Restraints Education Program

2016 JHS Annual Mandatory Clinical Education
Program Goals

- Prevent, reduce and eliminate use of restraints
- Initiate restraint only when other less restrictive measures have been found to be ineffective
- Discontinue restraint as early as possible
- Protect the patient’s rights, dignity, and well-being
- Inform/educate patient, family/significant other, and/or authorized representative
- Identify causes of aggression/threatening behaviors in patients
- Recognize how staff behaviors can affect patient’s behavior
Definitions

• Restraint:
  – The direct application of physical force or chemical control to a patient, without the patient’s permission that restricts freedom of movement. The force may be human, mechanical, chemical, or a combination of all

• Physical Restraint:
  – Any manual method that restricts the patient's freedom of movement or normal access to his/her body. It can be material or equipment, attached to or adjacent to the patient’s body and that the patient cannot easily remove

• Chemical Restraint:
  – A drug or medication used to manage the patient’s behavior or restrict the patient’s freedom of movement that is not a standard treatment or dosage administered for the patient’s condition

• Seclusion:
  – The involuntary confinement of a person alone in a room or area where patient is physically prevented from leaving. Seclusion may only be used for management of violent or self-destructive behavior
Important Information About Restraints

- Only personnel trained and with demonstrated competency in restraint procedure can apply restraints

- Restraints will only be used when necessary, following assessment of patient and use of alternative interventions

- In the absence of patient’s authorized practitioner, an RN can initiate restraint use based on assessment of patient. Order is to be obtained during emergency application or immediately after restraint is applied. Notify authorized practitioner immediately after application

- Notify family/significant other/authorized representative of restraint episode as soon as possible, as appropriate
Important Information About Restraints

- Orders for medical surgical restraints are limited to one calendar day before renewal is required. An RN is to obtain order immediately. If patient is in danger of interrupting medical care or harming himself/herself or others, a competent RN (received training) may initiate restraint.

- Orders for restraint must include clinical justification, type of restraint, and time limited (one calendar day for medical-surgical restraints).

- All monitoring/observations/assessments are documented in the electronic health record or Restraint Flowsheet during downtime.
Important Information About Restraints

- There are no “trial releases”...once restraint is discontinued a new order is required

- Temporary, directly supervised release for purposes of caring for patient’s needs is not considered a discontinuation of restraint/seclusion as long as patient remains under direct staff supervision

- Evaluation of the plan of care is made upon initiation of any restraint and after changes are made

- RN trained in procedure may discontinue restraint whenever condition of patient indicates it is no longer needed
(4) Side-Rails: Restraint or Not?

**NO (no order needed)**

- Four or full side rails to prevent the patient from rolling out of bed (safety)
- Patient actively seizing or having involuntary movements
- Seizure Precautions
- Post-op patient recovering from anesthesia
- Patient on a gurney
- 3 side rails up where patient may freely exit

**YES**

- Raising all four side rails to prevent the patient from voluntarily getting out of bed - not following redirection
**ASSESSMENT**

The decision to use a restraint is NOT driven by diagnosis but by a comprehensive individual patient assessment.

**CAUSE**

Seek causes of situations or medical symptoms for which restraints are used or proposed; attempts to find alternatives to restraint use prior to implementation.

**TREATMENT**

Address identified or probable causes of symptoms.

**INITIATION**

Initiation of ordered restraints; Take into consideration physical safety of the patient.

**OPPORTUNITY**

Assess for opportunities to remove restraints.

**NEVER**

Never place patient in restraints for staff convenience.
Underlying Causes of Agitation, Anxiety or Threatening Behaviors in Patients

- **Physical**
  - Pain
  - Unmet needs like hunger, thirst, temperature, elimination

- **Psychological**
  - Change in routine
  - Increased stimulation
  - Lack of sleep
  - Unfamiliarity
  - Fear
  - Loneliness

- **Medical**
  - Drug/ETOH Intoxication
  - Electrolyte imbalance
  - Specific disease states
    - (Medical & Psychiatric)
    - Hypoglycemia
    - Delirium
    - Traumatic Brain Injury

- **Cognitive**
  - Alzheimer’s
  - Dementia(s)
  - Psychosis
Alternatives/Least Restrictive Interventions

- Decrease stimuli
- Family involvement
- Redirection/reorient
- Distraction/diversional activities
- Relaxation/exercise
- Offer PRN medication
- Meeting physical/comfort needs
- Relocating room closer to nurses’ station
- Raising 2 siderails

- Camouflaging equipment as appropriate
- Explain procedures
- Encourage verbalization of feelings
- Prepare patient in advance
- Allow questions
- Offer choices
- De-escalation techniques
- Setting limits
Choose the Least Restrictive

