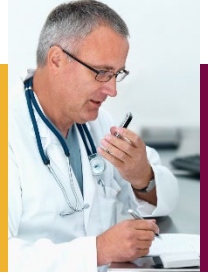
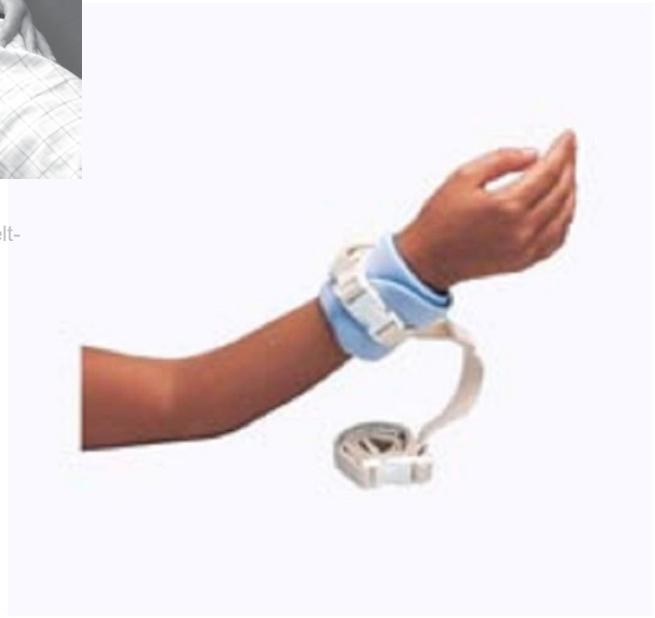


Approximate time: 30 minutes

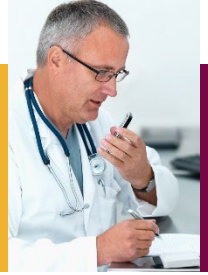
Managing Patient Restraints

Retrieved from: https://tidiproducts.com/wp-content/uploads/2019/07/I9205-Posey®-Soft-Belt-4125_Q_L.pdf

Retrieved from: https://www.rehabmart.com/product/posey-locking-twice-as-tough-cuffs-11467.html



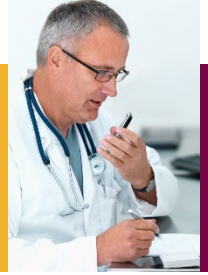
Retrieved from: http://shop.posey.com/Products/Posey-Quick-Release-Limb-Holders



Objectives

Nursing staff who are caring for patients in restraints will be able to state the following:

- Definition of restraint
- Assessment requirements for restrained patients
- First Aid techniques necessary to intervene if a patient is injured while in restraints
- Documentation requirements



Definitions:

Restraint:

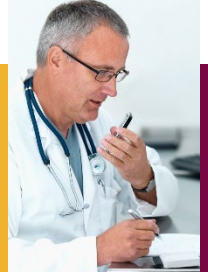
- Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces ability of a patient to move their legs, arms, body, or head freely
- A drug or medication when used as to manage the patient's behavior or restrict their freedom of movement and is not a standard treatment or dosage for the patient's condition (standard treatment would include anti anxiety meds, sleeping or pain meds, alcohol withdrawal meds)

Physical Restraint:

- Non-Violent Restraints: used to manage nonviolent/non self-destructive patients
- Violent/self-destructive: Reserved for violent/self- destructive behavior. Restraint type (Violent or Non-Violent) is determined by the reason for applying the restraints, not by the type of device used
- Physical Escort: If the patient cannot easily remove or escape the grasp of a physical escort, this would be considered physical restraint and all the requirements would apply
- Holding: Holding a patient in a manner that restricts the patient's movement against the patient's will is considered restraint

Seclusion (ECC Only):

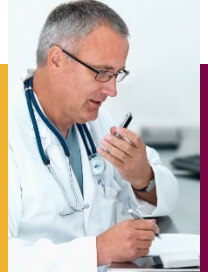
- Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving



Possible Reasons for Restraints

- To prevent danger/harm to patient or others
- Danger/Interference with medical equipment or interference with treatment
- Patient lacks understanding to comply with safety instructions
- Aggressive/disruptive/combative behavior
- Self injury

Although we recognize that there may be circumstances in which the use of restraint or seclusion (ECC only) may be necessary to prevent a patient situation from escalating, staff often skillfully intervene with alternative techniques to redirect a patient, engage the patient in constructive discussion or activity, or otherwise help the patient maintain self-control and avert escalation.



Covenant's Goal

Covenant HealthCare recognizes and supports patient rights & therefore, is committed to minimizing the use of restraints.

