


<b>Name of Policy:</b> <u>Acute Care Restraints</u> <b>Policy Number:</b> 3364-100-53-12 <b>Department:</b> Hospital Administration Medical Staff <b>Approving Officer:</b> Chief Executive Officer - UTMC <b>Responsible Agent:</b> Chief Nursing Officer/Director of Nursing <b>Scope:</b> The University of Toledo Medical Center (UTMC) and its Medical Staff	  <b>Effective Date:</b> 7/1/2017  Initial Effective Date: July 14, 1993
<input type="checkbox"/> New policy proposal <input type="checkbox"/> Major revision of existing policy	
<input checked="" type="checkbox"/> Minor/technical revision of existing policy <input type="checkbox"/> Reaffirmation of existing policy	

**(A) Policy Statement**

Restraints will only be implemented when least restrictive methods have been employed and are determined ineffective for preventing patients from harming themselves (self-destructive/violent), other patients, staff members, or interfering with medical regimens (non-self-destructive/non-violent).

**(B) Purpose of Policy**

It is the practice of UTMC to utilize the clinically appropriate use of restraints in a manner that protects patient’s rights, dignity and well-being. Refer to “Patients Rights and Responsibilities”, policy# 3364-100-60-2.

**(C) Procedure**

1. UTMC staff will adhere to applicable Joint Commission standards, organizational policies, as well as federal and state law.
2. All staff with direct patient contact will receive restraint training and education according to their scope of practice. Education on safe use of restraints and alternative methods shall be completed upon new hire orientation, and periodically.
3. Restraints are used only after less restrictive measures have failed and clinical assessment justifies their use.
4. Restraint use is based on the assessment of the patient’s needs in the immediate care environment.
5. The type of restraint employed will be based solely on patient assessment and need.
6. Restraints are discontinued as soon as there is no further clinical justification for their use, and as soon as safely possible. A physician’s order is not needed to discontinue the restraint(s), but restraint release is based on ordered release criteria as assessed by the Registered Nurse (RN).
7. The trained attending or treating physician reviews all uses of restraints for clinical appropriateness.
8. Refer to specific policies for restraint and seclusion for Kobacker Child & Adolescent Center (Policy # 3364-122-06)

**(D) Issues Surrounding Restraining Patients**

It has been well established that while restraining a patient may be necessary for the patient’s safety or staff safety, the effects of restraining can result in serious complications if the patient is not provided the care as outlined within this policy. Some of the complications that result include the following: development of atelectasis of lung tissue, development of stiffness in extremities which results in a loss of muscle mass and weakness, a marked increase in intracranial pressures, development of elevated blood pressure, weight loss related to inability to feed self, development of skin breakdown and can lead to more mental confusion. Extreme care and caution are to be exercised when restraining a patient.

**(E) Definition**

A restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely. A chemical restraint is defined as a drug or medication when it is used as a restriction to manage the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Seclusion is the involuntary confinement of a patient alone in a room/area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self destructive behavior. The UTMC acute care hospital does not seclude patients.

**(F) Exclusion**

Restraint clarification: devices and methods typically used in medical/surgical care are not considered restraints such as orthopedically prescribed equipment, surgical dressings or bandages. Protective helmets or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests or to protect the patient from falling out of bed or to permit the patient to participate in activities without the risk of physical harm are not restraints (this does not include escort). Refer to Mosby's Nursing Skills – Restraint-Free Environment.

