

YOUR HOSPITAL  
ORIGINATING DEPARTMENT: NURSING COUNCIL

TITLE: RESTRAINT PROTOCOL FOR PATIENTS  
INTERFERING WITH TREATMENT

POLICY # \_\_\_\_\_

AFFECTED DEPARTMENTS: PATIENT CARE SERVICES

APPROVED: MEC

EFFECTIVE DATE: FEBRUARY 1998

PROTOCOL:

It will not be necessary to obtain a physician's order for the protocol, however, a qualified registered nurse must record and complete the criteria on the 24 hour restraint flow sheet. The RN may institute this protocol after an assessment of the patient and if the patient has met the criteria. Least restrictive measures will always be attempted and found to be ineffective before the application of restraints. The patient's family will be notified of the need to apply restraints and will be given the opportunity to attend the patient prior to the application of restraints.

CRITERIA:

IF THE PATIENT HAS ONE OF THE FOLLOWING CONDITIONS (Check the appropriate category/categories in each section)

- Dementia
- Delirium
- Neurological impairment
- Altered level of consciousness
- Cognitive impairment

AND/OR

- Patient is unable to comprehend the seriousness of his/her condition.
- Patient is unable to comprehend the need for treatment
- Patient is unable to benefit from patient education and/or follow instructions.

AND PATIENT ATTEMPTS TO:

- Pull out IV and arterial or central lines \_\_\_\_\_  
(specify type and location)
- Pull out NG tube \_\_\_\_\_
- Pull out feeding tube \_\_\_\_\_  
(specify type)
- Pull out catheter(s) \_\_\_\_\_  
(Specify type and location)
- Remove intubation tube \_\_\_\_\_
- Other \_\_\_\_\_

