TuftsMedicine
Lowell General Hospital

Restraint Update for Medical Staff

March 2023

Why This is Important:

Each year, patients commit suicide in hospitals across the US. In fact, a recent study identified 55 - 85 reports yearly of patient suicide in the hospital or medical facilities within the US. Of those, 4-5 deaths occurred in an Emergency Department. The most common method of suicide was hanging with ligature points of doors, door handles, and door hinges being the most commonly used to accomplish the event. In each of the circumstances, "the method for monitoring patients to ensure their safety before the suicide was poorly documented and could not be reliably determined" (Williams et al., 2018).

Patient Rights

The American Medical Association (AMA) recognizes that individuals have a fundamental right to be free from unreasonable bodily restraint. At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient and others from harm.

Restraints and/or seclusion are only to be used when clinically necessary to improve the patient's well-being when all other available, less restrictive measures have been found to be ineffective to protect the patient, staff, or other individuals. Restraints shall not be used as a means of coercion, discipline, convenience or retaliation by staff. For incapacitated patients, their designated surrogate healthcare decisionmaker must be promptly contacted and informed of the need for restraint and/or seclusion. The ultimate goal is a restraint free environment.

(The Joint Commission E-edition (2022). Chapter: Provision of Care, Treatment and Services. PC.03.05.01 – PC.03.05.19)

Recent Regulatory Findings Related to Restraints

PC.03.05.05 EP 1: During medical record review of three patients placed in violent four point restraints, there was **no evidence of an order for the four point restraints as required by hospital policy**, "Restraint and/or Seclusion" dated 2/2022.

PC.03.05.05 EP 4: During medical record review of a patient placed in violent four point restraints, there was **no evidence of a renewal order for the four point every 4 hours as required by hospital policy**, "Restraint and/or Seclusion" dated 2/2022. Specifically, on 2/2/23 the patients was placed in 4 point and an order obtained at 10:50, the restraints were discontinued at 23:40 and there was no evidence of any renewal orders. This was confirmed with staff present at the time of review.

Findings Related to Restraints, cont.

PC.03.05.05 EP 5: During medical record review of a patient placed in violent restraints, there was **no evidence of an LIP re -evaluation for reordering violent restraints performed every 24hr, as required by hospital policy**, "Restraint and/or Seclusion" dated 2/2022. Specifically the patient was in violent restraints from 1/26/23 to 2/3/23 and there was no evidence of LIP re-evaluation for reordering the restraints on 1/28/23, 1/29/23, and 1/31/23.

