Restraints
Restraints or seclusion may only be used when:

less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm

The type or technique of restraint or seclusion used must be:

the least restrictive intervention that is effective in protecting patient, staff, or others from harm

Restraint or seclusion use should be:

In accordance with modifications to the patient’s plan of care

Implemented in accordance with safe and appropriate restraint and seclusion technique compliance per policy
An order is needed for restraints and must be obtained as soon as possible if restraints are initiated by the RN.

Restraint orders may never be written as standing or PRN.

Restraints should be discontinued at the earliest possible time.
What alternatives to restraints have you tried?
Alternatives to Restraints

- Reorientation
  - Provide basic needs, such as toileting, relief of pain, etc.

- Encourage family and friends to stay with patient

- Sitter
  - Diversional activity

- Stress reduction techniques

- Position medical equipment out of view
  - Active listening
Different Types of Restraints

Violent Self-Destructive Behavior:

Violent or Self-Destructive Behavior means behavior that jeopardizes the immediate physical safety of the patient, staff, or others. The behavior carries the intention of harm.

Non-Violent Non-Self-Destructive Behavior:

Non-Violent or Non-Self-Destructive Behavior means behavior that is non-violent and not intended to cause self-harm that, in the clinical judgment of appropriate staff, requires the use of a Restraint to support patient safety and healing, and to provide optimum medical care.
Types of Restraints

- All 4 side rails
- Mittens
- Gerichair/Cushion (only if used to prevent rising)
- Waist belt
- Chair with intent to prevent rising
- Using devices in conjunction with chair, such as tables, trays, bars, or belts that a patient cannot remove easily
- Enclosure bed

Type I – least restrictive
Types of Restraints

Type II
- Vest or jacket restraint

Type III
- Soft wrist/leg restraints (3 or less)

Type IV – most restrictive
- Therapeutic holding for greater than 30 minutes or brief therapeutic hold to administer IM medication
- Drugs used as a restraint (chemical restraint)
- Leather wrist/leg restraints
- Soft wrist/leg restraint (greater than 3)
- Restraint chair
Violent Self-Destructive Restraints

Max duration of restraint:

- 18 years or older: 4 hours
- 9-17 years old: 2 hours
- < 9 years old: 1 hour

Physician/NP/PA who is responsible for the care of the patient must conduct a face to face patient assessment before renewing the order, and within one hour of the initiation of restraints.
Non-Violent/Non-Self Destructive Restraints

Max duration of restraint is 24 hours

MD/NP/PA responsible for care must conduct a face to face assessment within the calendar day

Orders must be renewed every calendar day
  • A new order sheet is to be completed and placed on each chart after the MD does their assessment.

Re-assessment by the provider must be conducted each calendar day
Restraint Order

RN to call MD/NP/PA immediately after initiating restraints if the provider is not present. You do not have to wait for the provider to place them.

RN to enter appropriate (violent vs nonviolent) Seclusion/Restraints order

RN to enter Restraint Management IPOC to generate order set
RN in acute care setting also must complete paper Seclusion/ Restraint Order Form #999-2120

**Restraint Order**

- Documentation includes:
  - Assessment of current behaviors/clinical situation requiring use
  - Alternative interventions considered or attempted prior to use
  - Physical or psychological conditions that may place the patient at greater risk during use
  - Least restrictive type of restraint per limb selected based on current clinical assessment
  - Who the restraint use explanation given to (patient, family, or contact person)
  - Category of restraint (non-violent, violent, or seclusion)
When restraints are used, the following information must also be documented in the EMR:

- Restraint start/stop time
- Patient re-assessment, including response to intervention(s) used
- Any complications, if applicable
- Update the IPOC (interdisciplinary plan of care) every shift to include time-specific goals for:
  - Patient safety
  - Environmental safety
IPOC (Interdisciplinary Plan of Care)
At the bottom of the Q2H checks you need to document:

**Reassess (for change in behavior) and Re-Evaluate Plan**

- **No Change** = Continue
- **Deceleration of aggression/combativeness** = Less restrictive
  - Requires new order
- **Acceleration of aggression/combativeness** = More restrictive
  - Requires new order
- **Discontinue**
  - Requires order (protocol, no need to call provider)

**Anytime a different type of restraint is needed, a new order must be obtained**

- Elimination
- Activity
- Stress/Agitation
- Change in Behavior
- Patient Rights
- Re-eval/Plan

- Continue
- Less Restrictive (requires order)
- More Restrictive (requires order)
- Discontinue (requires order/update POC)
## Restraint Assessment & Documentation