**(G) Education**

1. Initial employment orientation, prior to participating in the application and use of restraints, and at least periodic training thereafter with a minimum of first aid training, will occur to insure that staff members are competent to safely apply, monitor and remove restraints.
2. Training applies to all staff involved with the application of restraints, providing care for a patient in restraints, or with assessing and monitoring the condition of the restrained patient.
3. Training points for all appropriate staff (for the nonviolent and violent patient) will include the following:
  - a. Strategies to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of restraints.
  - b. Training in the use of nonphysical intervention skills.
  - c. How to choose least restrictive interventions based on individual assessment, violent vs. non-violent condition.
  - d. How to safely apply restraints.
  - e. How to recognize and respond to physical and psychological distress.
  - f. How to identify specific clinical and behavioral changes indicating when restraints are no longer necessary.
  - g. Monitoring the physical/psychological well being of patients who are restrained including, but not limited to, respiratory and circulatory status, skin integrity and vital signs.
  - h. The use of first aid techniques and certification in the use of CPR, including required periodic certification.
4. Physicians, Certified Nurse Practitioners (CNP), Physician Assistants (PAs), and Clinical Nurse Specialists (CNSs) that are members of the allied health professional staff, authorized to order restraints by hospital policy, must have knowledge of this policy.
5. Individuals providing staff training in restraint/seclusion have education, training and experience in the techniques used to address patient behaviors that necessitate the use of restraint.

**(H) Other**

1. Physical restraints are applied and removed in accordance with manufacturer's instructions and in a manner not to cause undue physical discomfort, harm or pain. Refer to Mosby's Nursing Skills – Physical Restraints.
2. In the event of a fire emergency, a patient in physical restraints is immediately released and evacuated with the rest of the patient group.
3. Restraints that are not in use should be removed from the area.
4. Performance improvement seeks to identify opportunities to reduce risks associated with restraint use through preventative strategies and process improvements.

5. Any serious injury resulting from restraint use will be reported via occurrence reporting policy #3364-100-50-39.
6. The hospital will report to CMS: Region 5, Chicago, IL @ 312-886-0326 as follows: any death that occurs while a patient is restrained, any death that occurs within 24 hours after removal from restraints and within one week where it is reasonable to assume that the use of restraints directly or indirectly contributed to a patient's death (refer to Documentation for Expired Patients – form NU003 and NU168).

**PROCEDURE FOR RESTRAINT OF THE NON-VIOLENT/NON-SELF DESTRUCTIVE PATIENT  
(MEDICAL-SURGICAL RESTRAINT)**

**CARE ISSUES**

1. Maintain patient privacy and confidentiality.
2. The use of less-restrictive measures to prevent restraint use is documented in the medical record every shift and may include, but is not limited to:
  - Verbal intervention.
  - Increased observation or direct continuous observation (1:1 care).
  - Reorientation.
  - Participation of family in care process.
  - Decrease sensory stimulation, i.e.: excessive noise, light, etc.
  - Utilization of protective devices (i.e.: bed alarm, gap protectors, chair alarms, geri-chair/recliners).
  - Positioning changes/comfort changes. Use of devices such as torso support, wedge cushion.
  - Placements of call light and personal items within the patient's reach.
  - Use of barrier placements over tubes/lines such as Kerlix, a long sleeve shirt, long pants.
  - Pharmacological review or treatment interventions as ordered by the physician.
  - Diversional activities, such as TV or music.
  - Placement of bed in a low position.
  - Place patient close to nursing station.

**ORDERING PROCESS**

1. PRN restraint orders are never implemented.
2. Restraints are only used upon an order from Physicians, CNPs, PAs, and CNSs. In the absence of this personnel, competent, trained RN staff may implement emergency physical restraints in response to a patient who poses an immediate danger to self. An order must be obtained as soon as possible.
3. The physician needs to be contacted as soon as possible. The physician must see the patient by the next calendar day.
4. All initial orders for physical restraint are time limited with a maximum time period of one (1) calendar day and must be renewed each calendar day thereafter. Established criteria for restraint (located on the physician's order form) guides justification. If the physician ordering the restraints is not the attending physician, this ordering physician is responsible for notifying the attending physician within one (1) calendar day after the restraints are ordered.
5. If the physical restraint continues to be clinically justified, a physician must re-evaluate the patient every calendar day and re-order the restraints every calendar day.
6. All components of the restraint order form must be completed. These items include: date, time, unit, restraint type, patient behavior or condition or symptoms that warrants the use of restraint, reason for restraint, & release criteria.
7. If the restraints are terminated before the order expires and the same or similar behavior arises requiring restraints, a new order must be obtained. This old order cannot be used.

