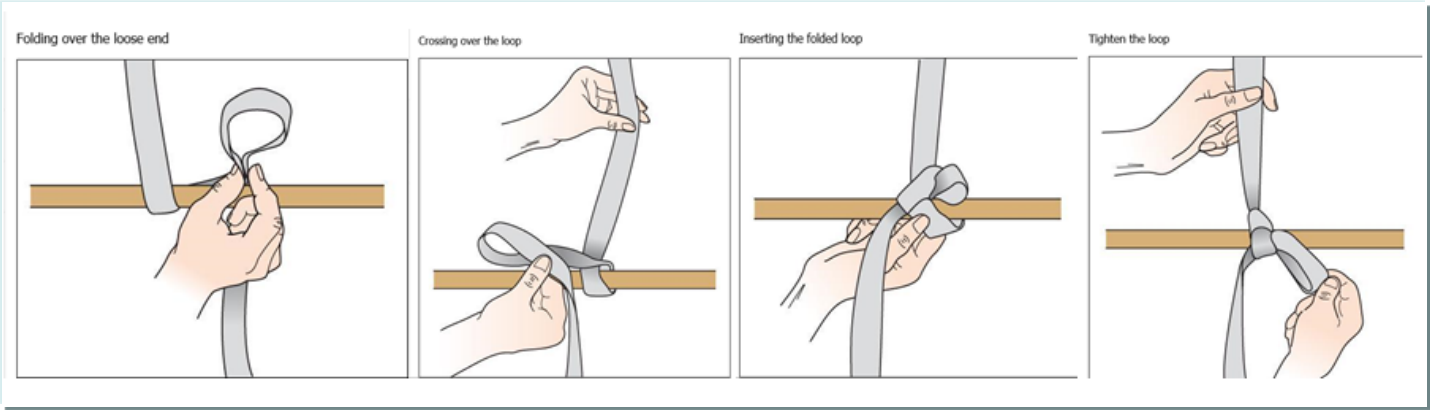
The patient in restraints should always be treated with respect.

He or she should be in a safe and clean environment, with staff awareness of patient's privacy, modesty and body temperature requirements, and provided opportunities to participate in patient education.

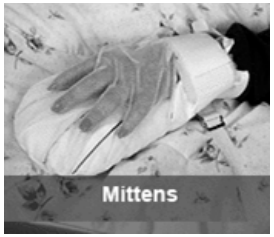
Step 4: Safe Application of Restraint

Securing the Restraint

Secure restraints with a “quick release” clip or slipknot (never a bowtie or double knot) to the moveable portion of bed frame or chair. Never secure ties to the bedrails.



From: Lippincott Procedures, Limb Restraint Application, Tying a Quick Release Knot. Revised July 10, 2015.



Secure mitten at narrowest distal aspect of wrist to minimize possibility of removal. Check for 2 finger access to ensure not too tight.

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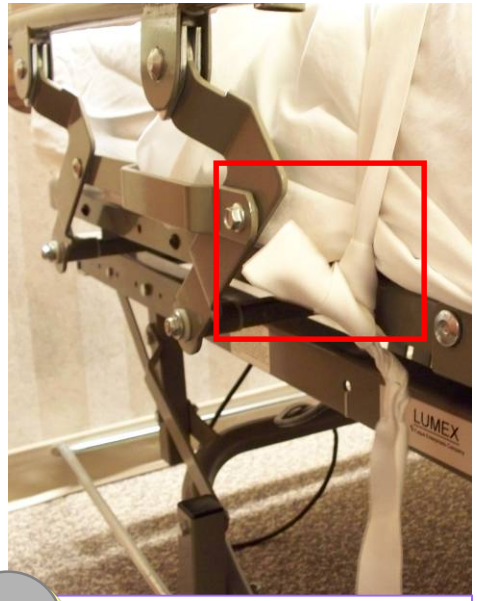
Patient Restraints

