Dignity Health
St. Rose Dominican

POLICY/PROCEDURE

SUBJECT: **Restraints, Management of Patients Requiring Restraint**
ORIGINATED: 11/80 EFFECTIVE: 11/18 SUPERSEDES: 10/15

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1.0 PURPOSE

1.1 Scope - To define the process for use of physical and chemical restraints for all patients who meet criteria and are receiving care and services at Dignity Health St. Rose Dominican (SRD).

1.2 Objective - To provide appropriate and safe practice for the use of restraints when necessary and in a manner designed to protect the patient's health and safety and preserves their dignity, rights, and well-being.

2.0 RESPONSIBILITIES

2.1 Clinical Staff - members of the interdisciplinary healthcare team with direct patient care responsibilities participating in the development and execution of the plan of care and who have demonstrated competency, are responsible for monitoring a patient in restraints and provide direct observation when applicable.

2.1.1 Registered Nurse (RN) – who have demonstrated competency, are responsible for initiating and discontinuing restraints as well as assessing and monitoring patients requiring restraints.

2.2 Licensed Independent Practitioners (LIP) - Medical staff, including Certified Physician Assistants and Nurse Practitioners, privileged and credentialed to do so; are responsible for ordering restraints.

2.3 Security Staff - who have demonstrated competency, are responsible for assisting the clinical staff when the application of physical restraint is necessary.

3.0 DEFINITIONS

3.1 Behavioral emergency – a situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, staff or others.

3.2 Chemical Restraint – medication used as a means to restrict or manage a patient's behavior, or restrict the patient's freedom of movement.

3.2.1 Standard treatment includes, but is not limited to the following:
- 3.2.1.1 Medication within the prescription parameters set by the Food & Drug Administration (FDA) and manufacturer for therapeutic use.
  - 3.2.1.1.1 Follows national practice standards.
  - 3.2.1.1.2 Used to treat a specific condition based on a patient's symptoms.
  - 3.2.1.1.3 Enables patient to have effective or appropriate functioning.

3.2.2 A medication used as a standardized treatment of a patient's condition is not a chemical restraint.

3.3 Direct Observation – means in-person, continuous direct visualization of a patient which may occur through a window or doorway since staff presence in the room in which the patient is restrained could be dangerous or add to the agitation of a patient.

3.4 Non-violent/self-destructive Restraint – a physical or chemical restraint used to restrict patient movement for patients requiring limitation of mobility to provide uninterrupted care, treatment and services.

3.5 Physical Restraint - Any manual method, physical or mechanical device, material, or equipment used to immobilize or reduce the ability of a patient to move their arms, legs, body, or head freely.

3.6 Restraint episode – the period of time covered by each order for restraint.

3.7 Seclusion **-** is the involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving and is not a practice utilized at SRDH.

3.8 Violent/self-destructive Restraint – a physical or chemical restraint used to restrict patient movement for the management of violent or self-destructive behavior that is an immediate threat to self, others or property.

4.0 POLICY

4.1 The use of the least-restrictive physical restraint is utilized after alternative interventions have either been considered or attempted. (See Reference 8.1)

4.1.1 Use of restraint for violent/self-destructive purposes is limited to a behavioral emergency.

4.1.2 Alternative interventions are based on individualized assessment of the patient's medical and/or behavioral status or condition.

4.1.2.1 Alternatives to be considered prior to use of restraint include, but are not limited to:

4.1.2.1.1 Re-orientation/redirection methods.
4.1.2.1.2 Move patient to a room close to nurse's station.
4.1.2.1.3 Activate bed alarms.
4.1.2.1.4 Exercise and ambulate, as appropriate.
4.1.2.1.5 Encourage family or support system visitation, as appropriate.
4.1.2.1.6 Increase staff observation.
4.1.2.1.7 Modify environmental factors such as decreased stimulation.
4.1.2.1.8 Verbal de-escalation.
4.1.2.1.9 Distraction methods/diversion activities such as TV, music therapy, picture books, games, relaxation tapes.
4.1.2.1.10 Develop toileting routine.

