Restraints Update

Updated May 2016
According to the Joint Commission (TJC), “All patients have the right to be free from restraints. Restraints may only be imposed to ensure the immediate physical safety of the patient or others and must be discontinued at the earliest possible time.”
Terminology

- **Restraint**: Any physical device or method that restricts a person’s freedom of movement. This can include any device that immobilizes the arms, legs, head or body, or any medication that is used to manage a patient’s behavior but is not standard treatment for the person’s condition.
Terminology

- **Seclusion**: Involuntarily confining a person in a room or area that he or she is physically prevented from leaving.
  - Seclusion may only be used in the face of self destructive behavior or to prevent violent behavior to others.
  - FMH has two seclusion rooms. One is located in the ED and the other is on the Behavioral Health Unit.
Regulatory Bodies

- Regulatory bodies have issued rules for the use of restraints that apply to all hospitals:
  - The Center for Medicare and Medicaid Services (CMS)
  - The Joint Commission (TJC)
  - State of Maryland

- The rules regarding restraint or seclusion are based on the patient’s simple right to move about freely.
  - Restraint or seclusion must only be imposed when absolutely necessary to protect the patient from doing harm to him or herself, staff, or others.
  - These rules apply to all locations within the hospital and they apply to all patients being restrained, regardless of age.
Center for Medicare and Medicaid Services (CMS)

- Restraints can be used to ensure the person’s immediate physical safety, even if the person is not violent or self-destructive.

- Restraint may be used only after less restrictive interventions have been ineffective.

- The method of restraint must be the least restrictive that will be effective and must be applied in a safe and appropriate manner.
Restraints may **NOT** be used at any time for:
- Convenience
- Discipline
- Staff reduction
- Risks to fall
- PRN
A medical restraint can only be ordered by a physician or a licensed independent practitioner who is responsible for the patient’s care.

If the attending physician was not the physician that ordered the restraint, the attending must be consulted as soon as possible.

The ordering physician must evaluate the patient within 24 hours after the order for restraint is written.

The medical restraint order must be renewed every 24 hours.
Orders and Evaluation - Behavioral

- A **one hour** face to face evaluation is **required** when restraints are implemented to protect against violent or self-destructive behavior.

- In cases where restraint is necessary to prevent violent behavior, an order for restraint are time limited.
  - 4 hours for adults
  - 2 hours for children 9-17 years of age
  - 1 hour for children <9
Assessing the Individual

- Are there underlying reasons for their behavior that may be treated?

- Physical causes:
  - abnormal lab values
  - abnormal vital signs
  - hypoxia
  - sleep deprivation
  - medication incompatibility or side effects
  - withdrawal from alcohol or drugs
  - organic brain syndromes such as Traumatic Brain Injury, Stroke, or Alzheimer’s

- Psychological causes:
  - sleep deprivation
  - withdrawal from alcohol or drugs
Risks

**Risks with Restraints**

- Strangulation
- Loss of Muscle Tone & Mobility
- Pressure Ulcers
- Agitation
- Increased Aggression
- Reduced Bone Mass
- Stiffness
- Loss of dignity
- Incontinence
- Constipation

**Risks without Restraints**

- Harm to self
- Harm to others

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Restraint Prevention Actions

- Comfort needs addressed
- Toileted and/or checked for incontinence
- Repositioned
- Offered food and fluids
- Offered warm blankets
- Room temperature adjusted to patient’s comfort
- Lights dimmed
- Noise minimized
- Chair and bed alarms in use
Restraint Prevention Actions

- Family or significant others contacted to sit with patient
- IV site disguised
- Oxygen applied
- Hypoglycemia addressed
- Abnormal lab values addressed
- Medications issues addressed
- Sleep deprivation addressed
Restraint Prevention for Aggressive Behavior

- Verbal de-escalation
- Offer PRN medications
- Quiet room (in BHU)
Unique Alternatives

- Folding Towels or Washcloths
- Sorting Objects
- Activity Aprons
Start With the Least Restrictive

RESTRAINT

Synthetic leathers

Roll belt
Freedom splint
Soft limb holders

Soft belt
4 side rails
Hand mitts

Arm boards
Wedge cushion

Toileting routine
Bed alarm
Cardiac chairs
Distraction

Move closer to nurse’s station
Family to stay
Familiar objects/photos
Camouflage sites

Meds
Labs
O2 sat
Pain

APPLICATION

Requires

MD ORDER

MOST RESTRICTIVE

(ED only)

LESS RESTRICTIVE

ALTERNATIVES

CONSIDER

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Hospital Bed as a Restraint Device

- The use of four side rails on a hospital bed is considered a restraint.
- Exceptions include but are not limited to:
  - ICU patients
  - Post Anesthesia Care Unit (PACU)
  - Patients with Seizure Precautions
Restraint Products

- Soft Mitt (Least Restrictive)
- Freedom Splint (More Restrictive)
- Soft Wrist (Even More Restrictive)
- Four Point Leather (Most Restrictive)
Restraint Products