*Points of emphasis*

- *No PRN orders*
- *Must have physician order for restraints*
  - *Both the initial order and renewing order are good until the end of each calendar day.*
  - *The Physician should address and renew restraints as needed during their daily rounds.*
- *The RN is the only one who can initiate the application of restraints in an urgent/emergent situation.*
- *The RN must obtain a verbal order as soon as possible after restraining in urgent/emergent situations.*
- *Complete all components of the form.*

**ASSESSMENT AND DOCUMENTATION PROCESS**

1. Requirements of documentation for the time period prior to restraining the patient.
  - In the medical record there must be identification of potential risk for the patient's behaviors, staff concerns for safety, risk to the patient, staff and others that necessitated the use of restraints (i.e.: patient appears to become confused or patient is sedated and unable to follow commands).
  - In the medical record there must be identification of interventions that were implemented (least restrictive measures) prior to restraining (i.e.: attempted to reorient and provided a night light for patient, or provided a patient with rolled up wash cloth to hold in hands in order to distract).
  - In the medical record there must be evaluation of the failed measures that were implemented (eg.: patient remains confused and trying to get out of bed, or patient continues to reach at NG tube despite distraction).
2. Requirements of documentation for the restraint event.
  - In the medical record, there must be documentation of providing the patient and/or family with an explanation for the reason for restraint, and the criteria for release from the physical restraint.
  - In the medical record, the care plan must be individualized to address the restraint usage. This can be done by adding a nursing diagnosis or by adding appropriate interventions.
  - In the medical record, there must be documentation of observation in accordance with the attestation.
  - The staff nurse or delegate monitors the patient and meets care needs:
    - i. The nurse should assess the patient (ongoing) for subtle changes in behavior or condition and intervention with documentation in the medical record to occur in a timely fashion. Least restrictive interventions should be implemented as soon as changes are noted. Changes or the use of restraints should be included in the patient's plan of care.
    - ii. Monitor a minimum of every two (2) hours. Documentation of monitoring and interventions will occur every shift including but not limited to:
      1. Patient's behavior, mental status with reorientation as needed.
      2. Verbal interventions, increased observation.
      3. Decrease in sensory stimuli.
      4. Protective device utilization.
      5. Placement of call light and personal items within reach.
      6. Use of barrier placements over tubes/lines.
      7. Diversional activities.
      8. The patient placed as close to the nurse's station as possible.
      9. Readiness for release from restraints whenever possible.
      10. If deemed unsafe to be up and about, then each individual limb is released from restraint and active or passive range of motion is given.
      11. Check temperature, pulse, respiration and blood pressure as ordered or clinically indicated.
      12. Offer bathroom privileges.
      13. Check skin condition and reposition if needed to prevent skin breakdown.
      14. Reinforcement of teaching of behaviors needed for early release.
      15. Check circulation, motor and sensory function below the level of restraint.
      16. Offer fluids, snacks and regular meals to assure nutritional intake.
      17. Unsafe objects were removed from the reach of the patient.
  - Least restrictive measures should be attempted and documented every shift.
3. Requirements of documentation for when the restraints are released

- Associated interventions, patient's condition, changes in patient's condition, and removal of the devices must be documented in the medical record.
- Document the time when the patient met release criteria and was released from physical restraints.
- Document the clinical need for and use of physical restraints on the patient's plan of care. When restraints are removed add to the care plan.