Step 4: Safe Application of Restraint

Securing the Restraint

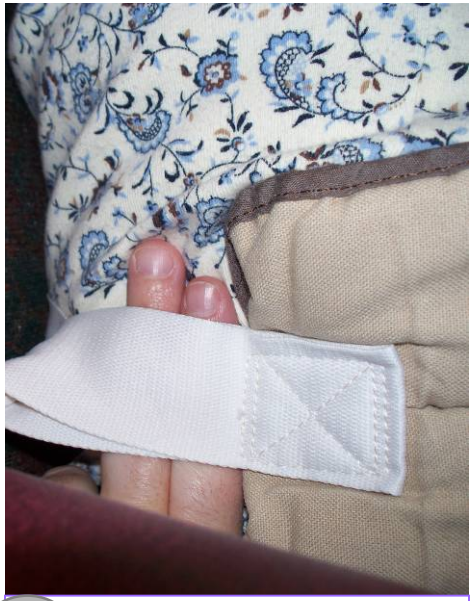
Follow these three securing guidelines :



1

Attach restraint to bed frame that adjusts with the head placement.

1. Always attach restraint to a part of the bed frame that moves when the head of the bed is raised or lowered.
2. Insert fingers under the secured restraint to ensure the restraint is not too tight or loose.
3. If patient is in a chair, secure ties under the armrests and tie at the back of chair.



2

Insert fingers under secured restraint to ensure proper fit.

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Patient Restraints

Step 5: Patient Monitoring

These timeframes MUST be followed – NO exceptions!

Monitoring the Patient

	Restraint for Non-Violent, Non-Self-Destructive Behavior	Restraint for Violent, Self-Destructive Behavior
Nurses:	Patient MUST be assessed at least every 2 hours	Patient MUST be assessed every 15 minutes
Doctors:	Requires face-to-face and medical assessment within 24 hours of restraint application with documentation of ongoing need	Requires face-to-face and medical assessment within 1 hour of restraint application with ongoing documentation

Step 5: Patient Monitoring

Nursing Assessment

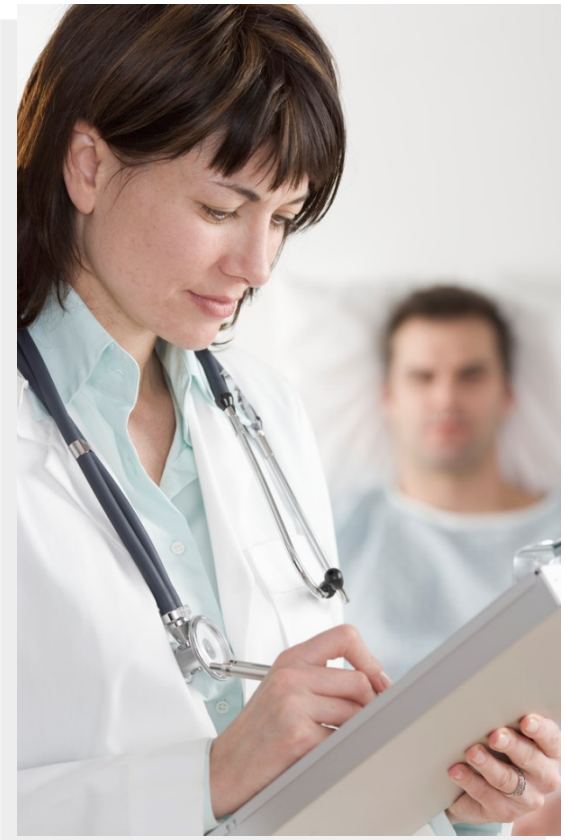
- Assessment should be performed regularly by a registered nurse.
- Frequency of assessment and monitoring is based on the patient's condition, cognitive status, and risks associated with the type of restraint used, as well as other factors relevant to the patient.
- Remove each restraint at least every two hours (or sooner based on patient condition) and:
  - assess the patient's physical and psychological condition (skin, circulation and overall condition and response to restraint)
  - attend to basic care needs
  - perform range of motion to affected limbs

When using full side rails to prevent unsafe exits from bed, the patient must be assessed for the risk of bed entrapment.

