

Restraints and Seclusion Policy

Purpose

The purpose of this policy is to specify the use of a device to involuntarily restrain the movement of the whole or a portion of the patient's body for medical immobilization and to guide its use and monitoring requirements.

Policy

This policy is consistent with the least restrictive measures possible to protect the patient or others from injury while maintaining the patient's rights for independence and self-determination. A patient requiring the use of restraints for behavioral purposes will be transferred to another facility with a Psychiatric Unit as soon as medically appropriate. Continuous measurement of restraint use will occur hospital-wide. Documentation in the Medical Record is monitored concurrently. This is a medically approved policy in collaboration with the Endotracheal Intubation and Ventilator Policies and Procedures, therefore no written physician's order is needed. Competent, trained staff will assess, reassess, and document adequate clinical justification with assessed needs for the application continuation, and discontinuation of restraints. These devices may be used to restrict a patient's access to part of his or her body during a medical procedure >2 hours in duration to prevent accidental injury to the patient and/or others. Seclusion and time-outs are not utilized at YOUR HOSPITAL

Definitions Adequate clinical justification refers to the criteria listing and discussion of symptoms and behaviors that indicate the need for a restraint after all other less restrictive alternatives have been attempted.

Assessed needs refers to the elements of a patient's current clinical condition that substantiates the application of a restraint.

Qualified staff refers to Registered Nurses employed by YOUR HOSPITAL who complete the hospital training program and pass the examination on use of behavioral restraints during orientation and annually thereafter.

Competent, trained staff refers to Registered Nurses employed by YOUR HOSPITAL who complete the hospital training program and pass both the written and practical examination on application, reassessment, monitoring, and releasing of behavioral restraints during orientation and annually thereafter.

Medical Immobilization Restraint Procedure

Qualified, competent, trained Registered Nurses will assess and document every alternative attempted prior to the initial application, reassessment and continuation of a Medical Restraint. These may include but are not limited to:

- family participation
- patient education
- orientation, cooperation and understanding
- close observation
- retaped, secured tubes whose removal would be life-threatening diversion

Competent, trained and qualified Registered Nurses must assess and document adequate clinical justification for the application and continuance of a Medical Immobilization Restraint upon initial application and every 12 hours thereafter. A restraint stamp will be used in the Nurses Notes for documentation. The criteria that a patient must meet for the application of these devices may include: .

- agitation; or
- confusion, disorientation; or
- lack of cooperative behavior, insight, or judgement-, or

- attempts to harm self or others; and
- patients behavior threatens removal of an essential tube/device after patient education performed

Documentation

The Registered Nurse that is primarily responsible for the patient will verify and document assessed needs with the restraint stamp in the Nursing Notes before initiation, every 12 hours during continuation, or discontinuation of a Medical Immobilization Restraint. This documentation must include but is not limited to:

- criteria for applying and continuing
- alternatives attempted before applying
- type and location
- patient education

Monitoring of the affected extremity, physiological needs being met, and Range of Motion with the restraint removed will be documented on the Nursing Flowsheet

Monitoring

The R.N. must perform:

- Range of Motion with the restraint removed every 4 hours.
- Circulation, skin, and sensation checks to the affected extremity every 2 hours
- Nutrition, fluids, and elimination opportunities every 2 hours.

Discontinuation

The medical Immobilization Restraint will be discontinued as soon as the patient no longer meets the criteria for continued application. These may include but are not limited to:

- orientation of patient with cooperation and understanding
- reduction/resolution of behaviors
- patient shows no indication of pulling essential tubes/devices
- essential tubes/devices removed
- patient is not combative
- less restrictive measures are effective
- no random movements present

The time of discontinuing the restraint and the criteria assessed will be documented with the restraint stamp in the Nursing Notes.

References

1. Zusman, J. (1997). Restraint and Seclusion: Improving Practice and Conquering the JCAHO Standards.
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3. www.acep.org/POLICY/P0004119.HTM (ACEP Policy Statement, Use of Patient Restraint). January 1996
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- 5 www.pangea.ca\rnarn%restrain, htm Manitoba Association of Registered Nurses Position
5. Statement: Nurse Practitioner. 2/19198.

6. www.inland-empire.com/clients/qmcs/restraint_guide.htm Quality Management Consultation Services. Physician Newsletter, Summer 1996, Volume 1 Issue 2.
7. Using Restraint Appropriate and Safe Guidelines.
8. www.mplus.com/carepolicy-htrn/ Fall Prevention Care Policies and Procedures.