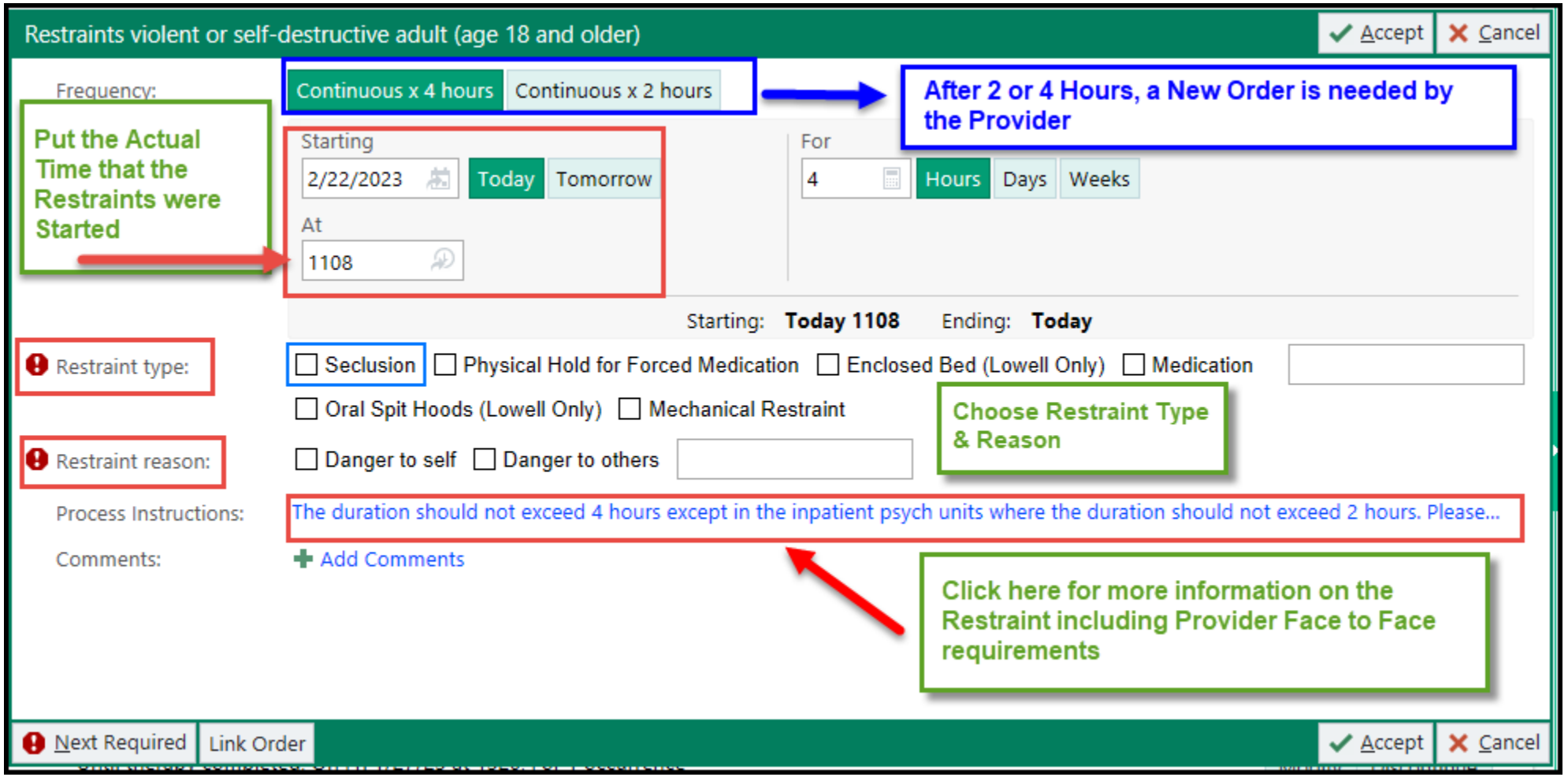
PC.03.05.15 EP 1: During medical record review of three patients placed in seclusion and/or violent four point restraints, there was **no evidence the Licensed Independent Practitioner (LIP) performed a face to face evaluation as required by hospital policy**, "Restraint and/or Seclusion" dated 2/2022. In addition, **the policy required specific elements to be included in the face to face evaluation and there was no evidence all these elements were reviewed** in the other two patients reviewed. Specifically, the type of restraint (four point restraints) were not included in the physician evaluation as well as there was no response to interventions or rationale for continued use. This was confirmed with the staff present at the time of review.