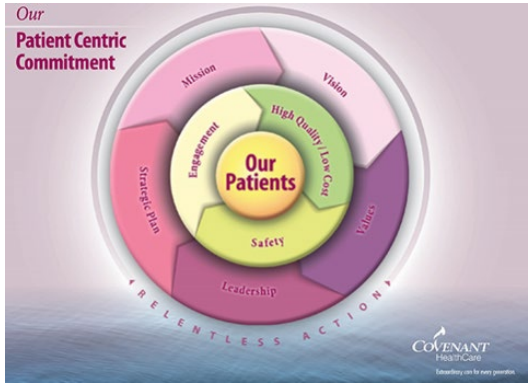
All patients have the right to:

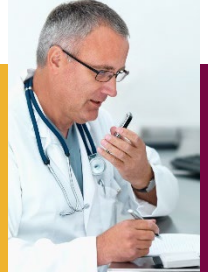
- Be free from physical and/or mental abuse
- Be free from restraint, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

Restraints are used as a last resort, and only in clinically justified situations where there is an imminent risk of a patient physically harming him or herself, staff or others

Assess, Identify and treat medical problems causing behavior change

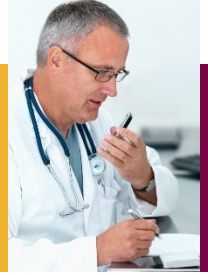
- Increased temperature
- Hypoxia
- Hypoglycemia
- Electrolyte Imbalance
- Drug Reactions





De-Escalation Techniques

- Before using restraints, attempt to de-escalate the situation by:
  - Diffusing aggressive Behavior
  - Listening effectively
  - Speaking calmly & use simple sentence
  - Being respectful
  - Using eye contact, gesture & facial expressions to communicate effectively
  - Communicating at patient's level



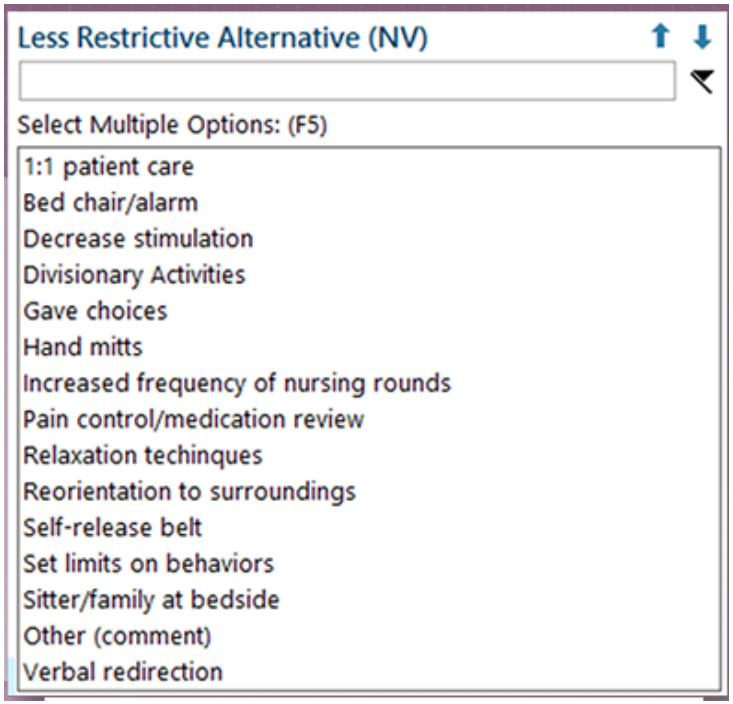
Restraint Alternatives

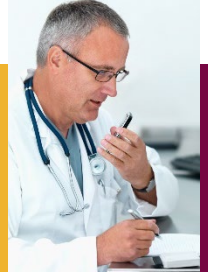
Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.

However:

Less restrictive interventions do not always need to be tried, but less restrictive interventions must be determined by staff to be ineffective to protect the patient or others from harm prior to the introduction of more restrictive measures.

- Alternatives attempted or the rationale for not using alternatives must be documented
- **Examples include:**



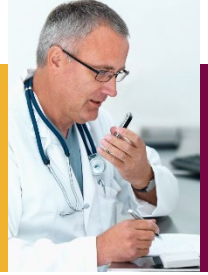


Risk Factors for Restraints

A risk factor is any reason not to put a patient in restraints, as it may do more harm to the patient

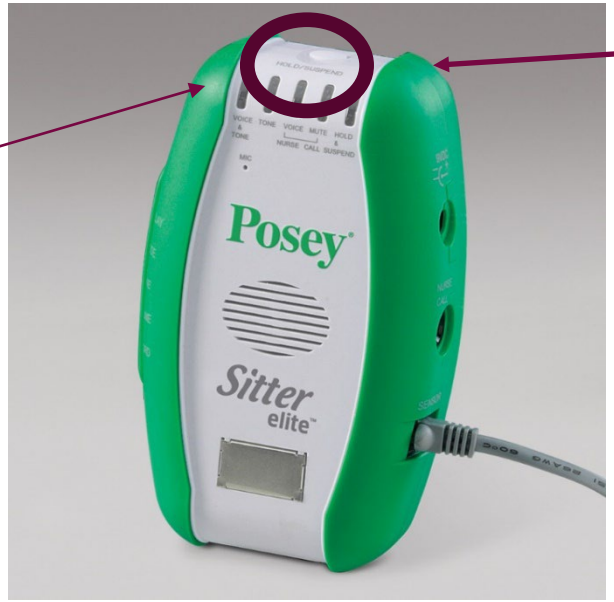
A Pre-existing Medical Condition (PEM) could be a broken arm or skin abrasions at the restraint site. Other risk factors include a history of sexual and/or physical abuse (HAS/HSP), physical disability (PD) like contractures, and pre-existing psychiatric condition (PEP) PTSD or anxiety