*Points of emphasis*

- *Document the date, time, and why the patient was released from restraints.*

**PROCEDURE FOR RESTRAINT OF THE VIOLENT/SELF DESTRUCTIVE PATIENT  
(BEHAVIORAL RESTRAINT)**

CARE ISSUES

1. Maintain patient privacy and confidentiality. The use of less-restrictive alternatives or measures to prevent restraint use is documented in the medical record:
  - Verbal intervention.
  - Increased observation.
  - Reorientation/removal of environmental stimuli (e.g., excessive noise, light, etc.).
  - Participation of family in care process.
  - Decrease sensory stimulation, i.e.: excessive noise, light, etc.
  - 1:1 interaction with the patient.
  - Redirection from environmental stimuli to safer alternatives.
  - Positioning changes/comfort changes. Use of devices such as torso support, wedge cushion.
  - Placements of call light and personal items within the patient's reach.
  - Pharmacological review or treatment interventions as ordered by the physician.
  - Environmental alterations, such as using visual barriers to obscure visual cues to dangerous behaviors, or creating a more soothing environment.
  - Diversional activities, such as TV or music.
  - Placement of the bed in a low position.

ORDERING PROCESS


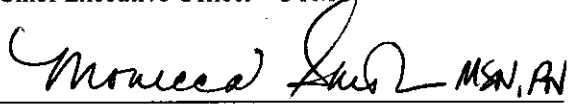
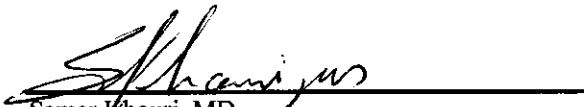
1. PRN restraint orders are never implemented.
2. Restraints are applied only upon a written order from Physicians, CNPs, PAs, and CNSs. Competent, trained RN staff may implement emergency (physical) restraints and obtain a restraint order as soon as safely restrained from a trained attending/treating physician in response to a patient posing immediate harm to self or others.
3. After initiation of restraints, for the violent self-destructive patient, the trained physician or designee must assess the patient within one hour to evaluate the patient's immediate situation, reaction to the intervention, medical or behavioral condition and the need to continue or terminate restraints.
4. Restraint orders are time limited to:
  - Adults – 18 years of age or older- original order and renewals limited to four hours.
  - Ages 9-17 – original order and renewals limited to two hours.
  - Under age 9 – original order and renewals limited to one hour.
5. Documentation by the physician should include any in-person medical and behavioral evaluation for restraint or seclusion.
6. Original orders may only be renewed every 4 hours for adults, two hours for ages 9-17, and every hour for ages under 9 up to a maximum of 24 consecutive hours.
7. Every 24 hours a physician sees and evaluates the patient before initiating a new order for restraint.

8. If a non-attending physician orders restraints, the treating physician must consult/notify the attending physician as soon as possible after the one hour evaluation.
9. Established criteria for restraint (located on the physician's iForm) guides justification. All components of the restraint order form must be completed. These items include: date, time, unit, physician assessment, patient's reaction to restraint intervention, medical and behavioral condition evaluation, release criteria, type of restraint, & time limit.
10. When restraints are terminated before the order expires and the same or similar behavior arises, and restraints are reapplied, a new order must be obtained.

