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.
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.
### Patient Restraints

#### Definition of Restraint

**Medical Immobilization**
- Arm board for IV stabilization
- Temporarily holding patient for a consented procedure
- Patient immobilized during MRI, surgery, or procedure

**Adaptive Devices**
- 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

Law enforcement devices for security purposes (e.g. handcuffs)

#### Pediatric Applications

Therapeutic holding, comforting

Examples of when a device is **NOT** a RESTRAINT

Medical Immobilization Adaptive Devices
- 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
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### Corrections Restrictions

Law enforcement devices for security purposes (e.g. handcuffs)

### Pediatric Applications

Therapeutic holding, comforting
Patient Restraints

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.
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.
Patient Restraints

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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Example of Restraints</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Restraint for Violent, Self-Destructive Behavior</strong></td>
<td></td>
</tr>
<tr>
<td>Patient presents with severely agitated or paranoid behavior, threatening to harm self</td>
<td>Soft limb holder</td>
</tr>
<tr>
<td></td>
<td>Medications: Haloperidol &amp; other antipsychotics</td>
</tr>
<tr>
<td><strong>Restraint for Non-Violent, Non-Self-Destructive Behavior</strong></td>
<td></td>
</tr>
<tr>
<td>Immobilization to keep confused or sedated patient from removing Medical devices (e.g., IV, endotracheal tube, catheter, etc.) or climbing out of bed</td>
<td>Mittens, elbow extenders, or soft limb holder</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> indwelling catheters/tubes can cause a patient to be agitated. On a daily basis, evaluate for medical necessity and remove when possible.</td>
</tr>
<tr>
<td>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.</td>
<td>Roll / lap belt or full side rails</td>
</tr>
</tbody>
</table>
Patient Restraints

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.
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.
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.
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**.
## Patient Restraints

### Step 1: Initial Assessment

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.

<table>
<thead>
<tr>
<th><strong>Patient</strong> triggers can include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical factors such as stroke, head trauma, brain tumor, delirium, dementia, or epilepsy</td>
</tr>
<tr>
<td>• Psychiatric conditions</td>
</tr>
<tr>
<td>• Physical discomfort in a patient with difficulty expressing needs, due to language or sensory impairment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Caregiver</strong> triggers can include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Overlooking the patient’s physical and cognitive needs</td>
</tr>
<tr>
<td>• Not realizing the patient speaks a foreign language</td>
</tr>
<tr>
<td>• Placing excessive demands on the patient</td>
</tr>
<tr>
<td>• Rushing or appearing impatient</td>
</tr>
<tr>
<td>• Appearing to be angry or uncaring</td>
</tr>
<tr>
<td>• Forgetting to explain procedures</td>
</tr>
<tr>
<td>• Talking too fast</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Environmental</strong> triggers can include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Excessive noise</td>
</tr>
<tr>
<td>• Sensory overload</td>
</tr>
<tr>
<td>• Change of environment, routine, or caregiver, especially for cognitively impaired patient</td>
</tr>
<tr>
<td>• Lack of stimulation</td>
</tr>
</tbody>
</table>
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

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 always 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.
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
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.
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.
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.

Patient Restraints

Step 4: Safe Application of Restraint

Securing the Restraint

Follow these three securing guidelines:

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.

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

Insert fingers under secured restraint to ensure proper fit.
### Patient Restraints

#### Step 5: Patient Monitoring

**Monitoring the Patient**

These timeframes **MUST** be followed - **NO exceptions**!

<table>
<thead>
<tr>
<th></th>
<th>Restraint for Non-Violent, Non-Self-Destructive Behavior</th>
<th>Restraint for Violent, Self-Destructive Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nurses:</strong></td>
<td>Patient MUST be assessed at least every 2 hours</td>
<td>Patient MUST be assessed every 15 minutes</td>
</tr>
<tr>
<td><strong>Doctors:</strong></td>
<td>Requires face-to-face and medical assessment within 24 hours of restraint application with documentation of ongoing need</td>
<td>Requires face-to-face and medical assessment within 1 hour of restraint application with ongoing documentation</td>
</tr>
</tbody>
</table>
Patient Restraints

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.
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:

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

- Behavioral (for violent patient in restraints)

Document in the rows as per policy:

- Every 2 hours Q Shift at minimum
- WDL rows—document by exception only

#### 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.

<table>
<thead>
<tr>
<th>Restraint Order</th>
<th>Order Status</th>
<th>CONTIN...</th>
<th>UPDATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less Restrictive Alternative</td>
<td>RP, RS,... AL, VR, RP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Justification</td>
<td>L, T, E, E, T, L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usage/Removal Explained</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Patient's Response</td>
<td>NL</td>
<td>NL</td>
<td></td>
</tr>
<tr>
<td>Family Notification</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Restraint Monitoring at Least Every 2 Hours</td>
<td>WDL** Circula performed; Fluids, Food/Meal and Elimination offered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 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** | |

