Objectives

Upon completing this education, the nurse should be able to:

- Distinguish the definitions of restraints and seclusions
- Identify time constraints and necessary components for assessment and documentation
- Identify the reporting structure for Restraint and Seclusion-related Deaths
- Demonstrate correct application of selected restraints
Restraint and Seclusion: Definitions

- Non-violent and non-self destructive behavior
  - Formerly referred to as *medical*
  - Assessment of patient indicates a medical symptom or condition that requires an intervention to promote medical healing and to protect the patient from harm
  - Patient is demonstrating a lack of awareness of potential injury to self and/or attempting to remove devices used for medical management
  - Order placed daily
Restraint and Seclusion: Definitions

- Violent and self-destructive behavior
  - Formerly referred to as *behavioral*
  - Patient exhibits violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff member, or others
  - New order must be placed every 2 hrs for ages 9 and older
  - Visual checks completed and documented every 15 minutes
Restraint and Seclusion: Definitions

• Chemical restraint
  • Drug/medication used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is *not* a standard treatment or dosage for the patient’s condition
Restraint and Seclusion: Definitions

• Devices *not* considered restraints:

  • Devices such as orthopedically prescribed devices, surgical dressings or bandages, or protective helmets
  
  • Devices or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests
Restraint and Seclusion: Definitions (cont)

• Devices *not* considered restraints:
  • Devices or methods to protect the patient from falling out of bed or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort)
  • Untied handmints are not a restraint and can be used as an alternate to restraints
Physician Order

• The attending physician shall perform an in-person assessment of the restrained patient at least once every calendar day at which time restraint shall be either re-ordered or discontinued as indicated

• If a consulting physician orders a restraint, the nurse must notify the attending physician

• The attending physician and the nurse will receive a notification that the patient’s restraints need to be re-ordered 4 hours before the restraint order expires

• The nurse may enter a telephone order from the physician if the physician has completed the in-person assessment for that calendar day
Physician Order (cont)

- If the order expires, you must document by adhocing the powerform until the next order is obtained within the calendar day.

- If restraints are discontinued and then reinitiated at a later time, a new physician order must be obtained.

- ED Physician orders do not carry over onto an inpatient unit.

- For ED admissions, new order must be obtained from the attending/admitting physician upon arrival to the nursing unit.
**Physician Downtime Order Sheet**

**Restraint/Seclusion Order (PRN Order Not Acceptable)**

- **Non-violent/Non self-destructive Restraint**
  - (to promote healing and protect patient from harm)
  - Requires a face-to-face examination of the patient by the physician within 24 hours of initial order, and each subsequent calendar day thereafter.

- **Indications:**
  - Lack of awareness of potential injury to self/others
  - Attempts to remove devices used for medical management
  - Lack of awareness of interfering with the provision of care

- **Time Restriction:**
  - Restraint application limited to
  - (limited to 1 calendar day maximum)

- **Type of Restraint:**
  - Bed rails
  - Vomit restraint
  - Limb holders, soft
  - Limb holders, hard
  - Other:

- **Pharmacological:**
  - *Not to be PRN*
  - Medication:
  - Frequency:
  - Dose:
  - Route:

- **Violent/Self-destructive Restraint**
  - (related to emotional/behavioral disorder)
  - Requires a face-to-face assessment of the patient by the physician within 1 hour of initial order and every 8 hours for patients 18 years of age or greater and every 4 hours for patients 17 years of age or less

- **Indications:**
  - Patient is demonstrating violent or self-destructive behavior toward self/others

- **Time Restriction:**
  - Restraint application limited to
  - (limited to one calendar day maximum)

- **Type of Restraint:**
  - Bed rails
  - Vomit restraint
  - Limb holders, soft
  - Limb holders, hard
  - Other:

- **Pharmacological:**
  - *Not to be PRN*
  - Medication:
  - Frequency:
  - Dose:
  - Route:

**Date**

**Time**

**Physician Signature:**
Restraint Initiation – Key Points

• Documentation of Restraint Initiation must be completed
  • When the patient is first placed in restraints
  • When the patient is admitted from the ED in restraints
  • When restraints are reapplied after a previous discontinuation

• Documentation of Restraint Care Plan must be completed by all departments
  • Upon admission
  • Daily after the admission plan is completed

• Use of the least restrictive means will vary from patient to patient
Non-Violent Restraint Initiation

Removal of "Restraint upon arrival from another facility" option

If "sitter at bedside" chosen, specify name and credentials of the individual.
Violent Restraint Initiation

