ATTACHMENT A

Alternative Interventions to Restraints

Purpose

The purpose of this attachment is to identify possible root causes and alternatives to avoid the inappropriate use of restraints.

Root Causes

Appropriate interventions should be initiated based on the root cause of behavior. Examples may include:

- hunger	- environmental changes	- bowel or bladder needs
- thirst	- cold/hot (uncomfortable)	- medication reaction/changes
- pain	- post traumatic brain injury	- substance withdrawal
- hypoxia	- intoxication	- abnormal laboratory levels
- infection	- sleep deprivation	- boredom

Alternative Interventions (some may require MD order)

- Examples may include:
- Patient education
- Reality orientation
- Up to bathroom at frequent intervals
- Call light within easy reach
- Reposition (i.e., up in chair, side vs. back)
- Implement DT Protocol
- Ambulation/exercise
- Closer observation (i.e., move patient to room closer to nursing station, have patient sit in recliner at nurses station)
- Provide diversional activities (i.e., TV, music, activities involving hands such as folding wash cloths, playing with a deck of cards and reading materials)
- Provide comfort measures
- Offer food/fluids more often
- Warm blankets
- Family observation/sitter (discuss options with family)
- Wrap catheter insertion site with tube gauze allowing access for visibility
- Secure the tubing along the extremity to prevent the tube/line from dangling. This measure may reduce the visibility and decrease the patient's tendency to pull at the tubing. This may work for both central and peripheral lines.
- Keep the IV or tube feeding pole behind the patient and out of his/her visual field
- Make a vest from large tube gauze or use mesh T-shirt and apply over the patient's chest to prevent him/her from pulling out a central line.
- Use an abdominal binder to cover a PEG, g-tube or JP bulbs
- Bed alarm and/or chair alarm
- Oxygen
- Environmental modification (i.e., lighting, remove clutter, bring familiar items from home)

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PT NAME

MR #

Date: _____ Time: _____

NO PRN ORDERS

Beginning at _____, patient
(time)
may be restrained up to _____ hours

- Not to exceed 24 hours for protection of tubes/lines
- Not to exceed (for violent/self destructive reason):
  4 hours – age 18 or over
  2 hours – age 9-17
  1 hour – under age 9

Type of physical restraint:
- ☐ Wrist
- ☐ Ankle
- ☐ Enclosure bed
- ☐ Other: _____

Reason for physical restraint:
- ☐ Protection of tube/line
- ☐ Violent /self destructive (if checked, complete the face to face assessment, description of behavior, alternatives attempted and patient's response below)
  - **1 hour face to face assessment due at _____. (time)**

  Description of patient's behavior and condition:

  _____

  _____

  Alternatives attempted:
  - ❑ Decrease stimuli
  - ❑ Orientation/ reassurance
  - ❑ PRN medication
  - ❑ DT Protocol initiated
  - ❑ Distraction
  - ❑ Listening
  - ❑ Other: _____

  _____

  Patient's response to restraint:

  _____

  _____

  _____

Physician Signature: _____ Provider #: _____

PATIENT RESTRAINT ORDER

ATTACHMENT C
GUIDELINES FOR ATTACHMENT D

RESTRAINT FLOWSHEET GUIDELINES

The purpose of the Restraint Flow Sheet is to document the assessment, teaching, observation and care of a patient who requires the use of a restraint, including the use of a least restrictive device. When completing the Restraint Flow Sheet, the nurse will follow these guidelines:

1. Date	Enter today's date.
2. Assessment of Behavior behavior.	Check the <u>one</u> box that most closely described the patient
3. Education completed.	Check <u>yes</u> is the patient and/or family education attempted or Check <u>no</u> if not, explain.
4. Alternatives attempted	Check all the alternatives attempted throughout the 24-hour period. Use additional documentation on back of form to describe.
5. Restraint type/location	Circle the type(s) and location(s) of restraint(s) used.
6. Patient Condition/Observation/	For each identified time period (0700-1500, 1500-1900, 1900-2400, 2400-0700), check Provision of Care or list under "other" all the patient conditions that apply. For each identified time period, a check in each of the categories will indicate care completed every 2 hours. If observation/care was not completed write "see back" in blank and document explanation on the back of the flow sheet under "Additional Documentation".
7. Modification of Care Plan	Check this box when the care plan has been modified based on the assessed/reassessed need for restraint. This must be done on initial application of restraint and anytime revisions in restraint use are needed.
8. Additional Documentation	Document further descriptions of the patient assessment and condition, patient response to alternatives, and any other documentation that relates to the use of restraint and the care of the patient. Use this area, also, anytime a restraint is discontinued and/or reapplied.

