Restraint Education Program

2017 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
- Initiate restraints based on assessment and intent, not location
- 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
Definition 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 **the patient cannot easily remove**

- Two types of physical restraints:
  - Restraints for Non-Violent or Non-Self Destructive Patients
  - Restraints for Violent or Self-Destructive Patients
Definition for Non-Violent, Non Self-Destructive Patient

• Refers to restraints that are applied to prevent the patient from impeding the healing process (e.g., to protect the integrity of lines/tubes and or to protect surgical and/or treatment sites.

*It's about the intent, not the location*
Prior to Implementation of Restraint

- The patient will be assessed to determine whether he or she requires a restraint to prevent interference with medical treatment:
  - The decision to use a restraint is **NOT** driven by diagnosis but by a comprehensive individual patient assessment
  - Seek causes of situations or medical symptoms for which restraints are used or proposed
  - Attempt to find least restrictive alternatives to restraint use prior to implementation
Least Restrictive Alternatives

Prior to the initiation of restraints, a **less restrictive alternative** must be attempted and determined to be ineffective to protect patient and / or others from harm such as:

- Decrease stimuli
- Family involvement
- Redirection/reorient
- Distraction/diversional activities
- Offer PRN medication
- Meeting physical/comfort needs
- Relocating room closer to nurses’ station
- Raising 2 side rails
- Camouflaging equipment as appropriate
- Explain procedures
- Prepare patient in advance
- Allow questions
- Offer choices
- De-escalation techniques
- Setting limits
Choose the Least Restrictive

The selection of the device will be based on what is least restrictive and presents the least risk to the patient.
Specific Individual Considerations

- Take into consideration the following physical and psychological needs of the individual:
  - Age (Including specific needs of children)
  - Gender
  - Frailty
  - Physical/mental/cognitive ability or limitation
  - Ethnic and cultural background
  - Religion
  - Existence of emergency
  - Past experiences
  - Type of restraint
Patient’s Rights

- The patient’s rights, dignity and well being will be protected and an attempt to inform/educate the patient, family/significant other and/or authorized representative will be made.

- When the patient is placed in restraints, staff monitors the patient’s environment for safety (including use of call bell), cleanliness, privacy and the ability to participate in the care process.

- Assess for opportunities to remove restraints.
Orders for Non-Violent, Non Self-Destructive Restraints

• Initiation of orders:
  – If the patient is in danger of interrupting medical care, a competent RN may initiate the restraint
  – Once the patient is safe, the order must be obtained from an authorized practitioner

• Orders for Non-violent, non self-destructive restraints are time limited to **one calendar day**, must include clinical justification for use and list the type of restraint to be used
Orders for Non-Violent, Non Self-Destructive Restraints
Initiate the IPOC when restraint is applied

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Documentation for Non-Violent, Non Self-Destructive Restraint

- Document the patient’s condition no less frequently than every 2 hours unless otherwise stated.
Patient / Significant Other / Family Education

• Explain why a restraint may be necessary
• Explain the possible benefits and risks of restraints
• Discuss available alternatives
• Ask patients / families / significant others for suggestions
Patient / Significant other / Education

Education provided to the patient/significant other/designee should be reflected in the Adult Education section of the Electronic Health Record (EHR) and the Interdisciplinary Plan of Care (IPOC)

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Discontinuation of Restraint

- An RN may terminate the restraint episode whenever the condition of the patient indicates it is no longer needed.
- A physician order is not required to terminate the restraint episode.
- The RN must discontinue the order and document the discontinuation of restraints time.
Discontinuation of Restraint

• When restraints are discontinued, a new order must be obtained prior to reapplying the restraints and the time limitations are resumed
  – A temporary, directly-supervised release, that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding or range of motion exercises) is not considered a discontinuation
  – However, the staff member must be at patient’s bedside the entire time the restraints are off or it is considered a discontinuation
  – Exclusions to the policy are as follow
Exclusion to the Policy

- **Four Side Rails up on all patients:**
  - Patients on stretchers
  - Children less than 12 years of age
  - Receiving medications that alter hemodynamic status and/or level of consciousness
  - If the patient is on a bed that constantly moves to improve circulation or prevent skin breakdown
  - If the patient is physically unable to get out of bed regardless of the side rails
  - A patient on seizure precautions
Exclusions to the Policy

- Stabilization of a line using an intravenous arm board NOT tied down or secured
- Mittens not tied or pinned down
- Elbow immobilizers used on children returning from cleft palate/lip surgery
- Pediatric age-appropriate safety devices including but not limited to:
  - Swaddling / Papouse
  - Cribs, bassinets, isoletted (infant/children <4 years old)
  - Stockinettes /sock hand covers on neonates not secured
Exclusions to the Policy

- Medically necessary positioning or securing devices are not considered restraints. They do not require a physician’s order.

