PURPOSE:

It is the intent of Community Hospital to support the limited use of restraints throughout all the clinical settings, through the development and promotion of preventive strategies and to use safe and effective alternatives that prevent injury to patients. The establishment of these guidelines supports the use of the least restrictive and most protective measures that will limit the use of restraint to those situations with appropriate and adequate justifications. Community Hospital does not use seclusion.

DEFINITIONS:

Restraint

A. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely. A restraint does not include devices such as: therapeutic rotation beds (see equipment: Side rails x 4), orthopedic-prescribed devices, surgical dressings, methods that involve the holding of a patient for the purpose of conducting routine physical examinations, interventions, or diagnostic testing. (Examples: holding one's arm for lab draws or IV starts, holding child/infant for lumbar puncture).

B. A drug or medication, when used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement when it is not considered a standard of treatment or dosage for the patient's condition. Therapeutic doses of psychotropics, anti-anxiety, sleeping, and analgesic medications are not considered a restraint when based on the assessed needs of the patient and carefully monitored to minimize adverse effects.

Forensic Restraint - see Forensic Patient Policy

Attending physician - is the physician or his/her physician designee working under the supervision of the attending physician responsible for the care and treatment of the patient.

Physician - An individual with a D.O., D.P.M. or M.D. degree, who is licensed or otherwise authorized to practice medicine in the State of Colorado (as documented in the Community Hospital Medical Staff by-laws). MDs and DOs are granted special licensing privileges by the state to order medical treatment as outlined in their scope of practice.

POLICY:

A. General Provisions: (Restraint Guide)
   1. **NO** PRN orders for restraints shall be written, accepted, or followed. Orders for restraints must be written at the time the restraint is applied (see medical and behavioral restraint physician ordering).
   2. When restraint is indicated, the least restrictive methods of restraint shall be chosen. Restraint shall not be used when less restrictive interventions would be effective. The use of restraint for behavioral health purposes is not based on the patient's history of use nor solely on the patient's history of dangerous behavior. The hospital does not permit restraint to be used for the purpose of coercion, discipline, convenience, or staff retaliation.
   3. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention, shall be documented at least once per shift.
   4. Discontinuation of Restraint: Restraint shall be discontinued when the RN or Physician assesses that the behavior or condition that was the basis for the restraint order is resolved, regardless of the duration of the enabling order.
   5. A new order MUST be obtained regardless of any previous order, if:
      a. the patient requires a more restrictive method of restraint, or
      b. restraints have been previously discontinued.
   6. Care Plan: The patient’s plan of care shall be modified to address restraint.
   7. The patient’s family will be notified promptly of the initiation of restraint if the patient has consented to have the family informed about his/her care,
treatment, and services and the family has agreed to be notified.

8. The placement of patients in behavioral restraints will be deferred to the ER or ICU unless bed availability is limited or extenuating circumstances prevent placement in the ER or ICU. Appropriate staffing will be maintained including the assessment of patient needing 1:1 status. (All patient assessments while in behavioral restraints must be completed by an RN).

9. Monitoring shall include the following, unless it is inappropriate for the type of restraint utilized
   a. Signs of any injury associated with applying restraint.
   b. Physical and psychological status and comfort.
   c. Nutrition and hydration.
   d. Circulation and range of motion in the extremities.
   e. Hygiene and elimination.
   f. Readiness for discontinuation of restraint.
   g. Pain management

10. Injuries resulting from restraint use will be reported to Quality Management.

11. Reporting of Restraint-related Deaths: hospital employees shall promptly contact Quality Management if:
   1. Any patient dies while restrained or within 24 hours of being released from a restraint.
   2. Any patient dies from a restraint-related condition within 7 days after restraint removal.
   3. Quality Management(QM) shall notify the Centers for Medicare and Medicaid Services of such deaths by the end of the next business day by contacting the CMS Denver Regional office located at: 1600 Broadway, Suite 700 Denver, CO 80202. Telephone: (303) 844-7048, Fax: (443) 380-8868. QM will document such notification in the patient’s medical record.

B. Training of staff (to include Medical Staff/Physicians/Licensed Independent Practitioners(LIPs)): Hospital staff members who assess patients for restraint or apply restraints shall receive training in the following subjects as it relates to duties performed under this policy.

1. Training shall take place before the new staff member is asked to implement the provisions of this policy and shall be repeated periodically as indicated in the hospital’s training plan, which shall be based on the results of quality monitoring activities.