Restraint Order for:
Violent or Self Destructive Behavior

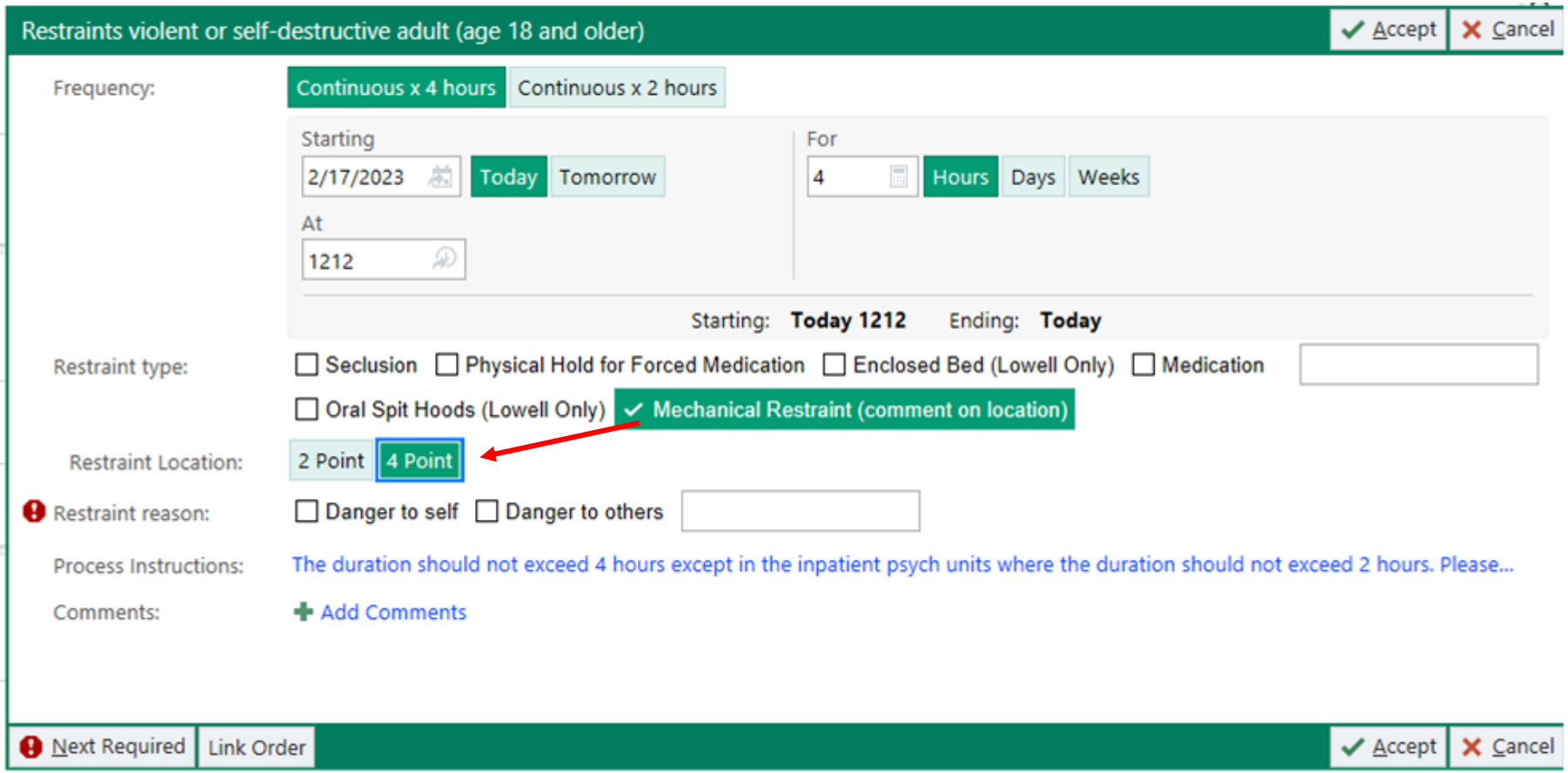
LIP Must:

1. **Write an Order for Application of a Restraint**
2. **Perform & document face to face assessment of patient within 1 hour**
   - Immediate situation
   - Reaction to intervention
   - Medical & Behavioral condition
   - Need to continue or terminate restraint
3. **Reassess Plan of Care every 24 hours**