Bed Alarm On → Untied Mitts → Elbow Immobilizer → 4 sides rail up

Enclosure Beds → Tied Mitts → Wrist/Ankle → Roll Belt → Posey Vest
Considerations During Restraints

• Complications
  – Suffocation
  – Physical Exhaustion
    • Cardiac arrest
    • Decrease oxygen perfusion
  – Respiratory Arrest
  – Fractures, sprains, etc.
  – Skin breakdown
  – Laceration, abrasions
  – Falls
  – Urinary Tract Infections

• Interventions
  – Monitor vital signs
  – Mental status
  – Respiratory assessment
  – Circulation checks
  – Range of motion
  – Skin precautions
  – Maintain hydration
  – Sedation scales as appropriate
  – Toilet/hygiene
  – Proper fit & selection of device
  – Assess need for continuation
Restraints for Violent or Self-destructive Patients, (Including “Baker Act” Patients) In Non-Behavioral Health Settings

- Trained personnel on restraint procedure can intervene under RN supervision and apply restraints in emergency situation in which patient is becoming increasingly combative, aggressive, or violent and may injure himself/herself or others, prior to obtaining a physician’s order.

- Use of Alternatives/Least Restrictive Interventions

- Notification OF ATTENDING PHYSICIAN immediately
Restraints for Violent or Self-destructive Patients, (Including “Baker Act” Patients) In Non-Behavioral Health Settings

• Authorized practitioner will conduct and document a face-to-face assessment **within 1 hour of initial restraint order** including both a **physical and behavioral assessment** of patient’s condition warranting the restraint and must be time limited

• If restraints are removed prior to arrival of authorized practitioner, he/she will still evaluate patient’s condition within 1 hour

• Time limits of orders for restraint for violent or self-destructive behaviors are limited to:
  • 4 hours for patients ages 18 and older
  • 2 hours for children and adolescents ages 9 -17
  • 1 hour for children under age 9
Restraints for Violent or Self-destructive Patients, (Including “Baker Act” Patients) In Non-Behavioral Health Settings

- Patients will be monitored by qualified staff with documentation every 15 minutes
- Every hour an assessment will be completed by RN
- Continuous monitoring is only required if patient is in both restraints and seclusion
- Based on RN’s assessment, restraint may be discontinued without obtaining a physician’s order
- If patient is removed from restraints after one hour face to face assessment, physician conducts in-person evaluation within 24 hours of original order.
Refer to

- Restraints for Violent or Self-Destructive Patients, including “Baker Act” Patients in Behavioral Health Settings refer to:
  - Behavioral Health Restraint Policy and Procedure # 208.2
  - Behavioral Health Seclusion Policy and Procedure # 208.3
Criteria for Release

- Clinical
  - Calm down
  - Follow direction
  - Comprehend need for treatment
  - Comprehend need to ask for assistance
  - Comprehend directions
  - Equipment/medical device(s) no longer needed or in use

- Behavioral
  - Calm down
  - Follow redirection
  - Refrain from self-harming behaviors
  - Refrain from harming others
Chemical Restraint Procedure

- Chemical restraint must be ordered by a physician as a one time order
- Use of force to physically hold a patient to administer medication against his/her wishes is considered a restraint and requires a physician’s order
- Ordering physician is responsible for conducting and documenting a face-to-face assessment within 1 hour of the chemical restraint order
- RN documents the effectiveness or side/adverse effects of intervention within first hour after administration
- Any untoward effects will be reported immediately to ordering physician
Common Medications Used for Chemical Restraint

- Haloperidol (Haldol®)
  - Watch for increased agitation
  - Watch for EPS (Extra Pyramidal Side Effects)
- Diazepam (Valium®)
- Lorazepam (Ativan®)
- Midazolam (Versed®)
  - Watch for respiratory depression
Psychological Considerations During and Post Restraints

- Complications
  - Feelings of humiliation
  - Resentment
  - Embarrassment
  - Resistance
  - Stress reaction

- Interventions
  - Maintain dignity, respect, privacy
  - Patient/family education
  - Re-establishing rapport
  - Listening
Notification of Risk Management In the Event of a Death While in Restraints

- Enter event report in Quantros for any patient who dies in restraints regardless of whether or not death is associated with restraint
- During business hours, immediately notify Risk Manager on call. All other hours immediately notify AIC
- Risk Management:
  - is required to report the death to CMS Regional Office no later than the next business day
  - maintains internal log for deaths that occur while patients in soft wrist restraints only, or within 24 hours after patient removed from such restraints
References

- Florida Administrative Code 65E-5.180. Right to quality treatment
- Florida Statutes 395.1041(6). Rights of persons being treated.
- Florida Statutes 395.003. Adherence to patient rights, standard of care and examination and placement procedures.
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