4.2 The presence of one (1) or more of the following criteria define the clinical justification for restraint:

4.2.1 Non-violent/self destructive.

4.2.2 Violent/self-destructive.

4.3 The use of restraint for the following reasons is strictly prohibited:

4.3.1 A potential condition or symptom, but not an actual associated behavior.

4.3.2 Based solely on a patient's history of prior restraint.

4.3.3 Punishment.

4.3.4 Deterrent to elopement.

4.3.5 Convenience to staff.

4.4 All patients requiring restraints shall have an order from an LIP. (See the *Restraint Ordering, Monitoring and Intervention Time Table,* Attachment A.)

4.4.1 The restraint order shall include:
4.4.1.1 Indication for restraint.
4.4.1.2 Type of restraint.
4.4.1.3 Date and Time restraint initiated.
4.4.1.4 LIP Signature with date and time.

4.4.2 Pre-printed physician orders are available for use. (See Reference 8.2 and 8.3)

4.4.3 As needed (PRN) restraint orders are not accepted and the practice of performing a "trial release" is considered a PRN order, therefore, not permitted.

4.5 Medical students may not write an order for restraints.

4.6 A RN must initiate and discontinue each restraint episode and verify the LIP order.

4.7 For the purposes of providing care, treatment and services; the following clinical staff may remove and reapply restraint devices:

4.7.1 Certified Nursing Assistants (CNA), under supervision of a RN

4.7.2 Therapists, i.e. Respiratory, Physical, Occupational

4.7.3 Technologist/technicians, i.e. Imaging, Laboratory

4.8 Only qualified clinical staff may monitor a patient in restraints and monitoring of patients may be performed using observation, interaction with the patient or direct examination. (See Attachment A)

4.9 When restraints are used for violent/self destructive behavioral purposes, SRD will evaluate staff levels and assignments on the following: (See Attachment A)

4.9.1 Staff qualifications.

4.9.2 Physical design of the environment.

4.9.3 Patient diagnoses and acuity levels.

4.9.4 Patient ages and developmental functioning.

4.10 Patients requiring restraint who are transported off the unit will be accompanied by qualified clinical staff.

4.11 The opportunity to debrief after each use of violent/self destructive restraint is provided for staff, patients, and family, as appropriate, and the information obtained from debriefings will be incorporated into performance improvement measures.

4.12 Restraint shall be discontinued when the behavior or condition which is the basis for the restraint is resolved even if the enabling order allows for a longer duration.

4.13 The following are approved physical restraints used at SRD:

4.13.1 Soft limb holders.

4.13.2 Mitten/wrist restraints.

4.13.3 Joint immobilizer, i.e. Freedom Splints.

4.13.3 Bed siderails, other than when used for safety considerations.

4.13.4 Locking limb holders.

4.14 Vest restraints will not be used at SRD.

4.14.1 Vest restraints will be removed if a patient is admitted with one in place and the LIP notified to obtain replacement orders if needed.

4.15 The following situations are not considered restraint per this policy:

4.15.1 Standard practices include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedures care processes. For example: surgical positioning, intravenous arm boards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients.

4.15.2 Adaptive support in response to assessed patient need. For example: postural support, orthopedic appliances, tabletop chairs.

4.15.3 Measures taken to protect patients from falling out of bed, excluding physical restraints.

4.15.4 Helmets.

4.15.5 Forensic and correction restrictions used for security. (See Reference 8.4)

4.16 The patient interdisciplinary plan of care shall be modified to include management and care of the patient in restraints. (See Reference 8.5)

4.17 Hospitals must report the following information directly to the Centers for Medicare and Medicaid Services (CMS) for deaths associated with the use of restraints. (See Reference 8.6)

4.17.1 Each death occurring while a patient is in restraint.

4.17.2 Each death occurring within twenty-four (24) hours after the patient has been removed from restraint.

4.17.3 Each death known to the hospital occurring within one (1) week after restraint where it is reasonable to assume the use of restraint contributed directly or indirectly to a patient's death.

