ANNA JAQUES HOSPITAL
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

Subject: **Restraint in the Acute Care Setting**	**Policy Number:** **R-9A**
Category:	**Effective Date:** **5/10**
Page **1 of 13**	**Revised Dates:** **3/11, 11/13**
Attachments: A. Restraint Order, Non-Violent, Non-Self-Destructive Behavior B. Restraint Order, Violent, Self-Destructive Behavior C. Restraint Reference Grid D. Medication Restraint Guidelines E. Violent, Self-Destructive, Restraint Monitoring Record	**Review Dates:**
References: **Nursing Policy, Enclosure Bed**	

POLICY
STATEMENT: Anna Jaques Hospital supports the elimination of the use of restraints in patient care. However, as a last resort, and when other alternatives have been ineffective, the least restrictive form of restraint will be used when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. The use and type of restraint used is based on the patient's presenting behavior, not on the patient's location or diagnosis. When the decision is made to use restraints, there will be on-going assessment to release at the earliest opportunity. Opportunities to reduce the use of restraints will be determined through preventive strategies, staff training, and patient/family involvement. The hospital does not use restraint as a means of coercion, discipline, convenience, or staff retaliation. Anna Jaques trains staff to safely implement restraints, and assesses their competence at regular intervals.

RESPONSIBILITY: Healthcare team

PROCESS:

I.

A. The acute care setting areas work to achieve the Policy Statement goal by its commitment to:

1. The prevention of emergencies that may lead to the use of restraint.
2. The limitation of the use of restraint to emergency situations in which there is imminent risk to the patient, staff or others and when alternative interventions have been unsuccessful.
3. The discontinuation as soon as possible of any episode of restraint, regardless of the scheduled expiration of the order.
4. Providing staff education from the Crisis Prevention Institute (CPI), de-escalation, alternatives to restraint, restraint application, restraint management, restraint removal and patient assessment and monitoring.
5. Addressing patients concerns and complaints on the use of restraint.
6. Including family members and significant others when available in providing support and advocacy for patients.

B. Restraint will not be:

1. Used as a means of coercion, discipline, convenience (staffing issue or otherwise) or retaliation by staff.
2. Used solely based on a prior history of violent or self-destructive behavior or prior use.
3. Discontinued and restarted without the benefit of a new order, as this would be considered a PRN order, which is not permitted.
4. Used solely based on a patient or family member's request.

C. The type and technique of restraint used must be the least restrictive intervention that will be effective in protecting the patient, a staff member or others from harm.

D. Restraint will only be used when less restrictive interventions have been determined to be ineffective in protecting patient, staff or others.

II. Definitions

A. Alternative Interventions to Restraint:
Less restrictive measure considered and attempted prior to use of more restrictive restraint, for example; bed alarm in place, family presence, decrease sensory stimuli and diversion activities.

B. Assessment:
Includes a review of the patient's response to the interventions, based on direct observation of the patient and/or information provided from other trained staff, for the purposes of determining if there is a need for a change in the **plan of care**.

C. Episode of Restraint:
For purposes of this policy, Episode of Restraint begins with the application of a restraint and ends when the intervention is discontinued, regardless of the time interval.

1. **Once the intervention is discontinued, a new order must be obtained with the exception of a "Temporary Release".**

D. Evaluation:
The in-person evaluation, conducted within one hour of the initiation of restraint for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others, including the following:

1. An evaluation of the patient's immediate situation
2. The patient's reaction to the intervention
3. The patient's medical and behavioral condition
4. The need to continue or terminate the restraint

E. Reassessment
The observation and reporting of the components of patient care related to safety, comfort and dignity which may include vital signs, circulation, skin integrity, nutritional, hydration and elimination needs, distress and agitation, mental status, cognitive functions and other needs such as range of motion.

F. Restraint:
42 CFR 482.13 (e)(1)(i)(A) Any 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 42 CFR 482.13(e)(l)(i)(B) (A restraint is -) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patients freedom of movement and is not a standard treatment or dosage for the patient's condition. 42 CFR 482.13(e)(l)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or 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).

G. Temporary Release:
A release from restraint to address patient needs, such as toileting, feeding, range of motion, etc. A Temporary Release is not considered a removal of an intervention (an episode of restraint) and does not require a new order as long as the patient remains under direct staff supervision.