A previous head trauma or CHF are *not* considered to be PEMs



Bed/Chair Alarms

- To be utilized with Bed/Chair Alarm Pads
- Check on patient hourly
- Push the HOLD/SUSPEND button on the top of the device to silence the alarm for 30 seconds, for position change, etc
- After 30 seconds, any pressure change on the sensor pad will **REACTIVATE** the alarm
- The alarm will beep once to indicate monitoring has resumed



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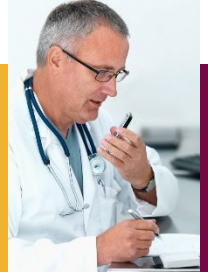
The ON/OFF switch is located on the back of the unit.

Only switch to the off position when the Posey Alarm is being discontinued.

These can help prevent patient falls!



Document Restraint Alternatives

Document Restraint alternatives in the Nursing Care Activity Flowsheet in the Safety/Comfort group, then Safety Measures Row

Search (Alt+Comma)	0800
Hygiene	
Bathing/Skin Care	
Perineal Care	
Oral Care Level RN ONLY	
Oral Care	
Adult Vent Mouth Care (RN or RT)	
Activities	
Activity Type	
Type of Assistance	
Distance (feet)	
Head of Bed (HOB)	
Patient Position	
Range of Motion	
Safety / Comfort	
Hourly Telemetry Check	
Adult Safety Check	
Safety Measures	Waist Belt...
Self-Release Return Demonstrated	
Precautions Maintained	
Equipment	
Warming/Cooling Devices	
Speciality Bed	
Immobilizers	

Safety Measures

Waist Belt, Self Releasing, Padded

- Arm Board
- Bed Alarm
- Chair Alarm
- Elopement Prevention Band
- Hand Mitts
- IV Shield
- Non-skid footwear gray/other (low fall risk)
- Non-skid footwear red (hot feet)
- Non-skid footwear yellow (high fall risk)
- Safety Equipment Connections Verified
- Sitter at Bedside, Start
- Sitter at Bedside, Continue
- Sitter at Bedside, Stop
- Velcro Wrap-Around Belt
- Virtual Monitoring On
- Virtual Monitoring Off
- Wheelchair Seat Belt, Alarming
- Waist Belt, Self Releasing, Padded

Self-Release Return Demonstrated

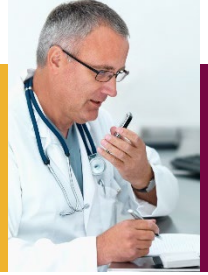
Select single option (F5)

Yes=Demonstrated ability to self-release belt

No=Remove the self-releasing posey, as it is no longer th...

Comments (Alt+M)

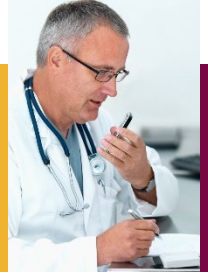
If using a self release belt, you must also document that the patient has demonstrated the ability to self-release



Not Restraints

- **IV arm boards** when used to prevent disruption of IV therapy if it does not limit the patient's freedom, physical activity, or normal access to their body
- **Side rails** used to keep a patient from falling out of bed or used for seizure precautions
- **Side rails** on critical care unit's specialty beds and pediatric beds are considered a safety intervention, not a restraint
- **Orthopedic devices**, **surgical dressings**, or **protective helmets**
- **Temporary immobilization** related to a procedure
- Restraint for **forensics and corrections** purposes only

- **Mitts alone are not considered restraints at Covenant Healthcare**

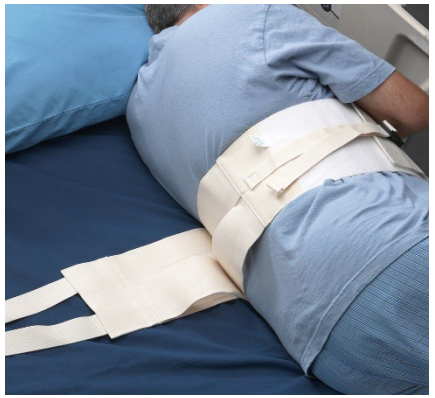


Types of Restraint Devices

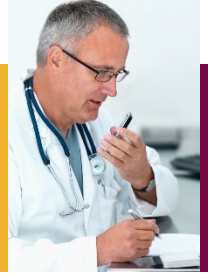
Soft Extremity

Locking

Waist Belt



- If Mitts secured with wrist restraint, an order for wrist restraints needs to be obtained
- If you use mitts in conjunction with a waist belt, the waist belt is considered the restraint, not the mitts



Classification of Restraints

- Non-Violent/Non-Destructive Restraint:
  - Used for the Non-Violent/Non-Destructive patient
- Violent/Self-Destructive Restraint:
  - Used for the Violent/Self –Destructive patient

- Violent or Non-Violent restraint orders are determined by the patient's behavior and reason for applying, not the type of device used. Start with the least restrictive restraint possible.
- Soft or Locking wrist restraints may be used for violent or non-violent patients if appropriate for the situation.

