

**YOUR HOSPITAL
ORGINATING DEPARTMENT: NURSING COUNCIL**

TITLE: Restraints and Seclusion Policy

POLICY # _____

AFFECTED DEPARTMENTS: Nursing Service

APPROVED: N.C. - 1/22/98
MEC - 2/18/98

EFFECTIVE DATE: February 18, 1998

REVISED DATE:

I. PURPOSE:

The purpose of this policy is to communicate organizational policy on the alternatives to and the appropriate use of restraint and seclusion within all patient care areas while insuring that patient rights are not violated.

II. POLICY:

A. Restraint may be used as the least restrictive effective measure based on the current assessment, by a Registered Nurse of the patient in the immediate care environment, after other measures have been unsuccessful or determined to be inappropriate (clinical justification). Clinical justification is guided by clear criteria and protocols. Two clinical care protocols are approved for use:

- * Patients Interfering with Treatment/Procedure, and
- * Patients at Risk for Falling

If an approved protocol is not appropriate for the given situation, i.e. combative patient, a time limited physician order is required in addition to adequate clinical justification. Documentation in the medical record must include other measures attempted and rational for continued use of restraint. The medical staff must approve all protocols utilized by nursing staff. Patients at YOUR Hospital are not placed in seclusion as there is no appropriate site. Violent patients will be attended at all times until transfer can be accomplished.

B. Definitions and Policy Exclusions:

1. Restraint: Use of any method to involuntarily restrain movement of the whole or a portion of a patient's body as a means of modifying a patient's physical activities to protect the patient or others from injury.

- * **Excluded from the definition of restraint are any devices used voluntarily and/or for reasons of medical immobilization, forensic purposes, adaptive support, or protection.** A physician's order is not required, although, adequate documentation of continued assessment must be recorded in the medical record. (See Section H)
 - a. Voluntarily - In order for a device to be applied voluntarily, documented verbal consent for the restraining device must be obtained from a cognitively intact patient. Examples might include a woman who has just taken a sleeping pill and has agreed or requested to have a lap belt applied for the evening as a reminder not to get up out of bed without pressing the call button to ask for assistance from the nursing staff.
 - b. Medical Immobilization - Mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures/tests that are considered a regular part of such procedures/tests. These mechanisms usually include

- body restraint for post operative and post anesthetic care.
 - c. Forensic (law enforcement purposes) - Direct application by law enforcement agents. Medical record documentation reflects that the restraint was applied by forensic staff.
 - d. Adaptive Support/Protective Device - Mechanisms intended to permit a patient to achieve maximum normative bodily functioning, including orthopedic appliances, brace, wheelchairs, or other devices used for postural support. This could include tabletop chairs or helmets. The top two siderails on a patient's bed may be utilized by the patient to assist with repositioning and enhance access to bed controls. The lower siderails are a restraint and justification for their use must be made by an RN assessment.
2. Seclusion: Involuntary confinement of a person alone in a room where the person is physically prevented from leaving (not done at YOUR).
 3. Primary behavioral health: All forms of illness in which psychological, emotional, or behavioral disturbances are the dominating feature and the focus of treatment.
 4. Monitor: Observation and direct face to face interaction with the patient. Patient's physical and emotional needs are met, i.e. nourishment and personal care.
 5. Reassessment: Used primarily to determine the continuing needs for restraints or seclusion.
 6. Interdisciplinary: Relating to or involving two or more academic disciplines that are usually considered distinct i.e. Medicine and Nursing.
 7. Protocol: A plan or set of steps to be followed in an intervention (see attached protocols).
 8. Trainer: Has demonstrated competencies and has the educational expertise to facilitate staff education and training.

C. Indications and Contraindications:

The use of restraints and/or seclusion requires special justification with documentation that:

- * no other less restrictive measure is appropriate per the assessment and/or other measures have been tried, and failed, or:
- * the patient is a potential danger to himself or others, or;
- * the patient behavior is not manageable within the care environment.

A collaborative approach is taken in reviewing the need for use of restraint/seclusion, and efforts are focused upon working toward the least restrictive, effective measures for safety.

Contraindications to the use of restraints/seclusion may include any medical or psychiatric condition that could be exacerbated by its use, i.e., broken or burned extremities or claustrophobia. The benefits as compared to the risks must be evaluated.

All prisoners from the jail are shackled (ankle and wrist) prior to being transported to the hospital. When in bed, one extremity is shackled to the bed. During the time the patient is hospitalized, the extremities are shackled and observed for injury. A guard is furnished by law enforcement agency.

