



POLICIES AND PROCEDURES MANUAL

System Department

Supersede: BMC-NUR 01_052

Section: CARE OF PATIENTS (TX)

Subject: Restraint Use

Number: TX01

Attachments: [Attachment A: Alternative Interventions to Restraints](#)

Date Effective: 09/14/98

5/01, 12/01, 5/03, 3/04, 1/06, 4/07, 6/09, 5/11, 11/11, 2/12, 7/12, 12/12, 12/13, 03/14, 11/15,

Date Reviewed: 1/16

PHILOSOPHY

The philosophy of Nebraska Medicine is to reduce/limit the use of physical and chemical restraint while maintaining safety and preserving the dignity, rights and well-being of patients. Nebraska Medicine respects the patient's right to be free of restraints of any form that are not medically necessary. Functional mobility will be promoted by utilizing restraint as a last resort following the failure of alternative interventions. Multidisciplinary teams will work in conjunction with the patient/family to ensure this care decision is based on the assessed needs of the patient.

POLICY

1. It is the policy of Nebraska Medicine to ensure the safety and general well-being of all patients, whose condition necessitates the use of restraints, paying particular attention to the risk associated with vulnerable patient populations, such as emergency, pediatric, and cognitively or physically limited patients.
2. Restraint may only be imposed to ensure the immediate physical safety of the patient, staff or others and must be discontinued as soon as safely possible, regardless of the scheduled expiration of the order.
3. Restraint is only to be used when alternative or less restrictive interventions are ineffective. Members of the multi-disciplinary team serve as resources in development of alternative measures (e.g., OT/PT consults).
4. Nebraska Medicine staff use the least restrictive form of restraint that protects the physical safety of the patient, staff, or others.
5. Nebraska Medicine does not permit restraint use for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.
6. Restraint used on patients because of violent or self-destructive behavior is limited to emergencies in which there is imminent risk of a patient physically harming himself, staff or others, and non-physical interventions would not be effective.
7. The use of restraint is not based on a patient's restraint history or solely on a history of dangerous behavior.
8. The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.
9. New RN staff members who initiate or terminate restraint will be specifically trained to do so during orientation and before participating in the application of restraint. Ongoing education of existing employees will be done as needs are identified and will emphasize prevention, alternative measures and protecting vulnerable patient populations. Only RNs who prove competency in orientation, complete mandatory education and competency, and are current in BLS certification may make decisions about, implement, and discontinue restraint use. This staff training, education and competency will focus on:

- a. Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion.
 - b. Consideration or failure of non-physical interventions.
 - c. Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition.
 - d. Safe application and use of all types of restraint used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress.
 - e. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary.
 - f. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion.
 - g. Use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including periodic recertification.
10. Only physicians who are trained on the Restraint Use policy may order restraint interventions. Attending Physicians and residents receive and acknowledge the medical staff's policy on the use of restraint, and sign the attestation. This attestation will become a part of attending physicians physicians' credentials file and will be part of the re-credentialing process. The attestation for the residents will be documented in their training file.
 11. If the restraint is ordered by a resident, the attending physician must be consulted by the resident as soon as possible (when the immediate crisis is past).
 12. Staff will implement restraint using safe techniques as identified in Nursing Policy Mis-6, Restraint Application.
 13. All restraint use is in accordance with a written modification to the patient's plan of care.
 14. Each patient care area, as applicable, will participate in performance improvement activities to develop alternatives to the use of restraint. Each area will collect and assess aggregate data on all episodes of restraint with the goal of reducing use.
 15. The following situations must be reported by the appropriate unit manager (or designee) to the office of Compliance and Accreditation. Reports will be submitted as soon as possible by sending an email to the Outlook group titled Restraint Reporting:
 - a. Patients who die while in restraints. The staff nurse caring for the patient will immediately notify his/her manager.
 - b. Patients who die within 24 hours after restraints are removed.
 - c. Any death known to have occurred within one week after restraints have been removed when it is reasonable to assume that the use of restraints contributed directly or indirectly to the death.

The office of Compliance and Accreditation will confirm receipt of the message and file the necessary and appropriate reports.

