Restraints, Seduction, and Safety Devices

The full policy is located in PolicyTech

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Definition

A restraint is defined as a manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to control the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s medical or psychiatric condition.
Use Restraints As A Last Resort!

Restraints keep patients inactive causing muscles and joints to weaken.

This places patients at greater risk for injuries like falls, contractures, pressure sores, and incontinence.

They can cause emotional and psychological problems like depression and confusion, and can even make the patient more combative.
Some alternatives to restraints include:

- **Monitoring**: Have a family/friend sit with the patient. Maintain close, frequent observation.

- **Environmental**: Attempt to make them more comfortable.
  - bed position
  - lighting
  - decrease noise level

- **Comfort measures**: Address any pain or discomfort.

- **Medication/nutrition**: Provide snacks and hydration. Assess and provide PRN medication.
More Alternatives

Other alternatives include:

- **Toileting**: Establish a routine and respond promptly.
- **Diversion**: Redirect their attention with TV, video, radio, puzzles, toys, or reading material.
- **Interpersonal skills**: Use active listening, calm reassurance, etc.

See the policy for a more detailed list.
Always Assess for Medical Causes with New Onset/ Worsening Behavior

Prior to restraining patient (if possible), and always within 30 minutes of initiation, assess the patient for the following:

- Hypoglycemia (Accuchek)
- Hypoxia/Hypotension/Dysrhythmia (vital signs, pulse ox)
- Fever
- Recent surgery (pulmonary embolus)
- Admission for overdose
- History of alcohol dependence
- Recent fall/head injury
- Assess baseline mental status (dementia/Alzheimer’s)
Types of Restraint Devices

Some of the types of restraints include:

- Soft limb devices
- Rigid limb devices
- Immobilizers (pediatrics no-no’s included)
- Vests
- Mittens
- Enclosure bed
- Side rails (depending on intent)
Types of Restraint Devices

Some of the types of restraints include:

- Chemicals/Medications (with specifications)
- Therapeutic Hold
- Seclusion (Behavioral Health method)
- Time Out (Behavioral Health method)
- Geri chair
Ties for soft limb, vest, and mittens

Tie soft limb restraints, vests, and mittens using a quick release knot (slip knot).

Secure the knot out of the patient’s reach and away from moving parts like the bed rail, wheels, or brake of wheelchair.

Do not secure ties to shoulder loops of vest or tie to head of bed.
Checking for accurate fit

Make sure you use the appropriate technique to check for an accurate fit:

- **Soft limb:** only 2 fingers should fit between device and patient’s skin.

- **Immobilizer:** 2 sizes available — small for arm and longer for leg. Check for adequate distal pulse and capillary refill.

- **Vest:** color coded based on size/weight. Only 2 fingers should fit at waist between device and patient.

- **Mitten:** only 2 fingers should fit between cuff and patient’s skin.
4-Point Restraints

Sometimes it is necessary to apply all 4 soft limb devices.

Rigid restraints may also be used if other types of restraints are insufficient to protect the patient.

When either of these situations occur it is necessary to:

- Utilize a safety attendant in the room at all times
- Document every 15 minutes
4-Point Restraints

Discontinuation is unique:

— Start with one limb and assess patient response
— Proceed to opposite extremity and opposite half of body
— Once two are off, assess then remove remaining restraints
— Patient should never have one half of body out of restraints
When are side rails considered a restraint?

Side rails are considered restraints if the intent is to limit the patient’s ability to freely exit the bed, regardless of the number that you use.

They are NOT considered restraints:

- During patient transportation
- Specialty beds requiring side rails raised for therapy
- Pt is sedated for medical purposes or recovering from anesthesia
- Pt is not physically able to get out of bed regardless of whether side rails are raised or not
- As an aid to mobility or movement
Two Different Standards for Restraints

There are two different standards for restraints:

- Med-Surg
- Behavioral

There are big differences in the definitions, documentation requirements, and physician assessments.
Med-Surg Restraints

A restraint falls under the Medical/Surgical category if the restraint is used to ensure the physical safety of the non-violent, non-self-destructive patient.