Step 5: Patient Monitoring

Nursing Assessment (con't):

After the initial application of restraint, the regular assessments must evaluate and document the status of the following:



- Patient's physical and emotional well-being: note signs/level of distress, agitation, mental status, cognitive functioning, respiratory or circulatory status, skin integrity, and may include vital signs per RN clinical judgement.
- Appropriateness of the restraint application or reapplication
- Circulation in all restrained extremities
- Comfort and care needs (such as nutrition, hydration and elimination needs)
- Assessment of the readiness for discontinuing the restraint.

Patient Restraints

Patient Asleep

- Based on the patient's needs and situational factors, the RN may use his/her clinical judgment and choose not to *awaken* a sleeping patient in restraints.
- After indicating that the patient is asleep in the "Behavior/Mental Status" row, **document** that the circulation of restrained extremity was assessed, and that the visual check was performed in the new "Patient Asleep-Assessment Required" row.
- The RN *must complete* a visual check of the patient to ensure their safety and an assessment of the circulation of the restrained extremity.
  - ❑ For patient restraint for Non-Violent, Non-Self-Destructive Behavior this is every 2 hours.
  - ❑ For patient restraint for Violent, Self-Destructive Behavior this is every 15 minutes.

Patient Restraints

KPHC Documentation

Doc Flowsheet

Pull in the appropriate flowsheet-

In KPHC choices are listed as:

•Non-Behavioral (for non-violent patient in restraints)

OR

•Behavioral (for violent patient in restraints)

Document in the rows as per policy:

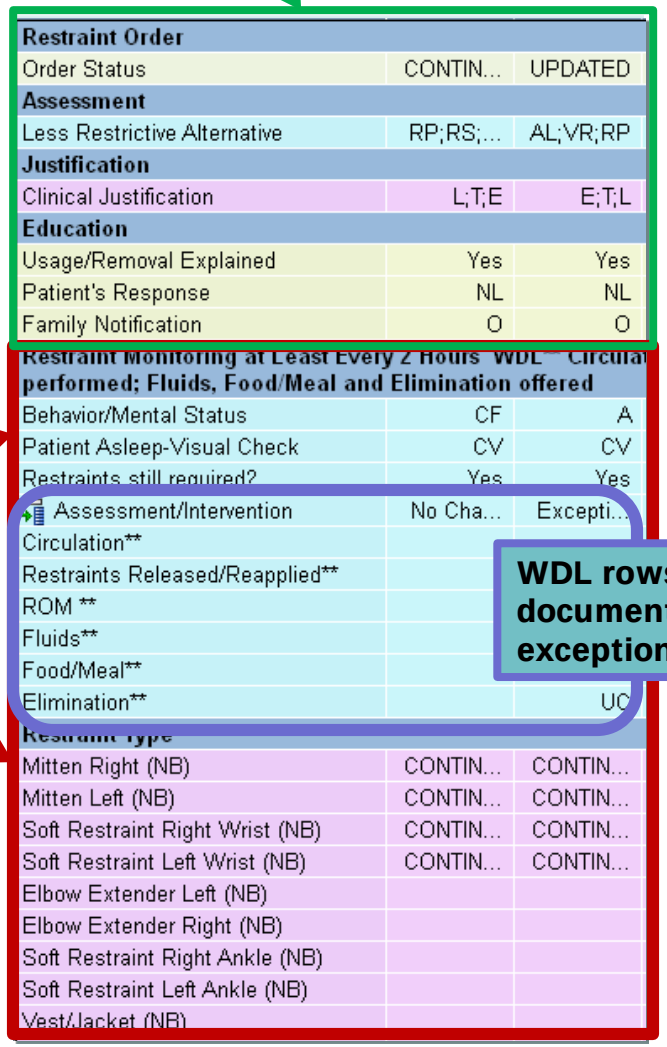
Care Plan

Care plan must be individualized to reflect restraints. Add in a template or use dotphrase to customize per facility guidelines. Be sure to resolve or update to reflect when the restraints are discontinued.