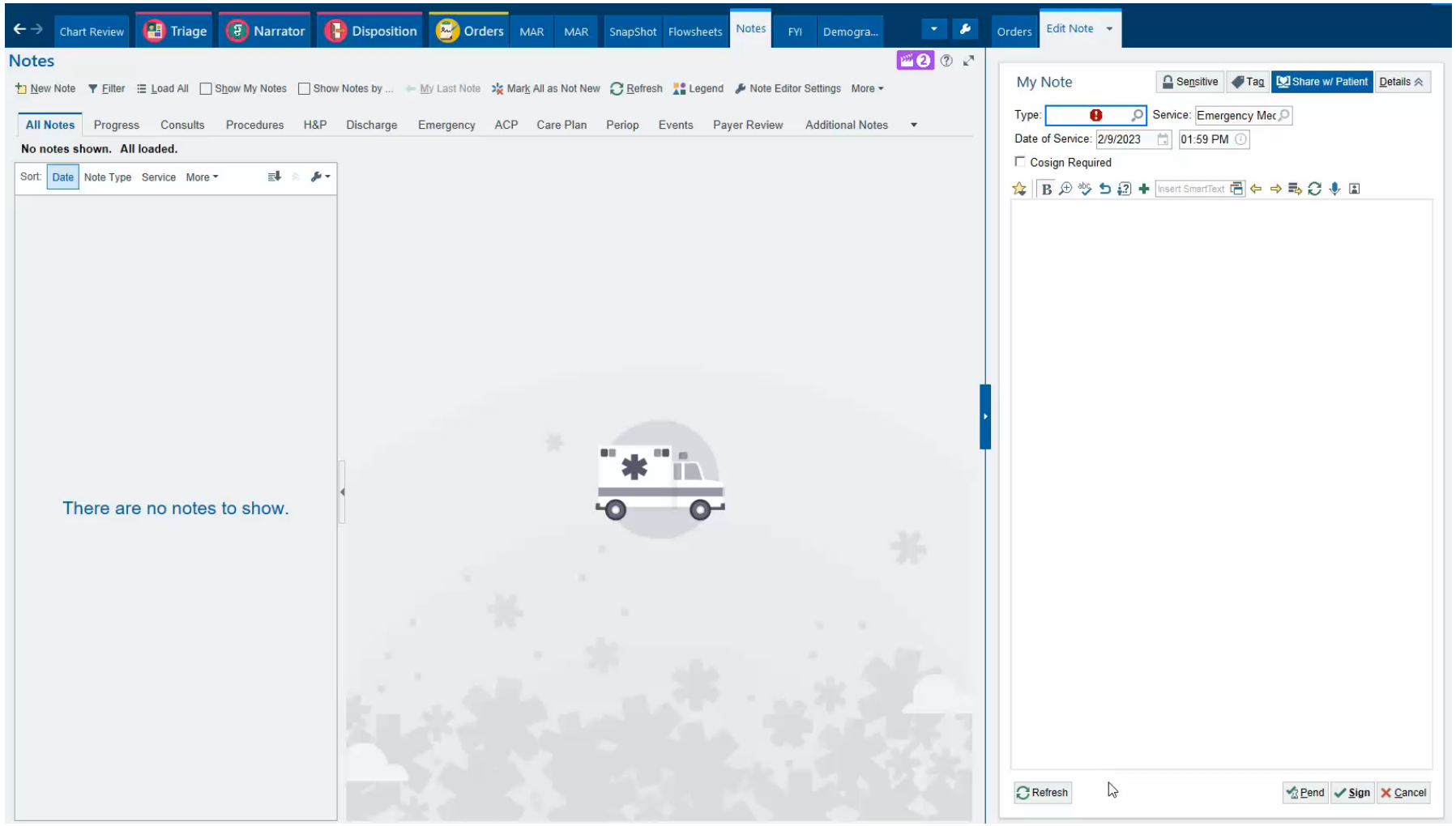
Order for Restraints Violent or Self-Destructive – Mechanical/Medication



Order for Restraint Violent or Self-Destructive – Mechanical 4 Point



Restraint Face-to-Face Documentation (play video)



Restraint for: Violent or Self Destructive Behavior for Nursing

RN Must confirm presence of Order in EMR

In EPIC, you are still able to document even without a Restraint Order. PLEASE make sure that you have a CURRENT order

Each order for a physical restraint or seclusion is limited to

- **4 hours for adults**
- **2 hours for children and adolescents ages 9 to 17**
- **1 hour for patients under 9**

ALL patients in violent restraints for Violence require, at minimum, constant observation