4.16.4 Quality Management will notify the CMS within twenty-four (24) hours following knowledge of the patient's death if criteria are met.

4.18 SRD uses performance improvement processes to identify opportunities to reduce the incidence of and risks associated with the use of restraint.

4.18.1 This process will include:
- 4.18.1.1 Collection of data on the incidence and indications for restraint.
- 4.18.1.2 Aggregation and analysis of the data to determine patterns, trends and clusters of restraint use.
- 4.18.1.3 Identification and evaluation of opportunities to reduce the use of restraint and/or redesign care processes.
- 4.18.1.4 Evaluation of the effectiveness of actions taken.

4.19 Restraint education, training and competency will be provided as part of the initial orientation of all new and contract staff and as part of ongoing in-service training for clinical staff with direct patient care responsibilities. (See Reference 8.7)

5.0 PROCEDURE

5.1 Physical restraint will be implemented in accordance with safe, appropriate restraint techniques and in accordance with applicable standards. (See Reference 8.6 & 8.7)

5.2 When physical restraint is implemented a *Patient & Family Information – Managing Restraints* brochure will be offered to all patients, family, guardian and/or significant other as appropriate. (See Reference 8.8)

5.3 Manufacturer's instructions will be followed for the application of all physical restraint devices.

5.4 Follow the procedures outlined in *Clinical Skills,* Dignity Health Clinical Reference (CR) icon found on your desktop.

5.4.1 *Restraint-Free Environment.*

5.4.2 *Restraint Application and Monitoring*.

5.4.3 *Restraint Application and Monitoring (Pediatric).*

5.4.4 *Safe Environment (Pediatric).*

5.5 Follow the procedures as outlined in the *Restraint Guidelines* (see Reference 8.9).

6.0 PATIENT AND FAMILY EDUCATION

6.1 Clinical staff will provide on-going education to the patient and/or patient representative on the initiation of and desired behavior for discontinuation of restraints with attention to patient and family involvement in the achievement of goals. (See Reference 8.8 & 8.10)

7.0 DOCUMENTATION

7.1 Document restraints in the patient's health record according to the *Restraint Ordering, Monitoring and Intervention Time Table,* Attachment A. (See References 8.11 & 8.12)

7.1.1 Debriefing events following the discontinuation of violent/self-destructive restraint will be documented in the patient's health record.

8.0 REFERENCES

8.1 *Conditions of Admission and Treatment – Patient Rights and Responsibilities,* SRD form # S1377.

8.2 *Non-Violent/Self-Destructive Restraint Orders*, SRD form #S1400.

8.3 *Violent/Self-Destructive Restraint Orders*, SRD form #S1399.

8.4 *Legal Custody & Forensic Orientation Care of Patients*, SRDH Clinical policy #OPD.P16.21.

8.5 *Interdisciplinary Plan of Care*, SRDH Clinical policy #OPD-M13-14.

8.6 Department of Health and Human Services: Centers for Medicare & Medicaid Services (CMS) *Conditions of Participation, Appendix A* at 42 CFR 482.13 (e), (f), (g). Federal Register (71 FR 71378), updated October 17, 2008.

8.7 The Joint Commission (2010). Hospital Accreditation Standards: Provision of Care, Treatment, and Services (Standards PC.03.02.01-PC.03.05.03). Joint Commission on Accreditation of Healthcare Organizations, Oakbrook, IL.

8.8 *Patient & Family Information - Managing Restraints*, SRD Brochure # XRX # 90.

8.9 *Restraints Guidelines*, found in the Clinical Policies/Guidelines folder.