<table>
<thead>
<tr>
<th>Restraint Type</th>
<th>CONTIN...</th>
<th>CONTIN...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mitten Right (NB)</td>
<td>CONTIN...</td>
<td>CONTIN...</td>
</tr>
<tr>
<td>Mitten Left (NB)</td>
<td>CONTIN...</td>
<td>CONTIN...</td>
</tr>
<tr>
<td>Soft Restraint Right Wrist (NB)</td>
<td>CONTIN...</td>
<td>CONTIN...</td>
</tr>
<tr>
<td>Soft Restraint Left Wrist (NB)</td>
<td>CONTIN...</td>
<td>CONTIN...</td>
</tr>
<tr>
<td>Elbow Extender Left (NB)</td>
<td>CONTIN...</td>
<td>CONTIN...</td>
</tr>
<tr>
<td>Elbow Extender Right (NB)</td>
<td>CONTIN...</td>
<td>CONTIN...</td>
</tr>
<tr>
<td>Soft Restraint Right Ankle (NB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft Restraint Left Ankle (NB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vest/Jacket (NB)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

#### Duration of Initial Order

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

#### Reassess/Renewal of MD Order

<table>
<thead>
<tr>
<th>Restraint for Non-Violent, Non-Self-Destructive Behavior</th>
<th>Restraint for Violent, Self-Destructive Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of the next calendar day or earlier</td>
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<td></td>
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<tr>
<td></td>
<td>• 1 hour for children under 9 yrs</td>
</tr>
<tr>
<td></td>
<td>• Renew up to maximum duration of 24 hours</td>
</tr>
</tbody>
</table>
## Patient Restraints

### Step 5: Patient Monitoring

#### Observation Frequency

<table>
<thead>
<tr>
<th>Restraint for Non-Violent, Non-Self-Destructive Behavior</th>
<th>Restraint for Violent, Self-Destructive Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least every two hours, or more frequently as indicated by patient condition or type of restraint</td>
<td>Continuous observation and documenting of observation every 15 minutes</td>
</tr>
</tbody>
</table>

#### Assessment

<table>
<thead>
<tr>
<th>Restraint for Non-Violent, Non-Self-Destructive Behavior</th>
<th>Restraint for Violent, Self-Destructive Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Nursing: At least every 15 minutes. This includes assessing if restraints can be discontinued.</td>
</tr>
<tr>
<td>Physician: Within 24 hours of being placed in restraint</td>
<td>Physician: within one hour</td>
</tr>
</tbody>
</table>
## Release from Restraint

<table>
<thead>
<tr>
<th>Restraint for Non-Violent, Non-Self-Destructive Behavior</th>
<th>Restraint for Violent, Self-Destructive Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least every 2 hours</td>
<td>At least every 2 hours</td>
</tr>
</tbody>
</table>

## Patient Education

<table>
<thead>
<tr>
<th>Restraint for Non-Violent, Non-Self-Destructive Behavior</th>
<th>Restraint for Violent, Self-Destructive Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Explain and document rationale, purpose (including when restraint will be discontinued), risks, and benefits of restraint</td>
<td>• Same as with non-behavioral restraint</td>
</tr>
<tr>
<td>• Should notify family</td>
<td>• Must notify family members in accordance with patient wishes</td>
</tr>
</tbody>
</table>
Patient Restraints

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

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.

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

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.
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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of a patient <strong>while in restraints</strong></td>
<td>CMS (even if death not associated with restraints)</td>
</tr>
<tr>
<td>Death <strong>associated with the use</strong> of restraints or bed rails</td>
<td>CMS and MedWatch; FDA in 5 working days</td>
</tr>
<tr>
<td>Death that occurs within <strong>24H after</strong> patient has been removed from restraint</td>
<td>CMS</td>
</tr>
<tr>
<td>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</td>
<td>State agency and CMS</td>
</tr>
<tr>
<td>Serious disability associated with the use of restraints</td>
<td>MedWatch Report to restraint manufacturer within 10 working days</td>
</tr>
</tbody>
</table>

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?

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.

MD Order / Renewals:
Restrain 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)

-Or-

Notify Physician of Patient’s Condition and Obtain a Restraint Order

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 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

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.

Were less restrictive alternatives and/or interventions effective?

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)


**References**: The Joint Commission Comprehensive Accreditation Manual for Hospitals, Chapter: Provision of Care, Treatment and Services, Standards: Restraint and Seclusion.
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