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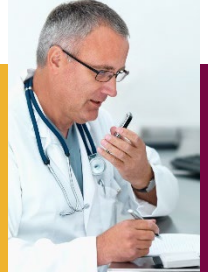
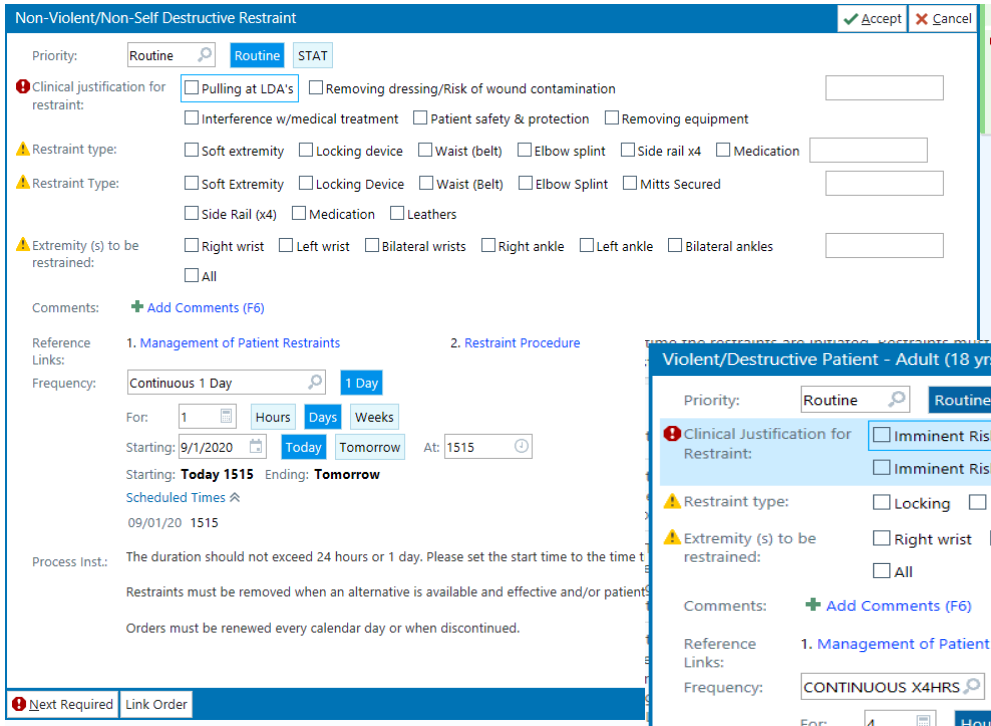
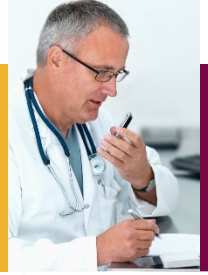


Violent and Non-Violent Restraint Order:



- **All fields must be filled out especially clinical Justification for Restraints, Restraint type, and the Extremity(s) to be restrained**



Order Requirements:

Initial order must be obtained prior to the application, *unless* the patient is in immediate danger to himself/herself or others, then the order must be obtained during or immediately after application.

If the attending physician is not the ordering physician, they must be notified as soon as possible.

The order must never be written as a "per protocol" or PRN order

No Trial Releases allowed.

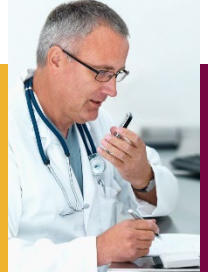
You cannot document on a restraint flowsheet until a restraint order is placed (BPA will fire)

<u>Additional Restraint Orders:</u> When ordering additional restraints to a patient already in restraints, the previous order is automatically discontinued. The chart will only reflect the new order.

<u>Patients Going to the OR:</u> Qualified staff member (NCA, LPN, RN) must remain with patient until patient is sedated. "Discontinued" must be documented on the doc. flowsheet and RN discontinues the restraint order. Restraints must be postoperatively reordered if indicated.

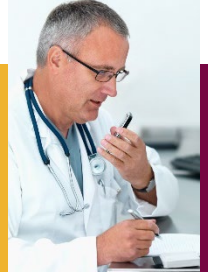
Patients in restraints being transported to CT/MRI/X-ray need to be accompanied by qualified staff (RN, LPN, NCA).