This type of restraint directly supports medical healing for acute medical and surgical care by temporarily immobilizing and limiting mobility.
Med-Surg Restraints

A Med-Surg Restraint is justified if the patient:

   — threatens placement and/or patency of necessary lines/tubes; and/or
   
   — interferes with necessary treatment; and/or
   
   — is unable to follow directions to avoid self-injury.
Behavioral Restraints

A restraint falls under the Behavioral category if the restraint is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff member, or others.

Behavioral restraints are used to protect the patient from injuries to self or others in emergency situations.

These are only used if behavior is aggressive and violent and presents an immediate and serious danger to the safety of the patient or others.
A Behavioral Restraint is justified if the patient:

- Is harmful to self as evidenced by hitting, pulling hair, striking, or biting themselves;
- Is harmful to others as evidenced by hitting, pulling hair, striking, or biting others;
- Has caused serious damage to unit property.
Chemical Restraint

A Chemical Restraint is defined as a drug or medication when it is used as a restriction to control the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s medical or psychiatric condition.

Medications considered to be high profile risks as a chemical restraint are psychotropics and sedatives.
Can restraints be written as PRN?

There are no PRN or standing orders for restraints.

If the restraint is removed, a new order must be obtained to re-initiate the restraint. The exception is if staff does not leave the room after removing the restraint. If the patient remains under constant 1:1 staff supervision while the restraint is removed for a short period, it may be reapplied without obtaining a new order.

In an emergency, a licensed nurse may initiate restraints. However, the MD must be notified within 30 minutes to obtain a telephone order.
What is needed in the MD order for either category of restraints?

An MD order requires the completion of the pre-printed Restraint/Seclusion Orders Form with all components addressed:

- Category of Restraint (Med-Surg or Behavioral)
- Reason/Justification for Restraint
- Duration of Restraint Order (max is one calendar day for Med-Surg, and 4 hours for Behavioral adults)
- Type(s) of Restraint
- Least Restrictive Measures tried or considered

Time of discontinuation is not written in the order because discontinuation is determined by the patient’s behavior.
Face to Face MD Assessment

For Med/Surg restraints: the MD assessment is due upon initiation or within **24 hours** of the order being written.

The med/surg order is valid for one calendar day unless specified for a lesser time period on the orders.

For example, if the med/surg restraint was initiated at 0200 on Tuesday, it would expire at 2359 on Wednesday.
Face to Face MD Assessment

For behavioral restraints: the MD assessment is due upon initiation or within 1 hour.

The order is valid for:

- 4 hours for 18 years or older
- 2 hours for ages 9-17
- 1 hour for ages under 9
Why is the Behavioral Restraint so time-limited?

The fact that the patient’s behavior required restraint indicates a serious medical or psychological need for a prompt assessment of the incident/situation that led to the intervention as well as the physiological and psychological condition of the patient at the time of the assessment.
Paperwork

Once the order is obtained:

– Enter the order into ValleyLink.
– Initiate the restraint flowsheet.
A new flow sheet is begun with each new restraint order. The patient is monitored for the intent to prevent harm, maintain well-being, to ensure that the physical and emotional needs are met during use, and to address exercise, nourishment, and personal use.

The restraint nursing care plan is located on the restraint flow sheet. The care plan is initiated with the RN initialing it. The care plan is then updated daily by the RN initialing each subsequent flow sheet.
Restraint Flowsheet

Components of physical and emotional needs include:

- Signs of injury
- Circulation and range of motion of each extremity
- Vital signs
- Hygiene and elimination
- Nutrition and hydration
- Comfort
- Readiness to discontinue restraint or seclusion
- Position

These components are addressed every 2 hours!
Documentation on Flowsheet

Documentation should be done

- **Med/Surg**: every 2 hours
- **Behavioral**: every 15 minutes
Important Reminders about the Flowsheet

Don’t forget to complete the top half of the form with all pertinent background information.