- **They do** require documentation in nursing progress record every shift:
  - Indication for use
  - Time initiated/time removed
  - Assessment
  - Monitoring and care

- Restraint used for security purposes for individuals under forensic or corrections restrictions are not considered restraints.
Definitions for Violent or Self-Destructive Patient

- Refers to the management of an emergent/life threatening situation in which the patient is demonstrating sudden combative, aggressive, or violent behavior and can injure themselves or others unless restrained.

- The restraint for violent or self-destructive patients applies to the use of restraints that are to protect the patient regardless of the clinical setting.

It's about the intent, not the location.
Definition for Physical Holding

- Includes the holding of a patient for the purpose of conducting routine physical examinations or tests. However, patients **do** have the right to refuse treatment. This includes the right to refuse physical examinations or tests. Holding a patient in a manner that restricts the patient’s movement against the patient's will is considered restraint and all the requirements would apply.
Definition for Physical Escort

• Includes a “light” grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint and all the requirements would apply.

Doctor’s order required for either if restricting movement
Indication for Mechanical or Physical Restraint / Seclusion

• Used only to protect patient from injury to self or others, due to emotional or behavioral disorder
  – Interventions may include:
    • Physical Hold / Physical Escort
    • Seclusion
    • Mechanical restraint

  – **Seclusion:**
    • Only in designated seclusion rooms in Jackson Behavioral Health or other JHS Behavioral Health Units
Prior to the Initiation of Violent, Self-Destructive Restraint

Alternative means of protecting the patient must be attempted

– Upon admission to a JHS Behavioral Unit, a Personal Safety Assessment will be completed, identifying individual triggers and calming interventions as needed

– If needed, trained personnel on restraint can intervene under RN supervision and apply restraint in an emergency situation in which the patient is becoming increasingly combative, aggressive, or violent and may injure himself/herself or others, prior to obtaining a physician’s order
Underlying Causes of Agitation, Anxiety or Threatening Behaviors in Patient

- **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
Orders for Violent and Self-Destructive Restraint

Orders must include:

- The clinical justification with specific behaviors that justify use
- The type of restraint
- **Time limits** in accordance with the patient’s age:
  - 4 hours for patients ages 18 and older
  - 2 hours for children and adolescents ages 9 -17
  - 1 hour for children under age 9
Patient Monitoring for Violent and Self-Destructive Restraint

- Patients in restraint or seclusion will be observed at least every **15 minutes** to include:
  - Behavioral observation
  - Mental status
  - Adequacy of circulation and perfusion, and range of motion
  - Significant changes in patient’s condition

- Offer food, fluids and toileting at least every two hours
- Vital signs are monitored per unit standards and as appropriate
Definition for Chemical Restraint

- A drug or medication used to manage the patient’s behavior or restrict the patient’s freedom of movement. It is **not a standard treatment** or dosage administered for the patient’s condition.
Chemical Restraint

• Chemical restraint must be ordered by an authorized practitioner 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

• The RN assess and documents the individual's response to the pharmacological intervention
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
Physical Considerations During Restraint

- 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
Criteria for Release

- Non-violent/Non Self-Destructive
  - 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

- Violent/Self-Destructive
  - Calm down
  - Follow redirection
  - Refrain from self-harming behaviors
  - Refrain from harming others
Psychological Considerations During and Post Restraint

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

- Interventions
  - Maintain dignity, respect, privacy
  - Patient/family education
  - Re-establishing rapport
  - Listening
Post Restraint Episode

Debriefing for Violent and Self-Destructive Restraints

- Is conducted as soon as possible, but no longer than 24 hours after the discontinuation of restraint

- A review with the individual, individual’s family (when appropriate) and staff involved in the emergency safety intervention

- The review is to discuss the circumstances that resulted in the use of restraint and strategies that could be employed to prevent the need for restraint in the future
Notification of Risk Management In the Event of a Death While in Restraint

• 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.
• Hospital Accreditation Standards. (2013, January 1). Restraint/ Seclusions for Hospitals that Use the Joint Commission for deemed status purposes. The Joint Commission.