2. Hospital staff members who assess patients for restraint or who apply restraint shall receive training in the following:
   a. Techniques to identify staff and patient behaviors, events, and environmental factors that may avoid the use of restraints or trigger circumstances that require the use of a restraint.
   b. Choosing the least restrictive intervention based on an individualized assessment of the patient’s medical condition and/or behavioral status.
   c. The safe application and use of all types of restraint used by the staff member, including training in how to recognize and respond to signs of physical and psychological distress (e.g. positional asphyxia).
   d. Clinical identification of specific medical or behavioral changes that indicate that restraint is no longer necessary.
   e. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any additional monitoring necessary.
   f. Risks posed by restraint to vulnerable patient populations such as; emergency, pediatric patients, and patients who are cognitively, psychologically or physically challenged.
   g. At minimum, physicians and other LIPs authorized to order restraints must have a working knowledge of this policy.

3. Hospital staff members and physicians will remain current in basic life support.

C. Medical Restraints:

1. Indications:
   a. Restraint may be used for the following indications when less restrictive means would not be effective in protecting the patient:
      i. The patient is pulling at tubes, lines or dressings or may unpredictably and/or suddenly harm him/herself
      ii. The patient is confused, disoriented, or unable to follow commands and is interfering with the provision of care
      iii. The patient’s actions are endangering self or others

2. Physician Orders:
   a. If the attending physician is not available, an RN may initiate restraint in advance of a physician’s order.
   b. If the restraint is being initiated, the attending or on-call physician shall be contacted immediately for an order.
   c. If the restraint is being renewed, the attending or on-call physician must be notified for a renewal order for restraints as soon as possible or within 12 hours of the renewal order.
   d. The attending or on-call physician shall perform a face-to-face assessment of the patient within 24 hours of the initiation of the restraint.
   e. The attending or on-call physician shall perform subsequent face-to-face assessment of the restrained patient at least once every calendar day.
f. Restraint orders are valid for 24 hours.
g. A staff member cannot discontinue a restraint and then re-start it under the same order. A temporary, directly-supervised release for the purpose of caring for a patient’s needs such as feeding, turning, toileting, cleaning, ROM; is NOT considered a discontinuation of the restraint.

3. Monitoring:
   a. The patient will be monitored at least every 2 hours, or more frequently if indicated by the condition of the patient.

4. Documentation on the flow sheet will reflect:
   a. Type and location of the restraining device(s) shall be documented at least once per shift and when changed.
   b. The Clinical Justification for restraint (observed condition or behavior) shall be assessed on an ongoing basis and documented at least once per shift.
   c. Alternatives to and less restrictive forms of restraint considered by the caregiver shall be documented at least once per shift.
   d. Vital Signs will be taken at least every 2 hours. (Vital Sign documentation accessible in Meditech).
   e. The patient will be checked for hydration/food needs, bathroom needs, ROM, repositioning, and verification that the restraint is not causing any respiratory, circulation or skin integrity problems at least every 2 hours.

D. Behavioral Restraints:
1. Indications:
   a. When a patient is a danger to self or others and when less restrictive means would not be effective in protecting the patient or others related to the patient’s specific behavior.

2. Physician Orders:
   a. If the attending physician is not available, an RN may initiate restraints in advance of a physician’s order.
   b. The attending or on-call physician MUST be notified IMMEDIATELY
   c. The attending physician will be notified as soon as possible.
   d. Behavioral Restraint order are valid for and must be renewed or discontinued every:
      i. 4 hours for an adult age >18
      ii. 2 hours for children ages 9 - 17
      iii. 1 hour for children ages < 9.
   e. The attending or on-call physician must perform a face-to-face assessment of the patient within 1 hour of the initiation of the behavioral restraint and review with the staff the patient’s physical and psychological status. They shall work with the patient to identify and implement strategies to help the patient to regain self-control.
      i. The face-to-face assessment, conducted within 1 hour of the initiation of the restraint for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others will include the following:
         I. An evaluation of the patient’s immediate situation,
         II. The patient’s reaction to the intervention,
         III. The patient’s medical and behavioral condition, and
         IV. The need to continue use of the restraint.

3. Hospital Leadership (SNOC, Nursing Supervisor, and/or the Unit Director) shall be notified immediately of any instance in which a patient:
   a. Remains in behavioral restraints for more than 12 hours, or
   b. Experiences two or more separate episodes of behavioral restraint of any duration within 12 hours, and
   c. Thereafter, the Unit Director shall be notified every 24 hours if either of the above conditions continues.