Removal of “Restraint upon arrival from another facility” option

Restraint Initiation For Violent/Self-destructive Behavior

- **Restraint Status**: Initiated
- **Restraint Location**:
  - Wrist, left
  - Wrist, right
  - Wrist, bilateral
  - Ankle, left
  - Ankle, right
  - Ankle, bilateral
  - Arm, left
  - Arm, right
  - Arm, bilateral
  - Elbow, left
  - Elbow, right
  - Elbow, bilateral
  - Torso
- **Type of Restraint Used**:
  - Immobilizer
  - Soft
  - Vest
  - Therapeutic hold
  - Nylon
  - Side rails X4
  - Enclosed bed

- **Restraint Initiation Time**: 0:00:00
- **Behavior Description**: None
- **Initiation Debriefing**: None

- **Behavior Necessitating the Use of Restraints**:
  - Physical abuse to others
  - Self-injurious behavior
  - Verbal aggression with potential harm to self or others
  - Other

- **Prerestraint Alternatives Attempted**:
  - Ask others to leave area
  - Crisis team
  - Distractive activities
  - Enhanced observation
  - Environmental changes
  - Limiting visitors
  - Negotiation
  - Relaxation/Exercise activities
  - Verbal limit setting
  - Intervention attempted, not successful
  - Intervention not appropriate, emergent situation
  - Other

AULTMAN
Restraint Initiation – Care Plan

Addition of link for Care Plan completion upon initiation
Restraint Initiation – Care Plan

Example of Non-Violent Restraint Care Plan to be completed upon initiation
## Restraint Daily Care Plan

### Example of Non-Violent Restraint Care Plan

<table>
<thead>
<tr>
<th>NON Violent/Self-destructive Restraint Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Med/Surg Restraint Use Related to</strong></td>
</tr>
<tr>
<td>- Lack of awareness of potential injury to self</td>
</tr>
<tr>
<td>- Attempts to remove medical management devices</td>
</tr>
<tr>
<td><strong>Med/Surg Restraint Use Goals</strong></td>
</tr>
<tr>
<td>- Restraint will be used without injury</td>
</tr>
<tr>
<td>- Least restrictive restraint will be used</td>
</tr>
<tr>
<td>- Restraint will be used for minimal time</td>
</tr>
<tr>
<td>- Other,</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Med/Surg Restraint Use Interventions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Face to face exam by Dr within first 24 hours</td>
</tr>
<tr>
<td>- Face to face exam by Dr each calendar day</td>
</tr>
<tr>
<td>- Visual checks every 30 minutes</td>
</tr>
<tr>
<td>- Bedrails</td>
</tr>
<tr>
<td>- Geriatric</td>
</tr>
<tr>
<td>- Non-releasing lapbelt</td>
</tr>
<tr>
<td>- Vest</td>
</tr>
<tr>
<td>- Sling</td>
</tr>
<tr>
<td>- Soft limb holders</td>
</tr>
<tr>
<td>- Clinical needs assessment every 2 hours</td>
</tr>
<tr>
<td>- RN assess restraint need every 8 hours</td>
</tr>
<tr>
<td>- Utilize alternatives to restraints</td>
</tr>
<tr>
<td>- Instruct patient on use</td>
</tr>
<tr>
<td>- Instruct family on use</td>
</tr>
<tr>
<td>- Other,</td>
</tr>
</tbody>
</table>

### Goal Review

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Goal attained</td>
</tr>
<tr>
<td>- Goals updated</td>
</tr>
<tr>
<td>- Goal met</td>
</tr>
<tr>
<td>- Goal partially met</td>
</tr>
<tr>
<td>- Goal not met</td>
</tr>
</tbody>
</table>
If “sitter at bedside” chosen, specify name and credentials of the individual.
**Restraint Monitoring**

<table>
<thead>
<tr>
<th>Are You Initiating Restraints?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are You Discontinuing Restraints?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Restrain Status**
- Continue

**Restrain Location**
- Wrist, left
- Wrist, right
- Arm, left
- Arm, right
- Ankle, bilateral
- Elbow, bilateral
- Elbow, right
- Torso

**Type of Restrainment Used**
- Immobilizer
- Side rails X4
- Sling
- Enclosed bed
- Vest
- Sedation
- Therapeutic hold
- Other

**Range of Motion/Positioning**
- Active range of motion
- Passive range of motion
- Repositioned
- Other

**Circulation/Skin**
- Skin intact
- Fullness intact
- Edema
- Cyanotic
- Reddened
- Other

**Affect/Behavior**
- Appropriate
- Calm
- Cooperative
- Agitated
- Anxious
- Apoplectic
- Restless
- Uncooperative
- Other