DEFINITIONS

1. **Root cause:** Reason for the patient's behavior. Examples may include hunger, thirst, pain, boredom, bowel or bladder needs, hot/cold (uncomfortable) or medication reaction. (See Attachment A for examples).
2. **Alternative Interventions: Measures which modify the environment enhance interpersonal interaction or provide treatment so as to minimize or eliminate the problems/behaviors which place the patient at risk.** (See Attachment A for examples).
3. **Least Restrictive Interventions:** Measures which permit the maximum amount of freedom of movement consistent with patient safety and protection from injury.
4. **Physical Restraints:** Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.
5. **Chemical Restraints:** A drug or when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.
6. **Medical Immobilization:** Restraints used for medical, dental, diagnostic, or surgical procedures are based on standard practice for the procedure. Examples are:
 - a. Devices for surgical positioning
 - b. Devices for radiotherapy procedures
 - c. A cast for a broken limb
 - d. Area restraint (e.g. arm board) during intravenous administration
 - e. Devices for diagnostic imaging positioning
7. **Adaptive Devices:** These devices may limit a patient's movement and differ from a restraint in that they are intended to permit a patient to achieve maximum normative bodily functioning. These devices are based on the assessed need for the individual patient and are documented in the medical record. Some examples are postural support and orthopedic appliances.
8. **Protective Devices:** These devices are not considered a restraint when they are used to compensate for a patient's specific deficit or to prevent safety incidents. Such use is always based on the assessed needs of the individual patient and is documented on the medical record. Examples are:
 - a. Protective helmets
 - b. Cart straps used during treatments or transportation activities

RESTRAINT PROCEDURE

1. **ASSESSMENT/CRITERIA**
 - a. Assessment of the patient considers root cause of behavior and alternative measures to restraint use (See Attachment A). Alternative measures are to be considered prior to application of restraint devices. Risks associated with any interventions must be considered in the context of an ongoing loop of assessment, intervention, evaluation, and re-intervention.

- b. A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint are outweighed by the risk of not using it. Least restrictive methods/interventions should always be attempted first.
- c. The use of restraints will be determined by the treating physician.
- d. The criteria for use of restraints are:
 - i. Patient's behavior exhibits danger to self or others.
 - ii. Alternative measures are ineffective.

2. EDUCATION

- a. The risks and benefits will be discussed with the patient, or the patient's representative. The patient, or patient's representative, should be involved in the decision making process when appropriate. Patient family/significant others request for the use of restraint cannot be a determining factor in the decision to use a restraint.

3. PHYSICIAN ORDER

Time limited order for Medical/Surgical restraint

- a. The treating physician's time-limited order, written for a specific episode must be obtained for use of any type of restraint. Written and verbal orders must be documented on the Restraint Order Form. The use of PRN or standing restraint orders is prohibited. The treating physician's time limited order cannot exceed 24 hours, and will specify the reason for the restraint use and the type of restraint.
- b. If the treating physician is not available to issue an order, physical restraint use may be initiated by a registered nurse based on assessment of the patient. The treating physician is notified during or immediately after restraint application and a verbal order or written order is obtained. A written order, based on an examination of the patient by the treating physician, must be signed within 24 hours of the initiation of the restraint.
- c. Continued use of restraint beyond the initial time limited order is authorized by the treating physician renewing the original order or issuing a new order if restraint use continues to be clinically justified. Such renewal or new order, for patients restrained for non violent or self destructive behavior, is issued no less often than once every calendar day and is based upon an examination of the patient by the treating physician.

Time limited order for patients restrained because of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.

- a. Initial orders for adult patients restrained because of violent or self –destructive behavior will be for a maximum of four hours, two hours for children/adolescent (age 9-17), and one hour for children under nine. The treating physician must conduct an in person evaluation of the patient and write the order within one hour of the initiation of restraint. At the time of this in-person evaluation, the treating physician works with the patient and staff to:
 - i. Evaluate the patient's physical and psychological condition and immediate situation
 - ii. Evaluate the patient's reaction to the intervention

- iii. Determines whether restraint should be continued or terminated
 - iv. Identify ways to help the patient regain control, so that restraint can be discontinued
 - v. Make any necessary revisions to the patient's treatment plan
 - vi. Provide a new written order, if restraint not terminated.
- b. If the patient's attending physician is not the physician who gives the order, the patient's physician will be notified of the patient's status as soon as possible if the restraint is continued.
- c. Re-evaluation/assessment of the continuation of the behavioral restraint order must be done in person as a "face to face" assessment and written by the treating physician or as a verbal order by the registered nurse every 4 hours for adults over 18 years, every 2 hours for children and adolescents age 9-17, and every hour for children under age 9.
- d. The treating physician must do a face to face re-evaluation/assessment every 24 hours for patients, age 18 and older and every 4 hours for patients ages 17 and younger.