Nursing Observation, Reassessment and Documentation every 15 minutes

Document discontinuation of Restraint

Discontinue Active restraint order when complete

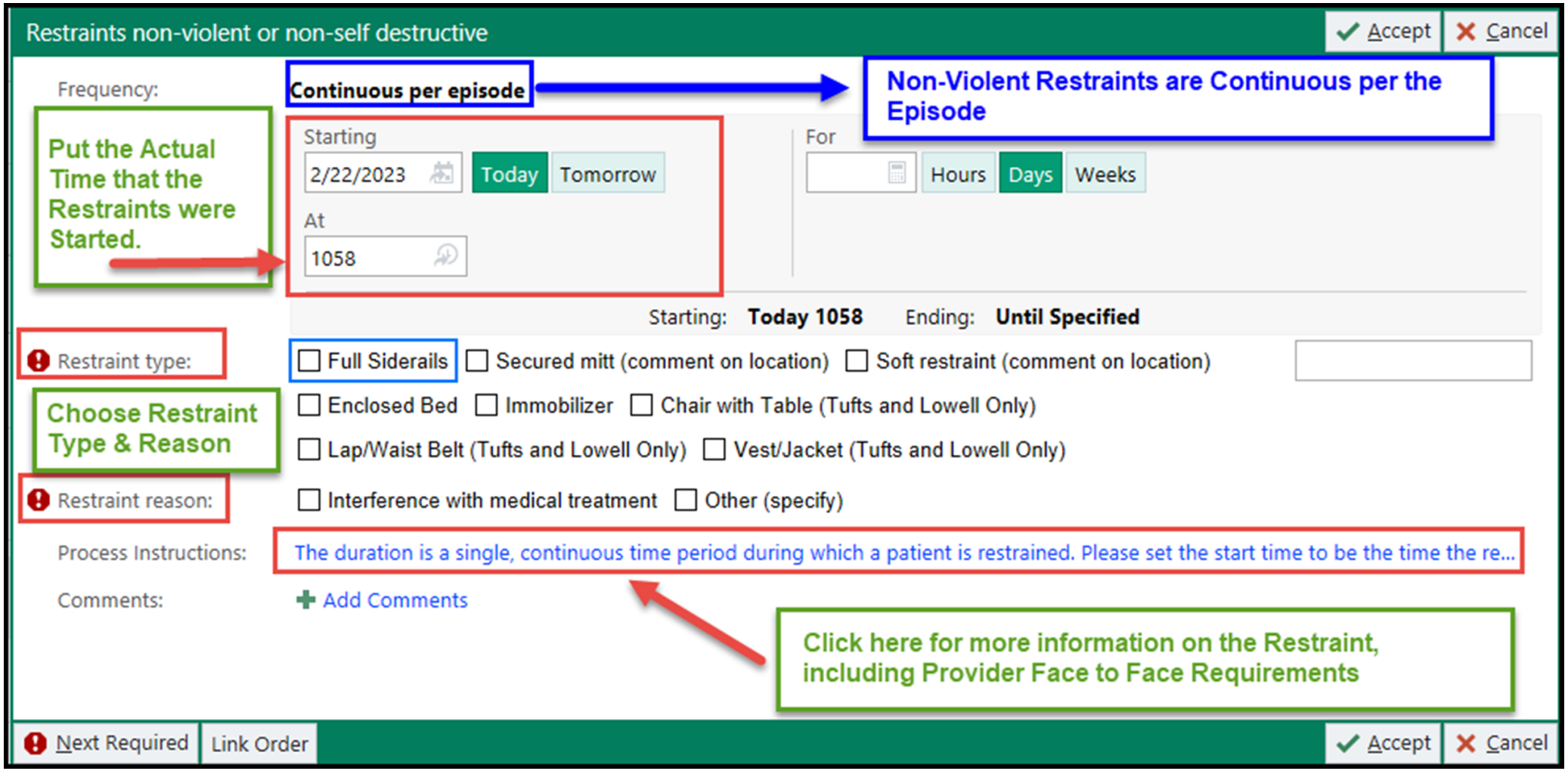
Must Obtain a NEW order for each restraint episode

Non-Violent or Non-Self Destructive Restraint

LIP Must:

Write an Order for Application of a Restraint
Complete face to face within 24 hours & document
Reassess Plan of Care each calendar day

Order for Restraint Non-Violent or Non-Self Destructive Orders



Non-Violent or Non-Self Destructive Restraint for Nursing

RN Must confirm presence of Order in EMR.

In EPIC, you are still able to document even without a Restraint order! PLEASE make sure that you have a CURRENT order.

Each order for a restraint is limited per episode

Nursing Observation, Reassessment and Documentation Every 2 hours

Document Discontinuation for Restraint and Discontinue order

New Restraint Log Introduced on Each Patient Care Unit

LGH ALL RESTRAINT (violent or non violent) LOG

Every restraint episode (every restraint order) requires an additional entry onto the log

MONTH:	YEAR:	UNIT:		
MR#	LAST NAME	FIRST NAME	AGE	RESTRAINT TYPE
[RESTRAINT TYPE = MITTS, LAP BELT, TABLE TOP CHAIR, SIDE RAILS X4, SOFT WRIST, SECURITY 4-POINT, ORAL SPIT HOOD, JACKET, ENCLOSED BED, SECLUSION, PHSYICAL HOLD]				
1				
2				
3				
4				
5				