Q Shift at minimum

Every 2 hours

WDL rows- document by exception only



Restraint Order		
Order Status	CONTIN...	UPDATED
Assessment		
Less Restrictive Alternative	RP;RS;...	AL;VR;RP
Justification		
Clinical Justification	L;T;E	E;T;L
Education		
Usage/Removal Explained	Yes	Yes
Patient's Response	NL	NL
Family Notification	O	O
Restraint Monitoring at Least Every 2 Hours WDL - Circulat performed; Fluids, Food/Meal and Elimination offered		
Behavior/Mental Status	CF	A
Patient Asleep-Visual Check	CV	CV
Restraints still required?	Yes	Yes
Assessment/Intervention	No Cha...	Excepti...
Circulation**		
Restraints Released/Reapplied**		
ROM **		
Fluids**		
Food/Meal**		
Elimination**		UO
Restraint Type		
Mitten Right (NB)	CONTIN...	CONTIN...
Mitten Left (NB)	CONTIN...	CONTIN...
Soft Restraint Right Wrist (NB)	CONTIN...	CONTIN...
Soft Restraint Left Wrist (NB)	CONTIN...	CONTIN...
Elbow Extender Left (NB)		
Elbow Extender Right (NB)		
Soft Restraint Right Ankle (NB)		
Soft Restraint Left Ankle (NB)		
Vest/Jacket (NB)		

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Step 5: Patient Monitoring

Recognizing Distress

Distress signs for restrained patients include:

- Circulatory compromise, numbness, difficulty moving extremities, color change to white, cool to touch, decreased pulse, reddened skin, or abrasions
- Escalation of behavior with restraints, such as thrashing, screaming, signs of terror, or hallucinations
- Positional asphyxia or respiratory distress

The RN must be notified at the first sign of distress; a full physical and behavioral assessment must be performed and physician notified.

Nursing interventions will be based on the nursing assessment.

Patient Restraints

Step 5: Patient Monitoring

Practice Guidelines

Duration of Initial Order

Restraint for Non-Violent, Non-Self-Destructive Behavior	Restraint for Violent, Self-Destructive Behavior
Maximum Time Limit of Initial Order: • By the end of the next calendar day or earlier • MD must reevaluate the patient within 24 hours	Maximum time limit of all orders: • 4 hours for adults (18+ years) • 2 hours for children 9-17 yrs • 1 hour for children under 9 yrs

Reassess/Renewal of MD Order

Restraint for Non-Violent, Non-Self-Destructive Behavior	Restraint for Violent, Self-Destructive Behavior
By the end of the next calendar day or earlier	• 4 hours for adults (18+ years) • 2 hours for children 9-17 yrs • 1 hour for children under 9 yrs • Renew up to maximum duration of 24 hours

Patient Restraints

Step 5: Patient Monitoring

Practice Guidelines

Observation Frequency

Restraint for Non-Violent, Non-Self-Destructive Behavior	Restraint for Violent, Self-Destructive Behavior
At least every two hours, or more frequently as indicated by patient condition or type of restraint	**Continuous observation and documenting of observation every 15 minutes**

Assessment

Restraint for Non-Violent, Non-Self-Destructive Behavior	Restraint for Violent, Self-Destructive Behavior
Nursing: At least every 2 hours, or more frequently as indicated by patient condition or type of restraint. This includes assessing if restraints can be discontinued. Physician: Within 24 hours of being placed in restraint	Nursing: At least every 15 minutes. This includes assessing if restraints can be discontinued. Physician: within one hour

Patient Restraints

Practice Guidelines

Step 5: Patient Monitoring

Release from Restraint

Restraint for Non-Violent, Non-Self-Destructive Behavior	Restraint for Violent, Self-Destructive Behavior
At least every 2 hours	At least every 2 hours

Patient Education

Restraint for Non-Violent, Non-Self-Destructive Behavior	Restraint for Violent, Self-Destructive Behavior
• Explain and document rationale, purpose (including when restraint will be discontinued), risks, and benefits of restraint • Should notify family	• Same as with non-behavioral restraint • Must notify family members in accordance with patient wishes

Step 5: Patient Monitoring

Discontinuing a Restraint

When the restraint patient is no longer demonstrating the behavior that required restraint use, the restraint must be discontinued.