8.10 *Interdisciplinary Patient & Family Education*, SRDH Clinical policy # OPD-I9.55.

8.11 *Patient Restraint Documentation: Non-Violent/Self-Destructive (Acute Medical-Surgical) Restraint,* SRD form # S1420.

8.12 *Patient Restraint Documentation: Violent/Self-Destructive (Behavioral Management) Restraint*, SRD form # S1419.

8.13 State of Nevada Department of Health and Human Services: Health Division Bureau of Health Care Quality and Compliance (December 5, 2008). Letter regarding CMS document: "*Hospital Restraint/Seclusion Death Reporting*", Appendix A at 42 CFR Part 482.13(e)-(9).

9.0 ATTACHMENTS

9.1 *Restraint Ordering, Monitoring and Intervention Time Table*, Attachment A.

Revision Reviewed/Approved:

Quality Management Services, September 2018
Multidisciplinary Policy & Procedure Committee, September 2018
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Dignity Health
St. Rose Dominican

Attachment A

Restraint Ordering, Monitoring, & Intervention Time Table

	Non-Violent/Self-Destructive Restraints	Violent/Self-Destructive Restraints
Orders for Restraint	**LIP ORDER:** An RN may initiate restraint without an order in an emergency situation, but must receive a telephone order from the LIP immediately. The LIP must conduct a face-to-face assessment of the patient within 24 hours of the initiation of restraints. Orders must be time-limited, include the type of restraint, reason for restraint and be signed, dated and timed by the LIP **SUBSEQUENT ORDER:** **Required every calendar day** Each calendar day, the LIP must conduct a face-to-face evaluation of the patient, reassess the need for restraints and write a new order, if indicated. ***PRN orders and telephone re-orders are NOT allowed.***	**LIP ORDER:** An RN may initiate restraint without an order in an emergency situation, however the LIP **must** perform a face-to-face assessment within 1 hour of restraint initiation. Restraint orders *expire* in: ● 1 hour for 8 years of age and younger ● 2 hours for 9-17 years of age ● 4 hours for 18 years of age and older ***PRN orders, verbal and telephone re-orders are NOT allowed.***
Monitoring, Assessment & Documentation (Aspects of monitoring may be assigned to a CNA)	After restraints are applied, **an immediate assessment must** be completed by a RN to ensure that restraints were properly and safely applied. Subsequent restraint assessment is performed a minimum of once a shift and as needed as the patient's condition changes. ***EVERY 2 HOURS, the following patient care needs are evaluated and appropriate interventions taken:*** Skin/Circulation Hydration/ Nutrition Hygiene/ Elimination ROM of extremities Mental status Continued need for restraints **Vital Signs:** Minimally every 8 hours or more frequent as per department/unit Standards Of Care for routine vital signs.	After restraints are applied, **an immediate assessment must** be completed by a RN to ensure that restraints were properly and safely applied. Subsequent restraint assessment is performed a minimum of once a shift and as needed as the patient's condition changes. ***EVERY 15 MINUTES, the following patient care needs are evaluated and appropriate interventions taken:*** Skin/Circulation Hydration/ Nutrition Hygiene/ Elimination ROM of extremities Safety Mental status code Continued need for restraints **Continuous Direct Observation required w/keys immediately available for locked restraints** **Vital Signs:** Minimally every 8 hours or more frequent as per department/unit Standards Of Care for routine vital signs.
Indications for Restraints	● Attempting to remove lines, tubes, equipment and/or dressings. ● Attempting to get out of bed or chair and lacks the ability to understand safety precautions.	● Danger to self ● Danger to others ● Danger to property
Indication for Removal of Restraints	No longer exhibiting the behavior(s) that lead to the initiation of restraint: ● Attempting to remove lines, tubes, equipment and/or dressings. ● Attempting to get out of bed or chair	No longer exhibiting the behavior(s) that lead to the initiation of restraint: ● Danger to self ● Danger to others ● Danger to property