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PT NAME

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Date _____

Assessment of Patient Behavior:

- ☐ Alternative measures have been tried and failed
- ☐ Unable to demonstrate clear understanding of consequences of behavior and/or tube/line removal
- ☐ Patient's behavior exhibits danger to self or others

Education/explanation given to patient/family regarding reason for restraint (check one):

- ☐ Yes
- ☐ No (explain) _____

Alternatives attempted *(Check all that apply and explain on back)*

☐ Patient education	☐ Device camouflage (i.e. wrap/cover tubing, line)
☐ Reality orientation	☐ Bed alarm or chair alarm
☐ Toileting regime	☐ Environmental modification
☐ Ambulation/exercise/reposition	☐ Other _____
☐ Closer observation family/sitter	

Restraint type and location (circle):

Enclosure Bed	Soft Wrist Right Left	Soft Ankle Right Left	Immobilizer Right arm Left arm	Air Splint Right arm Left arm	Mitt Right Left	Leather _____ Location	Other _____

Observations/Provisions of Care/ Patient Condition (check mark indicates care completed every 2 hours)	***0700-1500***	***1500-1900***	***1900-2400***	***2400-0700***	
Confused					07 _____ LPN Signature 07 _____ RN Signature
Restless					
Sleeping					15 _____ LPN Signature 15 _____ RN Signature
Cooperative					
Alert					
Other _____					
Skin intact under restraint. Adequate circulation of immobilized limb					19 _____ LPN Signature 19 _____ RN Signature
Active/Passive ROM					
Elimination needs addressed					
Food/fluid needs addressed					24 _____ LPN Signature 24 _____ RN Signature
Restraint need and alternative intervention reassessed.					
Modification to care plan – (on initial application of restraint and anytime revisions in restraint use needed)					_____ Signature

ASSESS AND ASSIST RESTRAINT CHECKLIST

Date: _____

"x" to signify task completion	0700	0715	0730	0745	0800	0815	0830	0845	0900	0915	0930	0945	1000	1015	1030	1045	1100	1115	1130	1145	1200	1215	1230	1245	1300	1315	1330	1345	1400	1415	1430	1445	1500	1515	1530	1545	1600	1615	1630	1645	1700	1715	1730	1745	1800	1815	1830	1845
MD Notified																																																	
Restraint																																																	
face to face assessment by MD																																																	
# of restraints used																																																	
Every 15 Minutes Assessments:																																																	
injury assessment																																																	
skin check under restraint																																																	
circulation of immobilized limb/ROM																																																	
physiological/psychological status & comfort																																																	
nutrition/hydration																																																	
hygiene & elimination																																																	
vital signs documented in chart																																																
Care Behavior Codes:																																																
agitated																																																	
physically aggressive																																																	
verbally aggressive																																																	
confused																																																	
sleeping																																																	
Risk of Injury Remains																																																	
Position Change																																																	
Other: _____																																																	
Initials																																																	

☐ Nutrition, hydration, elimination, ROM, hygiene, and position change to be offered no less than every 2 hours.

Initials	Name	Initials	Name

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ASSESS AND ASSIST RESTRAINT CHECKLIST

Date: _____

"x" to signify task completion	1900	1915	1930	1945	2000	2015	2030	2045	2100	2115	2130	2145	2200	2215	2230	2245	2300	2315	2330	2345	0000	0015	0030	0045	0100	0115	0130	0145	0200	0215	0230	0245	0300	0315	0330	0345	0400	0415	0430	0445	0500	0515	0530	0545	0600	0615	0630	0645
MD Notified																																																	
Restraint																																																	
face to face assessment by MD																																																
# of restraints used																																																	
Every 15 Minutes Assessments:																																																
injury assessment																																																
skin check under restraint																																																
circulation of immobilized limb/ROM																																																
physiological/psychological status & comfort																																																
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Initials	Name	Initials	Name

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