- The decision to discontinue the restraint should be based on the determination that:
  - ✓ the patient is no longer a threat to themselves or others (i.e. no longer exhibiting violent, or self-destructive behavior)
  - ✓ the unsafe situation no longer exists, **or**
  - ✓ the patient's safety can be maintained and care needs met with less restrictive methods.
- Document discontinuation of restraint in the **"Restraints still Required?" flowsheet row**.
- Staff cannot discontinue restraints and restart without obtaining a new physician order.

NOTE:

Restraints will be discontinued at the earliest possible time while ensuring patient safety.

Patient Restraints

Step 5: Patient Monitoring

Restraint Episode: The length of time from initiation of the restraint intervention to removal or discontinuation.

Temporary Release

- A temporary, directly-supervised release done for the purpose of caring for a patient's needs is not considered a discontinuation of the restraint as long as the patient remains under ***direct staff supervision***. Care needs can include toileting, range of motion exercises, physical therapy, and the required release from restraint at least every 2 hours.
- This temporary release does not require a physician's order.

Release of Restraint

Key patient behaviors that may indicate the restraint can be released:

- *Able to follow instructions*
- *Able to rest*
- *Calm and/or sleeping*
- *More coherent*
- *No longer restless*
- *Not interfering with lines or devices*
- *Speaking clearly*
- *Thrashing less*
- *Vital signs are within normal limits*

Leaving the patient out of restraint while supervised by family ends the restraint episode. A new order is then required in order to reapply the restraint (if needed) once the family leaves.

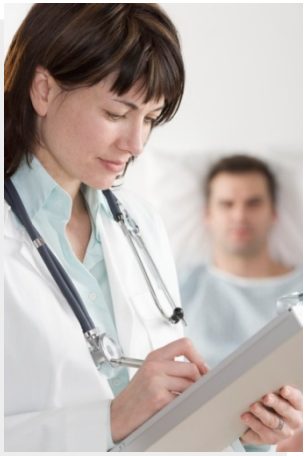
Patient Restraints

Step 6: Document and Reporting

Internal Reporting

Report to the physician:

- Initial assessment by the RN regarding the need for restraint
- Ineffectiveness of restraint for controlling the clinical situation and/or an increase in behavior that required use of restraint
- Respiratory, extremity or any other complications resulting from the use of restraint.



- For patients in Restraint for Violent, Self-Destructive Behavior, the **Nurse Manager or designee** must be notified if the patient remains in Restraint for Violent, Self-Destructive Behavior for more than 12 hours.
- The **Nurse Manager or designee** will review all patients in restraints every 24 hours.
- In the event of any patient death associated with the use of restraint, the RN shall immediately notify the **Nurse Manager or House Supervisor**, who will notify the ***Risk/Patient Safety Department of any patient death associated with the use of restraint.***

Patient Restraints

Step 6: Document and Reporting

External Reporting

Situation	Agency
Death of a patient **while in restraints**	CMS (even if death not associated with restraints)
Death **associated with the use** of restraints or bed rails	CMS and MedWatch ; FDA in 5 working days
Death that occurs within **24H after** patient has been removed from restraint	CMS
Death occurs with in one week after restraint where it is reasonable to assume that the use of restraint contributed directly or indirectly to the patient's death	State agency and CMS
Serious disability associated with the use of restraints	MedWatch Report to restraint manufacturer within 10 working days

CMS does not need to be notified of the death of a patient in restraints if the only restraints used on the patient were applied to the patient's wrist(s) and composed solely of soft, non-rigid, cloth-like materials (i.e. soft wrist restraints).

Restraint Use Algorithm

A restraint is any manual method, physical or mechanical device, material or equipment that immobilized or reduces the ability of a patient to move his/her arms, legs, body or head freely. A drug is also a restraint when used solely to manage behavior or restrict the patient's freedom of movement & is not standard treatment or dosage for the patient's condition.

Is the patient exhibiting behavior that requires restraint?

Yes

Assess & document use of alternative or less restrictive interventions that were attempted
Review Appendix C: Examples of Alternative Interventions and Less Restrictive Devices

Were less restrictive alternatives and/or interventions effective?