H. Types of Restraint Approved:
Two Point-Soft Wrist, Two Point-Hard Wrist, Four Point-Soft Restraint, Four Point-Hard Restraint, Four (4) Side Bed Rail, Medication Restraint

III. Restraint Orders

A. An order for restraint is obtained from a physician, physician assistant or advanced practice registered nurse who is responsible for the patient's care.

1. The attending physician will be consulted as soon as possible if they did not order the restraint.
2. In an emergency situation, restraint may be utilized prior to obtaining an order. Immediately following (within a few minutes) after restraint has been applied an order must be obtained.

B. A restraint order is required for each episode of restraint.

C. A restraint order must **never** be written as a standing or PRN order.

D. Orders for restraint may be given and renewed for the following time-periods:

1. **Non-violent, non-self destructive behavior**:
   a. Restraint order may be given, written or verbally obtained by phone.
   b. Restraint order is limited to one calendar day for one episode of restraint.
   c. Every 24 hours, a physician, Nurse Practitioner, Physician Assistant primarily responsible for the patient's ongoing care sees and evaluates the patient before writing a new order for restraint.
2. **Violent or self-destructive behavior**:
   a. A restraint order may be given and renewed with the following limits:
      i. Every 4 hours for adults 18 years of age or older
      ii. Every 2 hours for those between the ages of 9 and 17 years of age
      iii. Every 1 hour for children under the age of 9 years

3. Medication Restraint Orders

    a. Each medication order written for medication restraint is written as a one-time only order, it **cannot** be ordered PRN.

IV. Evaluation, Assessment/Reassessment And Monitoring During The Restraint

A. Evaluation of a patient will be conducted by a physician, physician assistant or advanced practice registered nurse.

B. Assessment/Reassessment will be conducted by an RN, Physician, physician assistant or advanced practice registered nurse.

C. Patient monitoring will be performed by trained staff

1. Information obtained from trained staff during the monitoring of the patient, for restraint is incorporated into the RN patient plan of care.

D. Based on clinical judgment, the frequency of assessment and monitoring may be greater than the established criteria based on the patient's condition, cognitive state, medications and type of restraints used.

E. **Non-violent, non-self destructive behavior:**

1. The RN will perform an initial patient assessment prior or immediately following the application of restraint and modifies the patient care plan.
2. Patient reassessment and monitoring will be conducted minimally every two (2) hours unless more frequent monitoring of the patient is determined to be necessary during the episode of restraint.
3. The RN assesses the patient's need for restraint and discontinues restraint based on patient's behavior, at the earliest possible time (see section VI.B.4).

F. **Violent or self-destructive behavior:**

1. A physician, physician assistant or advanced practice registered nurse must perform a face-to-face evaluation within one hour of the initiation of the restraint to evaluate the patient's: immediate situation, reaction to the intervention, medical and behavioral condition, and the need to continue or terminate the restraint. If evaluation is performed by a physician assistant or advanced practice registered nurse they must consult with the attending physician as soon as possible.

V. Nursing care and documentation (in Meditech electronic documentation) when Restraints are applied for Non-violent, non-self destructive behavior

A. All episodes of restraint utilization will have the following **initial assessment** parameters documented in Meditech electronic documentation:

1. Physician Order obtained (must be a new order for each calendar day)
2. Type of Restraint Utilized
3. Description of patient behavior/condition or symptoms warranting the use of restraints.
4. Acknowledgement that a patient activity is disrupting necessary medical treatment; and endangering patient safety

5. Consider risk factors that may put the patient at a higher risk for injury:
6. Alternative Measures to avoid restraints attempted
7. Assessments of a patients needs including:
    a. Dignity/privacy maintained
    b. Patient repositioned
    c. Correct application
    d. Nutrition/Hydration offered
    e. ROM performed
    f. Elimination if needed
    g. Circulation Sensation and Motion checked
    h. Vital signs
8. Family Member/Significant Other notified

B. At least every two (2) hours the patient will be **re-assessed** and the following elements of care documented in Meditech electronic documentation:

1. A current physician order (must be a new order for each calendar day)
2. Type of restraint utilized
3. Assessment of a patients needs including:
    a. Dignity/privacy maintained
    b. Patient repositioned, skin integrity maintained
    c. Correct application
    d. Nutrition/Hydration offered
    e. ROM performed
    f. Elimination if needed
    g. Circulation Sensation and Motion checked
    h. Vital signs per patient needs
4. Release restraint criteria including: Compliant with medical treatment, Demonstrates ability to maintain safety, i.e. decreased psychomotor agitation, or other, positive response to diversion tactics, Changes in behavior that deem restraints no longer needed.
5. Restraint removed, if NO, explain:

C. All patients in restraints will be accompanied by a nurse or patient care associate when being transported to an ancillary department for diagnostics.