<table>
<thead>
<tr>
<th>Monitoring and Documentation by a:</th>
<th>Non-Violent Behavior</th>
<th>Violent Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN/LPN (Nursing)</td>
<td>Q 4 hour &amp; PRN</td>
<td>Q 4 hour &amp; PRN</td>
</tr>
<tr>
<td>RN/LPN/MHC (Behavioral Health)</td>
<td>Q 15 min. &amp; PRN</td>
<td>Q 15 min. &amp; PRN</td>
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<tr>
<td>Vital signs</td>
<td></td>
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</tr>
<tr>
<td>Respirations (Violent Behavior)</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 15 min. &amp; PRN</td>
</tr>
<tr>
<td>Proper position of restraint/signs of injury</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 15 min. &amp; PRN</td>
</tr>
<tr>
<td>Circulation check</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 15 min. &amp; PRN</td>
</tr>
<tr>
<td>Least restrictive measure tried</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 15 min. &amp; PRN</td>
</tr>
<tr>
<td>Mental status and emotional well-being</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 15 min. &amp; PRN</td>
</tr>
<tr>
<td>Rights, dignity, and safety</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 15 min. &amp; PRN</td>
</tr>
<tr>
<td>Level of distress or agitation</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 15 min. &amp; PRN</td>
</tr>
<tr>
<td>Evaluation for removal</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 2 hour &amp; PRN</td>
</tr>
<tr>
<td>Nutrition/hydration</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 2 hour &amp; PRN</td>
</tr>
<tr>
<td>Elimination/hygiene</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 2 hour &amp; PRN</td>
</tr>
<tr>
<td>Turn/reposition/ambulate/ROM</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 2 hour &amp; PRN</td>
</tr>
<tr>
<td>Skin integrity under restraint</td>
<td>Q 2 hour &amp; PRN</td>
<td>Q 2 hour &amp; PRN</td>
</tr>
</tbody>
</table>
Signs and Symptoms of Distress

Illness
- GI Upset

Injury
- Cuts, broken bones, bruises, etc.
- Bleeding

Neurological
- Seizures
- Change in level of consciousness

Cardiac and Respiratory
- Change in color of lips and face
- Visible beating of artery on side of neck
- Nasal flaring
- Mouth breathing
- Use of accessory muscles, sternal breathing
- Change in respiratory rate
- Color, temperature, shape, any swelling, and nail bed color on extremities

Mental Distress
- Yelling out
- Sweating
- New-onset incontinence
- Behavior changes
Restraints Discontinued

When patients no longer meet the condition for a restraint:

- A discontinue restraint order must be placed
  - Enter the order as protocol

Chart discontinuation in EMR

Note discontinuation in IPOC
Patient Deaths in Restraints

**Report** any patient death to the **Nursing Supervisor**

Notify supervisor if patient **death occurred** while in restraints or within 24 hours of being in restraints.

Remember to fill out the **“Death Data Collection Tool”** which is found in FormImprint for any patient death and return to Supervision.

Supervision will provide **CMS** with appropriate notifications of deaths in restraints.
Always use Quick Release!

Pull here to remove
Restraint Scenarios

What would you do?
Your patient is an 85 year old male. He is confused due to a UTI and is trying to pull out his IV. You have tried moving him closer to the nurses’ station, distraction techniques, orienting him to his hospital room and need for the IV. He has a past medical history of hypertension and COPD.

What type of restraints would you use for him?
You decide to use 2 soft wrist restraints after your alternative interventions have failed. You put the restraints on.

Now what?
Call the provider to get an order!

Then you contact the family, but are unable to reach them by phone.

What is your next step?
Place restraint IPOC (interdisciplinary plan of care). Place appropriate order.

Document your restraint charting in Cerner.

Fill out your restraint order sheet.
Scenario 2

- Your patient is a 30-year-old female with ETOH withdrawal. She is trying to pull out her IV and she has a history of schizophrenia, depression, and anxiety. She is getting agitated and trying to leave her room. You have attempted to re-orient her to her surroundings. You have tried using her husband as a support person. You have also actively listened to her frustrations. You feel in order to keep her and the healthcare team safe, she needs to be put in restraints.

- What type of restraints would you use for her?
You decide to use 2 soft wrist restraints and a vest restraint. You put the restraints on.

Now what?
Call the provider to get an order!

Her husband is there so he has already been notified.

What is your next step?
▪ Place restraint IPOC (interdisciplinary plan of care). Place appropriate order.

▪ Document your restraint charting in Cerner.

▪ Fill out your restraint order sheet.
References

- Centra Policy CLIN.01.02.11 “Patient Restraint and Seclusion”