Written modification to Patient's plan of care within 12 hours of initial application of restraints and evaluation documented at least every 24 hours.



Ordering Violent Restraints

- Provider (or specially trained RN) must examine/assess the patient within **1 hour of initial application** and every 24 hours if patient in violent restraints continuously.
- A new order must be obtained every 4 hours (adults), every 2 hours (9-17 years) and every hour (under 9 years).
- If your patient goes from non-violent to violent (or vice versa), make sure you obtain the appropriate order from the provider and are documenting on the correlating flowsheet.
- If a patient is found to be in restraints without an order: Is a Level one citation per ACHC and a direct violation of patient rights. You could lose your license, or the hospital could be in jeopardy in this situation.



One Hour Face-to-Face Patient Evaluation for Violent Restraints or Seclusion

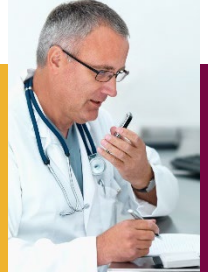
Must be conducted in person by a physician or other licensed independent practitioner (LIP), i.e. NP or PA or specially trained RN, **within one hour of the patient being placed in restraints**

Must address: the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraints

If the restraints or seclusion is discontinued before the physician, LIP or specially trained RN arrives to perform the face-to-face evaluation, the provider/practitioner is still required to see the patient face-to-face and conduct the evaluation within 1 hour after the initiation of the intervention

Use Direct Communication when notifying the physician of the Violent Restraints so they know what time the 1-hour face to face needs to occur and if they are going to be able to complete it.

If they cannot complete the face to face in that time frame notify REACH to complete the 1-hour face to face and utilize chain of command for any issues with communication regarding 1 hour face to face.



Monitoring Violent or Self-Destructive Patients

Caregiver must **perform** and **document:**

Every 15 minutes

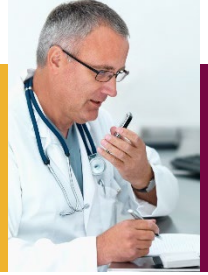
- Circulation and skin integrity for wrist/ankle restraints
- Emotional/Psychological status
- Comfort/safety
- Need for continued use

Every 2 hours

- Range of Motion
- Fluids
- Food/Meal
- Toileting

Monitor Q 15 Mins (V) Document Every 15 Minutes. NCA's May Document in This Section.		
Circulation Check (V)		
Skin Check (V)		
Emotional / Psychological Status (V)		
Patient Comfort and Safety (V)		
Need for Continued Use (V)		
Monitor Q 2 Hr (V) Document every 2 hours. NCA's May Document in This Section.		
Range of Motion		
Fluids (V)		
Food / Meal (V)		
Toileting (V)		

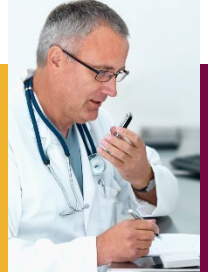
May have continuous in-person observation by a caregiver (NCA, LPN, RN) if necessary, but not required



Violent Flowsheet

Initiation Criteria - Document ONCE With START of Restraints - Not Every Order, If Continuous		
Face to Face		
Risk Factor (V)		
Attending Notified (V)		
Assessment/Clinical Justification (V) - Document at START and RENEWAL of Each Order		
Less Restrictive Alternative (V)		
Clinical Justification (V)		
Harmful Behavior(s)		
Education (V) - Document at the START and DAILY		
Restraint Criteria Explained		
Discontinuation Criteria Explained		
Patient's Response (V)		
Family Notification (V)		
Monitor Q 15 Mins (V) Document Every 15 Minutes. NCA's May Document in This Section.		
Circulation Check (V)		
Skin Check (V)		
Emotional / Psychological Status (V)		
Patient Comfort and Safety (V)		
Need for Continued Use (V)		
Monitor Q 2 Hr (V) Document every 2 hours. NCA's May Document in This Section.		
Range of Motion		
Fluids (V)		
Food / Meal (V)		
Toileting (V)		
Restraint Type (V) Document when restraints applied and renew order per policy until discontinued (Orde renew Q2H, < 9 yrs renew Q1H)		
Locking Restraint Right Wrist (V)		
Locking Restraint Left Wrist (V)		
Locking Restraint Right Ankle (V)		
Locking Restraint Left Ankle (V)		
Soft Restraint Right Wrist (V)		
Soft Restraint Left Wrist (V)		
Soft Restraint Right Ankle (V)		
Soft Restraint Left Ankle (V)		
Waist Restraint (V)		
Elbow Splint (V)		
Bed Rails x 4 (V) (Non-ICU)		
Medication (V)		
Seclusion (ECC Only)		

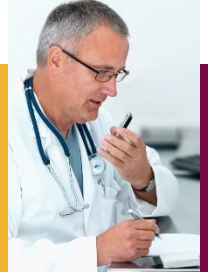
- Each section states what documentation requirements are and how often
- You must document the clinical justification
- Do not chart “yes” if the provider has not completed the face-to-face evaluation.
- Seclusion is for ECC only
- Restraint Type in use:
  - “START” when first applied
  - “CONTINUED” once per shift for the duration of use
  - “DISCONTINUED” at the time restraints are no longer in use



Ordering Non-Violent

A physician must examine the patient within 24 hours of a written order.