#### ASSESSMENT/DOCUMENTATION REQUIREMENTS

1. Requirements of documentation for the time period prior to restraining the patient.
  - In the medical record there must be identification of potential risk for the patient's behaviors, staff concerns for safety risk to the patient, staff, and others that necessitated the use of restraints.
  - In the medical record there must be identification of interventions that were implemented prior to restraining.
  - In the medical record there must be evaluation of the failed measures that were implemented.
2. Requirements of the restraint event.
  - In the medical record, there must be documentation of providing the patient and/or family with an explanation for the reason for restraint, and the criteria for release from the physical restraint.
  - In the medical record, the care plan must be individualized to address the restraint usage. This can be done by adding a nursing diagnosis or by adding appropriate interventions.
  - Observation of behavior and documentation in the medical record must occur as follows:
    - a. On the Special Monitoring Special Precautions Form (NU091) the information that should be documented every fifteen minutes includes:
      - i. Patient's behavior, mental status and readiness for release.
      - ii. Reinforcement of teaching of behaviors needed for early release.
    - b. In the Electronic Medical Record (EMR), the information that should be documented approximately every two hours includes:
      - i. If deemed unsafe to be up and about, then each individual limb is released from restraint and active or passive range of motion is given.
      - ii. Respiratory status.
      - iii. Check circulation, motor, and sensory function below the level of the restraint.
      - iv. Offer bathroom privileges.
      - v. Check skin condition, give skin care as needed and reposition if needed to prevent skin breakdown.
      - vi. Offer fluids snacks and regular meals to assure nutritional intake.
    - c. Document restraint use in the plan of care.
3. The staff nurse or delegate monitors the patient to meet care needs:
  - a. The nurse should assess the patient (ongoing) for subtle changes in behavior or condition and intervention in a timely fashion. Least restrictive interventions should be implemented as soon as changes are noted. Changes should be included in the patient's plan of care.
  - b. Elevate the head of the bed if possible to reduce aspiration.
  - c. Assess patient for deformities or medical conditions that would contraindicate use of physical restraining devices and/or warrant more careful monitoring.
  - d. Unsafe objects will be removed from the patient's room and reach and then placed in a safe area. Patients will be searched for unsafe objects. HSC Security can be called for assistance as necessary. Items include, but are not limited to, smoking materials, sharp objects, medications, and other potentially dangerous materials.
  - e. Any additional clinical observation and documentation.
4. Associated interventions, patient's condition, changes in patient's condition, and removal of these devices must be documented in the medical record.

5. Document the time when the patient met release criteria and was released from physical restraints.
6. The physician documents the date, time and clinical findings of the patient evaluation that occurs within one hour of restraint application. The restraint order form guides the required documentation elements.
7. Ensure that the clinical need for and use of physical restraints is included on the patient's care plan.
8. It is a requirement that at a minimum, a physician must perform a face-to-face evaluation every 24 hours with the patient.

<p><b>Approved by:</b></p> <div style="margin-bottom: 10px;">         Daniel Barbo, RN, BSN, MBA        Chief Executive Officer - UTMC        Date: _____     </div> <div style="margin-bottom: 10px;">         Monecca Smith, RN, MSN        Chief Nursing Officer        Date: 8.21.2017     </div> <div style="margin-bottom: 10px;">         Samer Khouri, MD        Chief of Staff     </div> <p><i>Review/Revision Completed By:</i>        Greg Shannon, MSN, RN, &amp; Dustin Ballinger, MSN, RN.        Nursing        Multidisciplinary Restraint Committee        Institutional Ethics        Medical Staff</p>	<p><b>Review/Revision Date:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1/10/96</td> <td style="width: 50%;">4/1/2015</td> </tr> <tr> <td>9/11/96</td> <td>7/1/2017</td> </tr> <tr> <td>2/12/97</td> <td></td> </tr> <tr> <td>11/12/97</td> <td></td> </tr> <tr> <td>5/12/99</td> <td></td> </tr> <tr> <td>1/10/01</td> <td></td> </tr> <tr> <td>9/11/02</td> <td></td> </tr> <tr> <td>3/10/04</td> <td></td> </tr> <tr> <td>7/13/04</td> <td></td> </tr> <tr> <td>12/8/04</td> <td></td> </tr> <tr> <td>8/10/05</td> <td></td> </tr> <tr> <td>10/10/07</td> <td></td> </tr> <tr> <td>3/25/2009</td> <td></td> </tr> <tr> <td>5/25/2011</td> <td></td> </tr> <tr> <td>5/1/2014</td> <td></td> </tr> </table> <p><b>Next Review Date:</b> 7/1/2020</p>	1/10/96	4/1/2015	9/11/96	7/1/2017	2/12/97		11/12/97		5/12/99		1/10/01		9/11/02		3/10/04		7/13/04		12/8/04		8/10/05		10/10/07		3/25/2009		5/25/2011		5/1/2014	
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<p><b>Policies Superseded by This Policy:</b> 7-53-12</p>																															