D. Initiation of Restraints:

The Restraint Decision Algorithm (Figure 1) should be followed. In instances where alternatives to restraint have been unsuccessful or determined to be inappropriate, restraint application may be initiated by time-limited physician order OR under one of the following attached protocols, if applicable:

- * Patient Interfering with Treatment/Procedure
- * Patient at Risk for Falling

Protocols are not appropriate in situations where the patient has become combative; orders must always be obtained. In an emergency, however, a qualified staff member (RN) may identify the need and initiate use of a restraint intervention, provided that a physician order is obtained within four (4) hours of initiation. Verbal orders must be authenticated by the responsible physician (either the ordering or covering physician) within 24 hours.

Regardless of whether a protocol or order is used to initiate restraints, the physician is responsible to ensure that the patient's assessed needs are met.

1. Initiation by Protocol:

To initiate restraint by protocol, the medical record shall clearly reflect the rationale for use, specifically alternative measures attempted or why alternatives are not appropriate. Under such circumstances, an RN may initiate use of a protocol for restraint use and collaborate with the physician. The RN will flag the medical record with a protocol notification stamp in the order sheet.

2. Time Limited Orders: (this is not required for patients under an approved protocol)

Each order must include: reason for restraint, type of restraint, start time of restraint and duration. The restraint order sheet should be utilized.

Written orders for restraint are limited to:

- * 24 hours

After the original order expires, the patient receives a face-to-face reassessment by a physician. The physician writes a new order if restraint is going to be continued. [This is not required for patients under an approved protocol.]

The physician must perform a face-face reassessment after the maximum of 24 hours.

E. Trial Releases:

Documentation must clearly state the behavior noted in which restrictive measures were implemented again. An RN shall assess for appropriateness of trial release at a minimum once per shift or whenever patient's behavior improves.

- * improved mental status
- * patient agreeable to comply with expected behavior
- * improved ability to ambulate without the risk of falling

The assessment for trial release shall be documented in the medical record.

F. Staff Competency and Training:

Competency of staff and trainers must be maintained, demonstrated, and documented on an annual basis.

Staff initiating, maintaining, or terminating the use of restraint shall receive specific training related to:

- * Age-appropriate use
- * Least restrictive alternatives
- * Application of restraints
- * Monitoring and reassessment
- * Trial releases

- * Documentation

G. Monitoring and Reassessment

- * Direct observation must be performed at:
 - a minimum of every 60 minutes for patients in one, two, or three point restraints,
 - a minimum of every 30 minutes for patients in 4 or 5 point restraints.
 - * Provide for hydration, nutrition, and toileting needs every 2 hours
 - * Assist the patient to perform activity as tolerated (ROM, chair, ambulation) every 2 - 4 hours
 - * If an extremity is restrained, assess Integumentary and Neurovascular status every 2 hours, remove restraint and allow for ROM
- Documentation must reflect these observations.

H. Documentation Requirements:

The medical record shall include:

- * Restraint Protocol/care plan (assessment, implementation, evaluation)
- * Less restrictive alternatives used prior to restraint
- * Behaviors exhibited by the patient and indications for restraint
- * Interdisciplinary collaboration, including patient and family when appropriate, related to potential or actual use of restraint
Appropriate protocol sticker will be placed in physician order sheet upon initiation
- * Evaluation of the patient's behavior
- * Behavior indicating the appropriateness of trial release
- * Behavior during trial release
- * Behavior justifying the reapplication of restraints or resuming seclusion
- * Attention to patient's physical and emotional needs

I. Transportation of Restrained Patients To and From Other Departments:

Restraints shall be maintained throughout transport, and the appropriate intensity of observation shall be maintained. Whenever restraints need to be removed for tests or treatment, the patient shall be observed during that period, and restraints shall be reapplied prior to transport back to the unit of origin. Documentation shall continue when the patient is off the nursing unit. Upon return to the patient room, restraints shall be resecured appropriately.

J. Performance Improvement:

Restraints are high risk and problem prone and thus are a component of our organization's performance-improvement program. The measurement and assessment process related to restraint seeks to understand the root cause of their use and incorporates this understanding into the organization's plans and priorities to evaluate and, if appropriate, reduce their use. Restraints will be measured and assessed for both quality control purposes and performance-improvement.

III. Procedure Summary:

- A. Least restrictive measures will always be attempted and found to be ineffective before the application of restraints.

- B. A time limited physician's order is required for restraint use, except when applied under an approved protocol.
- C. Protocols which are currently approved for use are:
 - * Patient is at risk for falling
 - * Patient interfering with treatment/procedure
- D. A RN shall assess for appropriateness of trial release at a minimum of once per shift or whenever patient behaviors improve, and must be documented in the medical record.