VI. Nursing Care And Documentation of Restraint Episodes Related To <u>Violent-Self Destructive Behavior</u>

A. At the time the nurse or other trained health care worker assesses the need to use restraints; the following procedure will be initiated. The Nurse will:

1. Assess patient behavior for imminent risk of harm to self or others
2. Conduct a safety search for medications, weapons, instruments and other contraband (i.e. shoes, jewelry, scarves, belts, portable radio headsets, etc.) that may harm the patient or others.
3. Assess the relevant physical, environmental, psychological and pathophysiological parameters influencing behavior before considering physical restraint
4. When appropriate, attempt to enlist the patient and or family in the decision to restrain.

B. When physical restraint is employed for **violent-self destructive behavior**, the following care elements will be monitored and documented in the patient's medical record at a minimum of every 15 minutes by a trained staff person. An authorized RN must assess the patient at least every 30 minutes:

1. Initial Restraint Assessment Monitoring will include:
   a. Prior to restraint what triggered the incident
   b. Describe alternatives tried before restraint used
   c. Family notified when applicable
   d. Registered nurse signature
2. Restraint Monitoring Record will include:
   a. Vital Sign/Care
   b. Skin Condition, if applicable
   c. Offered or provided fluids
   d. Extremity Circulation and ROM Check, if applicable
   e. Release readiness
      i. When medications are used, there will be a minimum of one (1) hour observation before release readiness instituted.
   f. RN Signature

VII. Performance Improvement

A. The Department Director or Nursing supervisor will be notified by the patient care unit Charge Nurse when any patient is placed in restraint. The Nursing Director / Supervisor will assess the patient and monitor documentation compliance.

B. The use of restraints will be monitored by the hospital Patient Safety Committee and Quality Improvement Committee.

VIII. Death Reporting Requirements

The hospital will report to CMS and DPH, patient deaths associated with the use of restraint by telephone no later than the close of business day following knowledge of the patient's death.

A. Each death that occurs while a patient is in restraint

B. Each death that occurs within 24 hours after the patient has been removed from restraint

C. Each death known to the hospital that occurs within one week of the restraint where it is reasonable to assume that the use of restraint contributed directly or indirectly to a patient's death.

D. The following elements/information should be included in the medical record when CMS reporting is required:

1. Date and time incident was reported to CMS must be included in medical record
    a. All deaths are reported to CMS by telephone no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.
2. Patient identity
3. Cause of death
4. Person making report

E. Quality Management will be responsible for required reporting to CMS and DPH and documenting communication with CMS in the patient's record when applicable.

F. An Occurrence Report will be completed by the RN caregiver, regarding injury or death that has occurred while patient was in restraint. This documentation will be maintained by Quality Management.

IX. Restraint Education

A. Physician, physician assistants or advanced practice registered nurses will have a working knowledge of the hospital policy regarding the use of restraints.

B. Staff Training & Requirements

1. CPI training completed and maintained (every 2 years)
2. Annual Review of Knowledge completion
3. Current BLS
4. Effectively communicates in English
5. Ability to use discretion and courtesy when working with patients, visitors and staff
6. Ability to carry out plan as directed by RN
7. Provide consistent, direct observation of assigned patient(s)
8. Demonstrate ability to recognize and report unusual behavior or complaints to charge nurse or supervisor
9. Intervene when needed to prevent patient from harming self or others, calling for assistance immediately
10. Assure a safe environment, notifying RN of concerns
11. Ability to sit for long periods of time remaining alert without distractions from personal business or other distractions
12. React to varying and unpredictable situations, including emergency/crisis situations
13. Observes and follows established hospital safety protocols.

