BATES COUNTY MEMORIAL HOSPITAL
Butler, Missouri

# TRAINING MODULE: RESTRAINTS

**PURPOSE:**

To assure the patient is free from any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the patient's medical condition.

**POLICY:**

Patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

**PROCEDURE:**
Definition: A *Restraint* is:

- 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; or
- A drug or medication 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 or dosage for the patient's condition.
- A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- The use of handcuffs, shackles, manacles or other chain-type restraint devices applied by non-hospital employed or contracted law enforcement are not considered health care restraints. The law enforcement officer is responsible for the use, application and monitoring of these devices. The hospital staff is responsible for appropriate patient assessment and the provision of safe appropriate care to the patient.

## MEDICAL SURGICAL RESTRAINTS

In acute medical and surgical care, a restraint may be necessary to ensure that an intravenous (IV) or feeding tube will not be removed, or that a patient who is temporarily or permanently mentally incapacitated with a broken hip, will not attempt to walk before it is medically appropriate. That is, medical restraint may be used to limit mobility, temporarily immobilize a patient related to a medical, post-surgical or dental procedure. Intervention is generally not undertaken because of an unanticipated outburst of severely aggressive or destructive behavior that poses an imminent danger to the patient or others.

A restraint can only be used if needed to improve the patient's well-being and less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. Definitive documentation must be present in the patient's electronic medical record describing the steps or interventions used prior to the use of the needed restraint. The Restraint Flowsheet must be completed by a RN every 2 – 12 hours or PRN. Other alternatives that could be explored before applying a restraint of any type include:

- Bed alert system
- Call light within reach
- Positioning devices
- Check medication list for possible adverse side effects
- Involve patient in activities.
- Offer food and/or drink every two (2) hours.

**Provide patient an opportunity to use the bathroom every two (2) hours or as per care plan.**
Ambulation, or exercise if possible

A voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint, (some patients lack the ability to walk without the use of leg braces, to sit upright without neck, head or back braces).

A medically necessary and voluntary positioning or securing device used to maintain the position, limit mobility or temporarily immobilize during medical, dental diagnostic, or surgical procedures is not considered a restraint.

Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers) that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool-aged child would not be considered restraint or seclusion.

There must be an order from a physician for all types of restraining measures, for a time period no longer than twenty-four (24) hours. At that point, the physician who ordered the use of restraints must see and assess the patient in person to determine whether the issuance of a new order is appropriate. PRN or "as needed" orders are not acceptable.

If the restraint is not ordered by the patient's treating physician, documentation must reflect that interactions or contacts were made with the treating physician as soon as possible.

Restraints must be used in accordance with the patient's plan of care. The restraints should be referred to in the patients "modified" plan of care to reinforce the expectation that restraints should not be a standard response to a particular behavior or situation.

The restraints must be implemented in the least restrictive manner possible and in accordance with safe and appropriate restraining techniques.

The Restraint Flowsheet is to be utilized for patients in restraints. A CNA may assist the RN or LPN in providing care to the patient.

### *Nursing Care of Patients in Restraints*

- Patient must be checked frequently, at least every thirty (30) minutes.
- Change patient's position at least every two (2) hours and document.
- Offer drinking water frequently.
- Offer toileting at regular intervals.
- Remove restraints to provide for range of motion every two (2) hours.
- Because of inactivity, good skin and back care is essential.
- Check skin around restraints for pressure areas and abrasion.
- Watch for signs of exhaustion.
- Never restrain all four limbs to one side of the bed.
- Patient should be assessed for need for restraint on an ongoing basis.
- Patient should be clinically assessed (head-to-toe) at least once a shift.

Removal of Restraints - As soon as the medical, post-surgical or dental procedure has been discontinued and limited mobility or immobilization is no longer necessary, the restraint is to be removed. This may be authorized by the Nursing Supervisor as per physician's order/ directive.

## *SECLUSION AND RESTRAINT FOR BEHAVIOR MANAGEMENT*

The patient has the right to be free from seclusion and restraints of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

***Definitions***

A *Restraint* is:

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; or
A drug or medication 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 or dosage for the patient's condition.
A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without he risk of physical harm (this does not include a physical escort).