4. MONITORING

- a. In most cases use of restraint requires the following observations, assessment, and care performed as often as needed but at least every two hours. Patients restrained because of violent or self-destructive behavior are assessed and monitored through in-person observation by a registered nurse at least every 15 minutes.
- b. The frequency of assessment and monitoring of a restrained patient should be individualized, taking into consideration variables such as patient condition, cognitive status, and other relevant factors. In some cases the time frames of the policy may not be sufficient and in others they may be disruptive to patient care.
- c. Observations/Assessments
 - i. placement of restraint
 - ii. skin condition under restraint
 - iii. circulation of immobilized limb
 - iv. patient condition, orientation status and comfort
- d. Provision of care
 - i. active/passive range of motion
 - ii. change of position
 - iii. hygiene/elimination needs addressed
 - iv. food/fluid intake
- e. Restraint need reassessed

5. REASSESSMENT/CONTINUATION

- a. During the period of restraint, the registered nurse reassesses the patient need for restraint at least every two hours (every 15 minutes for patients restrained for violent or self destructive behavior). This assessment and reassessment of the need for restraint, alternatives and least restrictive methods to be used will be reflected in a modification to the patient's plan of care. After the order expires, the patient receives a face to face reassessment by the treating physician. The treating physician writes a new order if the restraint order is going to be continued.

6. DOCUMENTATION

- a. Documentation of the initial restraint assessment and reassessment is completed by the registered nurse in the electronic medical record or on the paper restraint record. Documentation of patient/family education, observations, and alternatives attempted, and provision of care is completed by the registered nurse or the LPN in the electronic medical record or on the paper restraint record. Modification of the patient's plan of care is documented by the nurse in the care plan.
- b. For patients restrained for violent or self-destructive behavior, the face to face medical and behavioral evaluation by the treating physician will be documented in the electronic medical record or on the restraint order. It will include a description of the patient's behavior and condition, the intervention used, alternatives or least restrictive restrictions attempted and the patient's response.

7. TERMINATION

- a. Restraint may only be used while the unsafe situation continues. RNs that have had the education and the competency to recognize when the patient is no longer a threat may terminate restraint use earlier than the order indicates based on assessment of patient condition or may again attempt alternative measures. When the restraint is terminated and the unsafe condition is still evident and alternatives remain ineffective, a new order must be obtained to reapply the restraint. Termination of the restraint should be based on the determination, before the order expires, that the patient's behavior is no longer a threat to self, staff members or others.

REFERENCES

1. American Psychiatric Association, American Psychiatric Nurses Association, & National Association of Psychiatric Health Systems. Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health. Retrieved March 2, 2009 from www.naphs.org/rscampaign/Learning.pdf.
2. Joint Commission, Comprehensive Accreditation Manual for Hospitals – The Official Handbook, Restraint Standards, Refreshed Core, retrieved November 03, 2015 from <http://e-dition.jcrinc.com/Frame.aspx>
3. State Operations Manual Appendix A Interpretive Guidelines – Hospitals. Retrieved November 03, 2015, from CMS Web site: <http://www.cms.hhs.gov>.
4. Swauger, K, & Tomlin, C. (2000). Journal of Nursing Administration. *Moving Toward Restraint-Free Environment*. 30(6) pp. 325-329.

STAFF ACCOUNTABILITY

Medical Staff Executive Committee – *January 12, 2016*

By-Laws Committee – *January 7, 2016*

Nursing Policy and Procedure Committee – *November 24, 2015*

Risk Management Council – *November 12, 2015*

Department Approval

Signed | s |: George Greene, MD

Title: Chief of Staff

Administrative Approval

Signed | s |: Suzanne L. Nuss, PhD., RN

Title: Chief Nursing Officer