**Nutrition/Hydration**
- Offered
- Offer declined
- IV fluid
- Tube feeding
- NPO
- Other

**Hygiene/Elimination**
- Diaper change
- Ordered
- Other
- Urinary catheter
- Other

**Safety**
- Call device within reach
- Bed band check
- Allergy Band on
- Infant/Child security precautions
- Nurse alarms
- Night light
- Non-slip footwear
- Positioning device
- Parent at bedside
- Caregiver at bedside
- Other

**Bed Safety**
- Bed alert on
- Bed in low position
- Bedside rail up
- Hospital bed
- Open side
- Toys in bed removed
- Upper/Full length side rails up
- Wheels locked
- GIB rails up
- IV poles elevated
- Other

**Removal of "Release" and "Release/Reapply" options**
Assessment and Documentation

• All patients in restraints or seclusion will be assessed and documented on approximately every 2 hours or more frequently if indicated by the condition or behavior of the patient

• This applies to patients in restraints for non-violent/non-self destructive behavior and to patients in restraints for violent/self-destructive behavior

• Proper documentation is nonnegotiable and failure to complete will be subject to disciplinary action
Assessment and Documentation

• Assess and Document the following while explaining **specific** interventions attempted:

  • Restraint status, location, and type
  • Signs or symptoms of distress
  • Signs of any injury associated with the use of the restraint
  • Nutrition and hydration needs
  • Circulation and skin
  • Range of motion/positioning
  • Hygiene and elimination
  • Physical and psychological status
  • Specific comfort measures taken
  • Readiness for discontinuation/discontinuation attempts
  • Vital signs as indicated
Assessment and Documentation

- In addition, for patients who exhibit *violent and self-destructive behavior*, a trained staff member will **perform and document** a visual check **every** 15 minutes, or more frequently if indicated by the condition or behavior of the patient.

- Visual checks will assess for:
  - Signs and symptoms of distress
  - Assessment of circulation status as related to restraint application
Assessment and Documentation

• Simultaneous Restraint and Seclusion was previously known as Simultaneous Restraint or Seclusion

• Monitoring of patients in restraint and seclusion is accomplished through continuous, uninterrupted, observation by a trained staff member either:
  • In person OR;
  • By using simultaneous video and audio equipment

• If a staff member is physically holding the patient as the method of restraint, a second staff person is assigned
Assessment and Documentation
Do’s and Don’ts

• If you must assess and/or document at a time greater than 2 hours, DO NOT back time the entry

• DO document on the Care Plan to reflect the need for use of restraint and related interventions upon initiation and then daily

• DO NOT discontinue a restraint care plan order unless restraints are being discontinued

• DO verify restraint order is timed, dated, and is present for every calendar day
Restraint Discontinuation

- **Anytime** the patient is removed from restraints, document as *Discontinue* on the powerform.

- After the discontinuation is charted on the powerform, a nurse must discontinue the physician order for restraints.

- Discontinuation is frequently forgotten with terminal extubation.

- Discontinuation must be charted on the restraint powerform for patients discharged from the hospital, regardless of disposition.

- The trial release option has been eliminated from the hospital policy.
Discontinuation Readiness

Removal of “Comfort Measures” plus the addition of more specific “Readiness Attempt” choices
Release, Release/Reapply, Trial Release

• Releasing a patient from restraints requires discontinuation to be charted, as release, release/reapply, and trial release are no longer options

• If family members request a patient be out of restraints while they are in the room, and then for the restraints to be reapplied when they leave, discontinuation and reinitiation must be completed and a new order must be obtained

• If restraints are removed while the nurse is in the room to give care, discontinuation does not need charted and a new order does not need to be obtained
Trial Release
Non-Violent and Non-Self Destructive Behavior

Before

After
Trial Release
Violent and Self-Destructive Behavior

Before

After
The Joint Commission Coordinator/designee must report Restraint/Seclusion-related Deaths to the Centers for Medicare and Medicaid Services (CMS) if:

- Death occurs:
  - While the patient is in restraint or seclusion
  - Within 24 hours after removal from restraint or seclusion
  - Within one week after restraint or seclusion where the use of restraint or seclusion may have contributed to death
SBAR / Transport of Patients Within the Facility

- If patient leaves floor in restraints, nursing must complete a rounds report that includes:
  - Type of restraint
  - Reason for restraint
  - Time for next restraint assessment to be completed by area receiving the patient

- With the rounds report, nursing must send a copy of the Restraint Downtime paper documentation form
  - Area receiving patient will chart on this document
Restraint
Downtime
Documentation
Form
Placement of Restraints