There should be one flowsheet per each restraint episode (order) – so if the patient requires new order for restraint on the same day, a new flowsheet is initiated.

Write in the date/time of when restraints were discontinued or a new order obtained.

Do NOT draw a line through the column or across through the columns.
Important Reminders about the Flowsheet

Don’t forget that you may select more than one option to describe patient behavior. This is important especially for the patient that is both calm yet continues to pull at lines/tubes.

Another example: If a patient is currently sleeping, but confused and unable to follow directions to avoid self-injury when awake, both behaviors should always be reflected on the flow sheet checks to justify continuing the restraints.
Nursing documentation in the clinical notes should reveal a clear progression of circumstances leading to the restraint use and what alternatives were attempted prior to the implementation of restraints.
Therapeutic Hold

A therapeutic hold is a restraint and requires a restraint order and restraint documentation as any other restraint.

This is a brief physical holding of a patient in a manner that restricts movement for the purpose of calming or providing physical safety to the patient, other patients, staff members, or others.

If the patient just needs escorting without force it is not a therapeutic hold. If the hold is less than 15 minutes a restraint order is needed but a flow sheet will not be needed.
Therapeutic Hold

A therapeutic hold is used only by individuals trained in therapeutic hold techniques (Nonviolent Crisis Intervention® - NCI certified), and only when less restrictive measures have been attempted and have been determined to be ineffective.

To access individuals trained in therapeutic hold techniques, call a ‘code white’ by calling the operator at ‘22’.
Transport of Patient in Restraints

When you are transporting a patient in restraints, the MD or RN assesses if a restraint need exists. This documentation should be noted on the Ticket-to-Ride.

The RN then contacts staff in the receiving area to coordinate care and monitoring if restraints are continued. If a patient has a sitter, the sitter will continue to monitor the patient throughout the transport and procedure.

Upon arrival to the receiving area, the transporter notifies staff – reminding them about restraint use. The transporter remains with the patient until receiving department staff can resume monitoring of patient.
Discontinuation

Restraints are discontinued as soon as possible based on the following:

- Improved mental status;
- Patient’s agreement and compliance with instructions for safety;
- Improved ability to transfer or ambulate without risk of injury;
- Less restrictive measures are effective;
- Patient’s lines are discontinued or no longer required for medical treatment;
- Patient meets identified behavior criteria.
Discontinuation

The nurse may discontinue restraints based on clinical judgment.

No physician order is required to discontinue restraints.

Discontinuation is documented on the flow sheet.
Disposal of restraints

Use the proper technique when disposing of a restraint:

- **Soft limb:** cut into at least 3 pieces
- **Immobilizer:** cut between each metal bar
- **Vest:** cut into at least 3 pieces
- **Mittens:** cut down middle
- **Rigid limb:** send to central sterile supply

Always dispose outside of patient’s room and never send home with patient!
Notification of Death or Injury

The hospital reports to the Centers for Medicare and Medicaid Services (CMS) any deaths where restraints were in use within 24 hours of death, or within 7 days of death if the restraints are thought to have played a role in the death.

The Charge Nurse is made aware and the Nursing Supervisor is contacted.

The Nursing Supervisor completes the CMS Restraint Death Reporting Form and submits it to Risk Management who then notifies CMS.
Seclusion is the involuntary confinement of a patient alone in a room or area where the patient is physically prevented from leaving for a period of time and is separated from others.

Contraindications:

- Patient requires restraints;
- Patient is claustrophobic or extremely fearful of being alone;
- Patient has history of abuse in which they were locked alone in a room;
- The use increases the patient’s agitation.
Practices at BHC only

**Time Out** differs from Seclusion in that the room is not locked and the patient is **NOT** physically prevented from leaving.
Almost Done

This presentation has a test. Close this window and wait for your Assigned Items list to refresh.

When the system is done recording that you have finished the presentation, you can click on the item again to see the option to take the test.