Roll Belt

Least Restrictive

Soft Belt

More Restrictive

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Ordering Restraints

- The physician with the help of the RRT-QC nurse will enter the order for restraints
  - The nurse must enter the order using *Restraint Read-Back & Verified* as the order source. CALL RRT-QC nurse
Safe Application of Restraints

- The restraint applied must match the physician’s order
- Educate the patient and family on the use of the restraint
- Secure device to bed/stretcher frame
- When a restraint does not have a quick-release buckle, use a quick-release knot
Safe Application of Restraints

- Must be able to slip one finger under the cuff of a limb restraint

- Belts – open palm between skin and device

- For other restraints, please be aware of the manufacturer’s recommendations regarding appropriate placement

- Never attach a restraint to a bed rail

- Follow FMH Policy # PC 710, *Restraint and/or Seclusion Use (In Behavioral and Non Behavioral Health Settings)*
Documentation

- Restraint documentation must be:
  - Accurate
  - Timely
  - Complete

- A nursing note should include: *(Canned text available!)*
  - The patient’s symptoms or condition that warranted the restraint and what type of restraint was applied (which should match the order).
  - Any alternative interventions that were attempted prior to the restraint application.
  - A description of the patient’s response to the intervention.
  - The rationale for the continued use of the intervention.
Restraint Care

- Release device with ROM and skin care q2h if appropriate
- Monitor the patient’s circulation and skin every 2 hours
- Provide for toileting, exercise, food and fluids at least every two hours while restrained
- Bathing and oral hygiene are performed at least every 24 hours
- A patient in 4-point restraint is monitored for safety every 15 minutes and requires a 1:1 caregiver
  - After the first hour, may utilize continuous monitored simultaneous video and audio equipment as appropriate
Handoff Restraint Review

- What type of restraint is in use?
- Is the restraint clinically indicated?
- Is there a current physician order?
- Is the restraint that is on the patient the same restraint that was ordered?
- Is the restraint properly applied?
- Is the documentation complete and up to date?
No patient should die in restraints. CMS requires notification of all deaths that occur in restraints, and within 24 hours of removal of any restraints.

Restraints can be removed for patient care activities without a new order while the nurse remains with the patient.

If a restraint is discontinued, a new order must be generated to replace the restraint.
Top Things to Remember About Restraints

1. **Call the RRT nurse for EVERY restraint order, renewal, and discontinuation!** They will help you with accurate documentation, order entry and compliance with CMS and Joint Commission regulations.

2. The restraint that is ordered must match the restraint that is on the patient—**a new order is needed if you are changing the restraint type**.

3. Document restraints on initial placement, **every 2 hours exactly**, **document on the clocks**, and when the restraints are discontinued.
4. Descriptive and comprehensive nursing notes are required at the time of the restraint application, during the restraint period, and when restraints are discontinued. There is **canned text available**!
Top Things to Remember About Restraints

5. Nurses are not to release one limb at a time to step patients out of restraints. If a patient is no longer violent or a threat to self or others, they no longer require 4 point restraints and all 4 limbs need to be released.

6. When taking a patient out of restraints for nursing care, a staff member must be present in the room to act as the restraint. If they leave and the patient is unrestrained without staff present, another order must be obtained to reapply the restraints.

7. When discontinuing restraints, fill out the flowsheet at the time you are discontinuing the restraints. Document the date and time on the flowsheet and that the restraint is no longer needed and why!
Top Things to Remember About Restraints

8. You must document with a comment on the Plan of Care section of the restraint flowsheet **every two hours**. This comment needs to describe the patient’s behavior that warrants the usage of restraints.

<table>
<thead>
<tr>
<th>Restraint Monitoring - Medical</th>
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<tbody>
<tr>
<td>Patient Care</td>
</tr>
<tr>
<td>Call Light In Reach</td>
</tr>
<tr>
<td>Food/Hydration/Fluids</td>
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<tr>
<td>Toileting</td>
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<tr>
<td>Passive ROM Exercises</td>
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<tr>
<td>Skin/Back Care</td>
</tr>
<tr>
<td>Circulation/Sensation/Pulses Present</td>
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<tr>
<td>Skin Integrity Observed</td>
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<tr>
<td>Signs of Injury Related to Restraints/Seclusion</td>
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<tr>
<td>Patient Care Comments</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Restraint Plan of Care</th>
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</thead>
<tbody>
<tr>
<td>Plan of Care Outcome</td>
</tr>
<tr>
<td><strong>Patient Continues to Demonstrate Behaviors</strong></td>
</tr>
<tr>
<td><strong>Document Behaviors In Comment Section</strong></td>
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<tr>
<td><strong>Restraint No Longer Justified</strong></td>
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<tr>
<td><strong>Discontinue Restraint</strong></td>
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<table>
<thead>
<tr>
<th>Restraint, Discontinue</th>
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</thead>
<tbody>
<tr>
<td>Discontinuation</td>
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<tr>
<td>Date Restraints Discontinued</td>
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Take Test

When you are ready to take the test:

1. Return to the FMH internet page where you opened this course material

2. Click the link for the test (the test will appear on screen in Adobe Reader, in PDF format)

3. Print the test, then complete it and return it to your supervisor for grading