4. Monitoring:
   a. Staff will have direct visualization of the patient in behavioral restraints at all times. The RN must assess the patient in behavioral restraints either verbally, physically, or by direct visualization every 15 minutes. Vital signs and assessment for nourishment, hydration, elimination, hygiene, circulation, ROM shall be performed as indicated by the behavior or condition of the patient.

5. Documentation:
   a. Type and location of the behavioral restraining device(s) shall be documented with every new order and/or when changed.
   b. Alternatives to and less restrictive forms of restraint, considered by the caregiver, shall be documented with each new application of behavioral restraint.
   c. Staff will document the patient’s current behavior and any assessment performed (in that time period) for nourishment, hydration, elimination, hygiene, circulation, ROM on the behavioral restraint flow sheet Q 15 minutes.

E. Equipment:
<table>
<thead>
<tr>
<th>Type of Restraint</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft Limb Restraints</td>
<td>Soft padded material used to limit motion of extremities.</td>
<td>1. Place the padded cuff around the wrists or ankle.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Slip the tie through the slot and secure.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Fasten the ties to the frame of the bed.</td>
</tr>
<tr>
<td>Velcro Limb Restraints</td>
<td>Velcro Restraints used to limit motion of extremities more than soft limb restraints.</td>
<td>1. Secure Velcro straps to bed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Secure limb straps to patient</td>
</tr>
<tr>
<td>Geri Chair</td>
<td>Geri table secured in front of patient</td>
<td>1. Secure table in locked position</td>
</tr>
<tr>
<td>Pharmaceutical Restraint</td>
<td>Medication used with the intent to restrict the patient's freedom of movement. Medications which are not a standard treatment for the patient's condition.</td>
<td>Medicate patient as the doctor has ordered. Monitor patient as policy dictates.</td>
</tr>
<tr>
<td>*Side Rails x 4</td>
<td>When used as a restraint, side rails are not to be lowered by patient request.</td>
<td>1. Place all side rails up. *When all side rails are in use while a patient is occupying a therapeutic rotation bed or in use during a patient transfer from one area of the hospital to another does not constitute use of restraint</td>
</tr>
</tbody>
</table>

**PROCEDURE:**

A. Initiate appropriate restraint: (Restraint Guide)
B. Initiate restraint packet:
   1. Restraint Order (found in Optio)
   2. Initial Assessment for Restraints (found in Optio)
   3. Restraint Flow Sheet (found in Optio)

**RESPONSIBILITY:**

All Community Hospital clinical employees

All physicians with Community Hospital Privileges
Home Health does not use restraints and is excluded from this policy.

REFERENCES:

Howard, Gay, RN, CPHQ, CLNC. How to Comply with CMS and Joint Commission Restraint and Seclusion Requirements. 2007 HCPro.

The Joint Commission. 2011 Hospital Accreditation Standards.


Referenced Documents

<table>
<thead>
<tr>
<th>Reference Type</th>
<th>Title</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referenced Documents</td>
<td>(Restraint Guide)</td>
<td></td>
</tr>
<tr>
<td>Applicable Documents</td>
<td>Behavioral Health Policy</td>
<td></td>
</tr>
<tr>
<td>Referenced Documents</td>
<td>Forensic Patient Policy</td>
<td></td>
</tr>
<tr>
<td>Applicable Documents</td>
<td>M-1 Hold</td>
<td></td>
</tr>
<tr>
<td>Referenced Documents</td>
<td>Restraint Order</td>
<td></td>
</tr>
</tbody>
</table>

Signed by

( 03/04/2014 09:51AM PST ) Matt Price, ICU Director
( 03/25/2014 09:27PM PST ) Kristin M Gundt, CNO

Effective

03/25/2014

Revised

[08/27/2007 Rev. 1], [06/22/2009 Rev. 2], [07/21/2009 Rev. 3], [07/27/2009 Rev. 4], [08/18/2009 Rev. 5], [08/25/2010 Rev. 6], [07/28/2011 Rev. 7], [09/16/2011 Rev. 8], [12/04/2012 Rev. 9], [03/25/2014 Rev. 10]

Document Owner

Kitchens, Matt

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at https://www.lucidoc.com/cgi/doc-gw.pl?ref=bch:10652.