- The order must be renewed each **CALENDAR DAY**
- If a new order is not received, then the restraint must be discontinued until a new order is received from the physician.
- Ideally restraints should be reordered by the provider during daily rounds
- If the patient is violent/aggressive or harming self or others – utilize VIOLENT restraint order and flow sheet.



Monitoring Non-Violent Patients in Acute Care

- **Caregiver must perform the following every 2 hours:**
  - Assess circulation and skin integrity
  - Offer/Provide range of motion (ROM); this includes systematic release of restrained limb
  - Offer/provide fluids & nutrition
  - Offer/provide toileting
  - Ensure comfort & patient safety
  - Assess emotional & psychological status on initiation of restraints and every shift

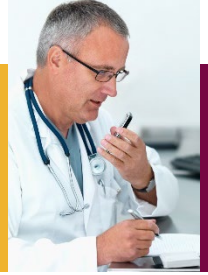
Restraint Monitoring Q2 Hrs (NV). Document in Each Row Every Two Hours. NCA's May Document in This Section.		
Circulation Check (NV)		
Skin Check (NV)		
Range of Motion		
Fluids (NV)		
Food/Meal (NV)		
Toileting (NV)		
Patient Comfort and Safety Maintained		

The monitoring section of the restraint flowsheet is the only place the NCA can document

Non-Violent Flowsheet

Notification/Assessment (NV) - Document ONCE With START of Restraints - Not Every Order		
Attending Notified (NV)		
Risk Factors (NV)		
Justification / Psychogical Status (NV) Document with INITIATION and Minimally ONCE Per Shift		
Less Restrictive Alternative (NV)		
Clinical Justification (NV)		
Emotional / Psychological Status (NV)		
Education (NV) - Document at the START and DAILY		
Restraint Criteria Explained		
Discontinuation Criteria Explained		
Patient's Response (NV)		
Family Notification (NV)		
Restraint Monitoring Q2 Hrs (NV). Document in Each Row Every Two Hours. NCA's May Document i		
Circulation Check (NV)		
Skin Check (NV)		
Range of Motion (NV)		
Fluids (NV)		
Food/Meal (NV)		
Toileting (NV)		
Patient Comfort and Safety Maintained		
Restraint Type (NV) Document START when applied; CONTINUED once per shift for the duration of		
Soft Restraint Right Wrist (NV)		
Soft Restraint Left Wrist (NV)		
Soft Restraint Right Ankle (NV)		
Soft Restraint Left Ankle (NV)		
Locking Restraint Right Wrist (NV)		
Locking Restraint Left Wrist (NV)		
Locking Restraint Right Ankle (NV)		
Locking Restraint Left Ankle (NV)		
Waist Restraint (NV)		
Mitt Restraint R (NV)		
Mitt Restraint L (NV)		
Bed Rails x 4 (NV) (Non-ICU)		
Enclosure Bed (NV)		
Elbow Splint (NV)		
Medication (NV)		

- Each section states what documentation requirements are and how often
- You must document the clinical justification
- Do not chart “yes” if the provider has not completed the face-to-face evaluation.
- Seclusion is for ECC only
- Restraint Type in use:
  - “START” when first applied
  - “CONTINUED” once per shift for the duration of use
  - “DISCONTINUED” at the time restraints are no longer in use



Restraint Application

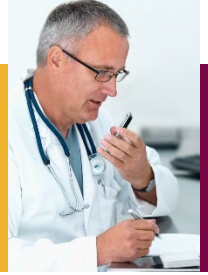
- **Do not** apply restraints to patients who:
  - Are exhibiting seizure activity
  - Have compromised respiratory status
  - Have recurrent emesis
  - Have a dislocation or fracture on the restrained limb
- **Apply** restraints to one, two, three, or all four extremities as ordered by physician.
- When using two restraints **do not** restrain an arm and leg on the same side of the patient's body. (i.e., if restraining the right arm, then restrain the left leg.)
- **Do not** restrain both ankles unless at least one wrist is also restrained.