Yes → **Continue to Monitor**

No

Non-Violent, Non-Self Destructive Restraint Use: For patients who are **NOT** demonstrating violent, self destructive behaviors and are demonstrating behaviors such as: confusion, impulsiveness, agitation; pulling at lines, tubes, and dressings.

(Review Appendix A&B)

MD Order / Renewals:

Restraint order will be obtained and **renewed by the end of the next calendar day** after MD assessment

Non-Violent, Non-Self Destructive Restraint Patient Monitoring

Patient Assessment at initiation & Monitoring at least Q 2 hrs and when discontinued: (see below)

→however, vital signs & other assessments are done per Unit Standards.

Notify Physician of Patient's Condition and **Obtain a Restraint Order**

-Or-

For ***emergent situations***, the

RN applies restraints, assesses patient's condition, notifies physician of patient's condition (SBAR), and obtains an order within a few minutes of restraint application.

Violent / Self Destructive Restraint Use:

For patients that **ARE** demonstrating violent, self-destructive behaviors such as: combative, destructive; hitting, kicking or suicidal. Behaviors may be intensified in patients with certain diagnoses, such as: aggressive dementia, detoxification; acute delirium and head injury

MD: **Perform the comprehensive Face-to-Face restraint assessment within 1 hr** of initiating restraint.
MD Order / renewals: The RN notifies physician of patient's condition (SBAR), and obtains an initial age specific order and renewal order prior to the previous restraint order expiration, if still indicated.

4 hours patients > 18 years old
2 hours patients 9-17 years old
1 hour for children < 9 years old

MD must assess the patient q 24 hrs if this restraint is still needed

(Review Appendix A&B)

Violent / Self Destructive Restraint Patient Monitoring:

Visual checks of patient are ongoing

Vital Signs & assessments per Unit Standards at Initiation& ongoing, Monitoring q 15 minutes and when Discontinue: (see below)

Assessment and Monitoring components:
at initiation of the restraint, at least q 2 hrs or q 15 min per type of restraint and when discontinue:

- Level of distress and agitation, mental status, cognitive functioning
- Circulation of all restrained extremities
- Comfort and care needs (such as)
  1. nutrition,
  2. hydration and
  3. elimination needs
  4. Release of restraint and Range of motion of restrained limbs (q 2 hrs for both types of restraint)
- Assessment of the readiness for discontinuing the restraint.

References

NURSING PATHWAYS

Content Developer:

Deborah Francis, MSN, RN, GCNS-BC WCC
Clinical Nurse Specialist, Gerontology
Kaiser Permanente, South Sacramento

Instructional Designers:
Kate Hance, MA
Kim Barber, MA

Course Reviewers:

Susan Woods, MS, RN
Clinical Nurse Consultant for Geriatrics
Kaiser Permanente, Portland, Oregon

Chad A. Baker, BSN, RN, CCRN, CEN
ACD/Educator, ICU/DOU
Kaiser Permanente, Downey, California

Maria Maglalang, MN, RN, NP
Professional Development Consultant
Distance Learning Program, Kaiser Permanente, NPCS

Updated August 2013/Reviewed December 2015: Caroline Waters, MSN, RN-BC, Clinical and Informatics Educator, Kaiser Permanente Sacramento

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Name: _____
Date: _____
Score: _____

RN Restraints test
(True/False)

1. A physician order for a restraint must be obtained either before the restraint is applied or immediately thereafter in the case of an emergency restraint (within a few minutes). T F

2. Alternatives to restraint for a cognitively impaired patient who wanders might include having a room close to the nursing station, and using a bed alarm. T F

3. If a patient is re-admitted who had required use of restraint during the last hospital stay, the same type of restraints used previously should be applied immediately. T F

4. A patient is attempting to pull out her NG tube, and is unable to follow directions to leave it alone. The least restrictive restraint would be elbow extenders or mittens. T F

5. If a patient's restraint was discontinued earlier in the shift, but the patient becomes confused again, and starts trying to get out of bed, it will be acceptable to reapply the restraint since the order is still less than 1 calendar day old. T F