*Seclusion* is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

Seclusion or restraint can only be used in an emergency situation if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective.

An emergency is defined as an unanticipated, catastrophic event, that may cause harm to self or others, and may occur over periods of time. However, focus should always be on removing the need for restrictive devices while still protecting the patient and others.

The Nursing Supervisor may initiate seclusion or restraint in an emergency situation until the physician can be contacted.

The patient's electronic health record should reflect the events occurring to the patient necessitating the use of seclusion or restraint, the alternatives to restraints that were attempted, and monitoring of patient while restrained, using the Restraint Flowsheet.

- Nursing Care of Patients in Restraints
- Patient must be checked frequently, at least every thirty (30) minutes.
- Change patient's position at least every two (2) hours and document.
- Offer drinking water frequently.
- Offer toileting at regular intervals.
- Remove restraints to provide for range of motion every two (2) hours.
- Because of inactivity, good skin and back care is essential.
- Check skin around restraints for pressure areas and abrasion.
- Watch for signs of exhaustion.
- Never restrain all four limbs to one side of the bed.
- Patient should be assessed for need for restraint on an ongoing basis.
- Patient should be clinically assessed (head-to-toe) at least once a shift.

The treating physician must be consulted as soon as possible, if the restraint or seclusion is not ordered by the patient's treating physician.

When restraint or seclusion 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, the patient must be seen face-to-face within 1 hour after the initiation of the intervention by a:

- Physician or other licensed independent practitioner; or
- RN Nursing Supervisor

*To evaluate:*

- The patient's immediate situation;
- The patient's reaction to the intervention;
- The patient's medical and behavioral condition;
- The need to continue or terminate the restraint or seclusion.

If the face-to-face evaluation is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as soon as possible after the completion of the 1 hour face-to-face evaluation.

Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

- 4 hours for adults 18 years of age or older:
- 2 hours for children and adolescents 9 to 17 years of age; or
- 1 hour for children under 9 years of age

The original order may only be renewed in accordance with these limits for up to a total of 24 hours.

After the original order expires (24 hours), a physician must see and assess the patient before issuing a new order.

The use of seclusion or restraints must be in accordance with a written modification to the patient's plan of care.

The use of seclusion or restraints must be implemented in the least restrictive manner possible.

The use of seclusion or restraints must be in accordance with safe and appropriate restraining techniques.

The use of seclusion or restraints must be ended at the earliest possible time. A physician's order is necessary.

A restraint and seclusion may not be used simultaneously unless the patient is continually monitored face – to – face by an assigned staff member. If the patient is in a 4-point restraint, one – to – one monitoring is required.

The condition of the patient who is in a restraint or in seclusion must continually be assessed, monitored, and re-evaluated.

When restraint or seclusion is used, there must be documentation in the patient's electronic medical record of the following:

- The 1 hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior.
- A description of the patient's behavior and the intervention used;
- Alternatives or other less restrictive interventions attempted (as applicable);
- The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and
- The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

The restraint release flow sheet is to be utilized for patients in restraints.  A CNA may assist the RN or LPN in providing care to the patient.

Nursing Staff should be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion. As part of orientation and annually, training content should include:

- Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
- The use of nonphysical intervention skills.
- Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
- The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);
- Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
- Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity and vital signs.
- The use of first aid techniques and certification in the use of cardiopulmonary resuscitation.

**DEATH OF PATIENT WHILE RESTRAINED OR IN SECLUSION**

Bates County Memorial Hospital must report to CMS deaths associated with the use of seclusion or restraint.

The hospital must report the following information to CMS:

- Each death that occurs while a patient is in restraint or seclusion.
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
- Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

Each death referenced in this paragraph must be reported to CMS Regional Office (816-426-2011) by telephone no later than the close of business the next business day following knowledge of the patient's death. This will be done by the CEO or his /her designee.

Staff must document in the patient's electronic medical record the date and time the death was reported to CMS.

***Policy is located on hospital's intranet (eConnect) – Resources – More Resources - Policies and Guidelines – Med-Surg***