Restraint Audit Process

1. Charge Nurse ensures patient is entered on log
2. Charge Nurse or designee completes initial audit (Non-violent or Violent)
3. Any discrepancies must be addressed in real time
4. Clinical Leadership completes secondary audit daily during worked hours

LGH NON - VIOLENT RESTRAINT AUDIT

Every restraint episode (every restraint order) requires an additional audit page

Restraint Date:	Restraint Start Time:	MR#:

	Charge Audit			Nsg Lead Audit		
	YES	NO	N/A	YES	NO	N/A
1- The order for restraints is present in the EMR, and includes type of restraint and reason for restraint						
2- The order for restraint is continuous per episode, or includes set end time						
3- Documentation of how less restrictive interventions were attempted prior to restraint & rationale for restraint being used						
4- The patient's response to use of restraint & reason for continuation of restraint						
5- Family notification or declination documented						
6- *If pediatric patient, legal guardian notified of restraint & documented						
7- Provider face-to-face assessment documented within 24 hours						
8- There is a provider reassessment documented each calendat day with the plan of care						
9- At least every 2 hours, documentation of reassessment is performed and includes: skin assessment, range of motion, nutrition/hydration status						

LGH VIOLENT/SELF-DESTRUCTIVE RESTRAINT AUDIT

Every restraint episode (every restraint order) requires an additional audit page

Restraint Date:	Restraint Start Time:	MR#:

	Charge Audit			Nsg Lead Audit		
	YES	NO	N/A	YES	NO	N/A
1- The order for restraints is present in the EMR, and includes type of restraint and reason for restraint						
2- The order for restraint includes appropriate start & end dates/times (max 4 hours for adults, 2 hours ages 9-17, 1 hour age <9)						
3- Ensure patient is on, at minimum, constant observation & that CO or 1:1 is documented						
4- Documentation of how less restrictive interventions were attempted prior to restraint & rationale for restraint being used						
5-The patient's response to use of restraint & reason for continuation of restraint						
6- Family notification or declination documented						
7- *If pediatric patient, legal guardian notified of restraint & documented						
8- Provider face-to-face assessment documented within 1 hour of restraint initiation, and includes: immediate situation, reaction to intervention,						
9- There is a provider reassessment documented within 24 hours of restraint application that documents patient's plan of care						

LIP documentation elements being audited

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7- "If pediatric patient, legal guardian notified of restraint & documented						
8- Provider face-to-face assessment documented within 1 hour of restraint initiation, and includes: immediate situation, reaction to						
9- There is a provider reassessment documented within 24 hours of restraint application that documents patient's plan of care						
10- At least every 15 minutes, documentation of reassessment is performed and includes: skin assessment, range of motion, nutrition/hydration status, hygeine/elimination status, restraint						
11- At least every 8 hours, documentation of: patient's behavior and level of distress/agitation, response to restraint, readiness for discontinuation, vital signs as indicated, any signs of injury associated						
12- If patient is in restraint for longer than the order, a new restraint order is placed- and another restraint audit is performed						
13- Date/time of restraint discontinuation documented, with behavior of patient documented						
14- If a patient requires 24 hours of continuous restraints, there is documentation that RN reviews with members of team the plan of care to consider alternatives to restraints						

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3- Documentation of how less restrictive interventions were attempted prior to restraint & rationale for restraint being used						
4- The patient's response to use of restraint & reason for continuation of restraint						
5- Family notification or declination documented						
6- "If pediatric patient, legal guardian notified of restraint & documented						
7- Provider face-to-face assessment documented within 24 hours						
8- There is a provider reassessment documented each calendat day with the plan of care						
9- At least every 2 hours, documentation of reassessment is performed and includes: skin assessment, range of motion, nutrition/hydration status, hygeine/elimination status, restraint discontinuation readiness status						
10- At least every 8 hours, documentation of: patient's behavior and level of distress/agitation, response to restraint, readiness for discontinuation, vital signs as indicated, any signs of injury associated with restraint						
11- Date/time of restraint discontinuation documented, with behavior of patient documented						
12- If restraints are removed and then needed again, a new restraint order is placed- and another restraint audit is performed						
13- If a patient requires 24 hours of continuous restraints, there is documentation that RN reviews with members of team the plan of care to consider alternatives to restraints						