Securing Self-Releasing Belt to Wheelchair or Bed

https://tidiproducts.com/product/self-releasing-padded-belts/

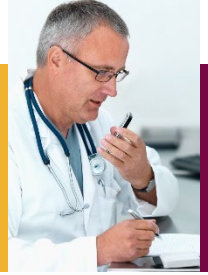
Application for wheelchair: place across patient's lap/thighs and crisscross straps behind wheelchair. Secure to kick spurs with slip knot

For use in hospital bed, place around waist & cross straps behind patient & through loops. Attach to bed frame



Restraint Related Asphyxia

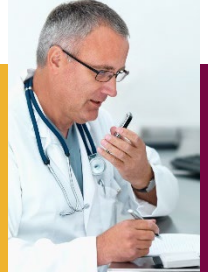
- Restraint-related positional asphyxia occurs when a person being restrained is placed in a position in which they cannot breathe properly and is not able to take in enough oxygen.
- This lack of oxygen can lead to disturbances in the rhythm of the heart and **death can result**.
- Patients at Risk:
  - Obese patients, those with physical injuries, use of alcohol or drugs, those with breathing problems or have physically exerted self
- Avoid positions that could lead to asphyxia:
  - Patients restrained face-down or positioned bent over limiting chest expansion



Responding to Signs of Distress

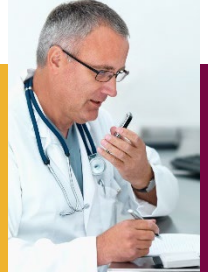
The use of physical restraints in acute care may increase the risk of falls, serious injury, & even death. Responding to signs of physical distress for patients in restraints is critical. Prompt notification to the RN & documentation of event is crucial.

Strangulation/Positional Asphyxia	• Release restraint immediately • Start CPR & call a code blue if indicated
If patient found bleeding	• Apply PPE • Apply pressure to site and dressing/bandage if indicated
Injured extremity	• Do not attempt to move the affected limb initially unless moving the limb will increase patient comfort • Perform patient assessment (including assessing the injured site) • Notify the physician
If patient is vomiting	• Turn patient's head to side to prevent aspiration • If unable to turn patient with restraints on, remove only what is necessary to reposition the patient • Any patient with recurrent vomiting should not be placed in restraints



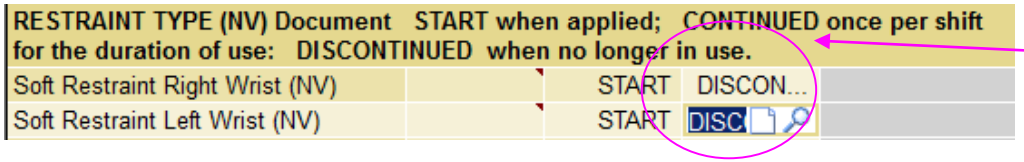
Discontinuing Restraints

- Discontinue restraints as soon as possible. May be determined by the provider or RN. Once the patient is determined by the provider or RN to no longer exhibit the behavior that caused him/her to be restrained, remove restraints and discontinue order
- “Trial release” is not acceptable. If the patient is taken out of restraints and then exhibits the same behaviors as before, a new order must be placed
- The decision to discontinue the intervention should be based on the determination that the need for restraint or seclusion is no longer present, or that the patient’s needs can be addressed using less restrictive methods. This can be shown by:
  - an ability to follow verbal direction
  - improved cognition or
  - ceasing of the behavior

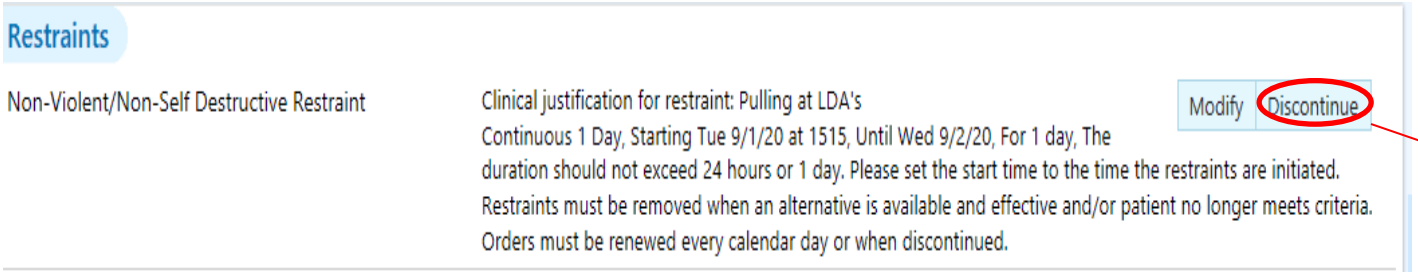


Discontinuing Restraints

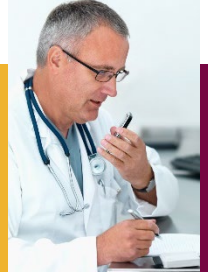
When your patient no longer requires restraints, you must document "DISCONTINUED" in the restraint flowsheet and DISCONTINUE THE ORDER:



Document "discontinued" in restraint flowsheet

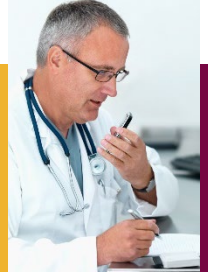


Go to "manage orders", click on "discontinue" link



Miscellaneous Information

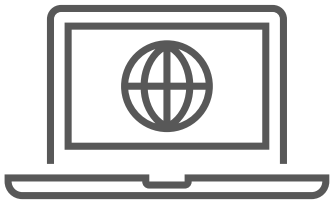
- For restrained patients leaving the unit for a procedure
  - RN must notify receiving department and assure that patient is accompanied by a qualified staff member (RN, LPN, NCA)
  - Patient will be handed off to the qualified staff in that area or remain with the patient for duration of test or procedure
  - For Endoscopy & Pre-Op Holding, staff remains until patient sedated
  - All restraint orders are discontinued when patient goes to OR
- Key for locked restraints is taped to white board in patient's room. Spare key is kept on unit (check with your unit for specific location of spare key)
- Orders must be entered into the EMR within minutes of receiving the order. **If you place a late order put "LATE ORDER" in the comment section of the note and nothing else**
- When a patient arrives from any other unit in restraints, the receiving RN MUST verify there is an active order for the restraint in use.
- Restraints should be included in bedside shift report between departments, between units, and between RN's during shift change.
- Please note: If locking restraints are discontinued, they must be locked, placed in plastic bag with campus, floor/unit & fill out laundering form

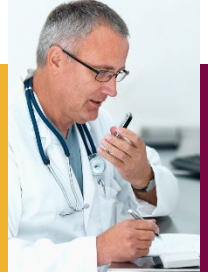


Care Plan Documentation

- A BPA will fire if a nurse documents on the restraint flowsheet and a Care Plan and/or Patient Education Plan has not been initiated.

- There is a template available for “Violent Restraint For Violent/Self-Destructive Behavior” and a template for “Non-Violent Restraint for Interference with Medical Safety”.



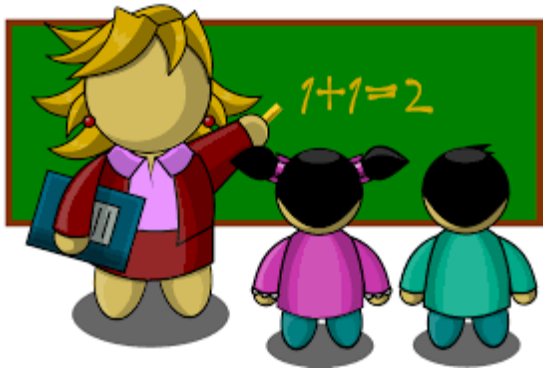


Education

Patient Education Titles:

- Restraint, Nonbehavioral Education (Adult, Pediatric)
- Restraint, Behavioral Acute Education (Adult, Pediatric)

Instruct patient & family on purpose of restraint, when restraint can be removed, S & S to report, safety measures, and how to communicate needs.



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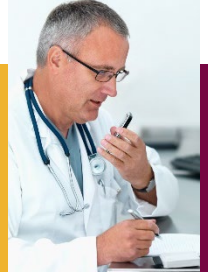
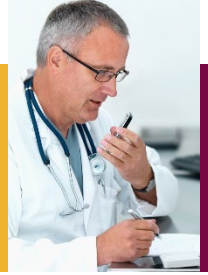


Seclusion (ECC Only)

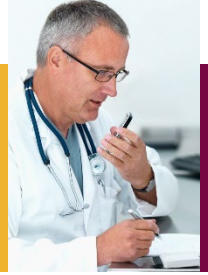
- Seclusion at Covenant HealthCare is only possible in the ECC (locked rooms preventing patients from leaving)
- Seclusion would be ordered under and follow all documentation/order requirements as Violent Restraints
- Patients must be removed from seclusion as soon as possible
- With the simultaneous use of restraint and seclusion, one-to-one observation with a staff member in constant attendance is necessary, either through face-to-face observation or through the use of both video and audio equipment (ECC only)



Reporting Deaths to CMS

- Required if a death occurs:
  - While a patient is in restraints/seclusion
  - Within 24 hours of restraints/seclusion removal
  - Within 7 days of restraints/seclusion use where death was directly or indirectly related to the use of restraints/seclusion

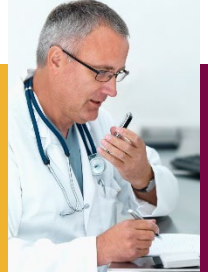
- Staff nurse must notify Nurse Manager/Coordinator that a death has occurred, and Manager/Coordinator must review chart, complete CMS form, and send to Patient Safety by 11:00 am of next business day. Patient Safety will report to CMS.



Restraint Documentation Audits

The restraint order and documentation (including the flowsheet and care plan) will be reviewed during bedside shift report at every hand off as everyone is aware of how important restraint documentation is as it is a patient right

All Nursing Leadership will be holding all staff to the same expectations related to restraint documentation



References

Covenant HealthCare. (2022). *Restraints- Management of Patient Restraints.* Retrieved from https://covnet.covenanthealthcare.com/global/policies-and-references/809.aspx