14. Education and competency on the use of Enclosure Beds (Non-violet/Non-self-Destructive Restraint alternative)

C. Patient and/or family education

1. Whenever possible, the nurse will inform and educate the patient and/or family of the organization's policy on the use of restraints and encourage their involvement.

Authorizing Signatures	Name / Title	Date
Administration: SIGNED ORIGINAL IN ADMINISTRATION	Delia O'Connor President / CEO	
Medical Staff Exec:	Joe Hull, MD President, Medical Staff	

Attachment A –

ANNA JAQUES HOSPITAL

Restraint Order
NON-VIOLENT, NON-SELF-DESTRUCTIVE BEHAVIOR
ACUTE CARE SETTING

Patient Label

Date:
Specific type of Restraint (*check one*):
❒ Two Point, Soft Wrist
❒ Four point, Soft Restraint
❒ Four (4) Side Bed Rails
❒ Enclosure Bed
Reason for (*check one*): ❑ Initial Restraint ❑ Continuation of Restraint:

Behavior Exhibited:

Maximum Duration: 24 Hours	
Start Time:	**End Time:**
Maximum time frame for a Physician/Nurse Practitioner (NP)/Physician Assistant (PA) in-person evaluation is 24 hours after initial application of restraint	
Continuation of restraint requires a Physician/NP/PA in-person evaluation every calendar day thereafter	

Physician Signature:	Date/Time
RN Telephone Order Received Signature (*if applicable*):	Date/Time
Order Noted Signature:	Date/Time

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Attachment B –

ANNA JAQUES HOSPITAL

Restraint Order
VIOLENT, SELF-DESTRUCTIVE BEHAVIOR
ACUTE CARE SETTING

Patient Label

Date:
Specific type of Restraint
❑ Two Point, Hard Wrist
❑ Four Point, Hard Restraint
❑ Medication

Maximum Duration:	4 Hours for age 18 and older 2 Hours for age 9 to 17 1 Hour for under age 9
Start Time:	**End Time:**
Maximum time frame for a Physician/Nurse Practitioner (NP)/Physician Assistant (PA) in-person evaluation is one (1) hour after initial application of restraint	
Continuation of restraint requires a Physician/NP/PA in-person evaluation prior to the end of Twenty-Four (24) hours	

Reason for (*check one*): ❑ Initial Restraint ❑ Continuation of Restraint:
❑ Substantial Risk of/Occurrence of serious self-destructive behavior
❑ Substantial Risk of/Occurrence of serious physical assault
❑ Other

Physician Signature:	Date/Time
RN Telephone Order Received Signature (*if applicable*):	Date/Time
Order Noted Signature:	Date/Time

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Attachment C –

ANNA JAQUES HOSPITAL

Restraint Reference Grid

Element	NON-Violent, NON Self-Destructive Restraint	Violent, Self-Destructive Restraint
Assessment for Need of Restraint	RN assesses need and contacts physician	
Alternatives to Restraint	RN assesses need and contacts physician	
Physician Notification	Physician, Nurse Practitioner (NP), or Physician Assistant (PA) primarily responsible for patient's care notified at time of restraint Written or telephone order is obtained by RN	
Restraint Order	Physician, NP, or PA	Physician, NP, or PA
In-Person Physician/NP/PA Evaluation	Within **24 hours** of restraint application	Within **1 hour** of restraint application physician/NP/PA is required to have face to face evaluation & write order or cosign telephone order
Renewal of Orders	Ordered every calendar day as necessary after evaluation of the patient	Every **4 hours** for age 18 and older Every **2 hours** for age 9 – 17 Every **1 hour** for under age 9 Orders may be renewed according to the time limits for a maximum of 24 consecutive hours Initial and every 24 hour after face-to-face evaluation
Nursing Reassessment	Minimum of every **2 hours**	Monitoring/assessment every **15 minutes** by trained staff person Assessment by authorized RN at least every **30 minutes**
Documentation & Nursing Assessment	Non-Violent, Non Self-Destructive Restraint Order Medical Records in NUR (Process Interventions) **Nursing will use the electronic documentation system where available.**	Violent, Self-Destructive Restraint Physician Order Violent, Self-Destructive Restraint Monitoring Record
Staff Training Requirements	Hospital trains staff to safely implement the use of restraints and assesses competence at prescribed intervals and training is documented	

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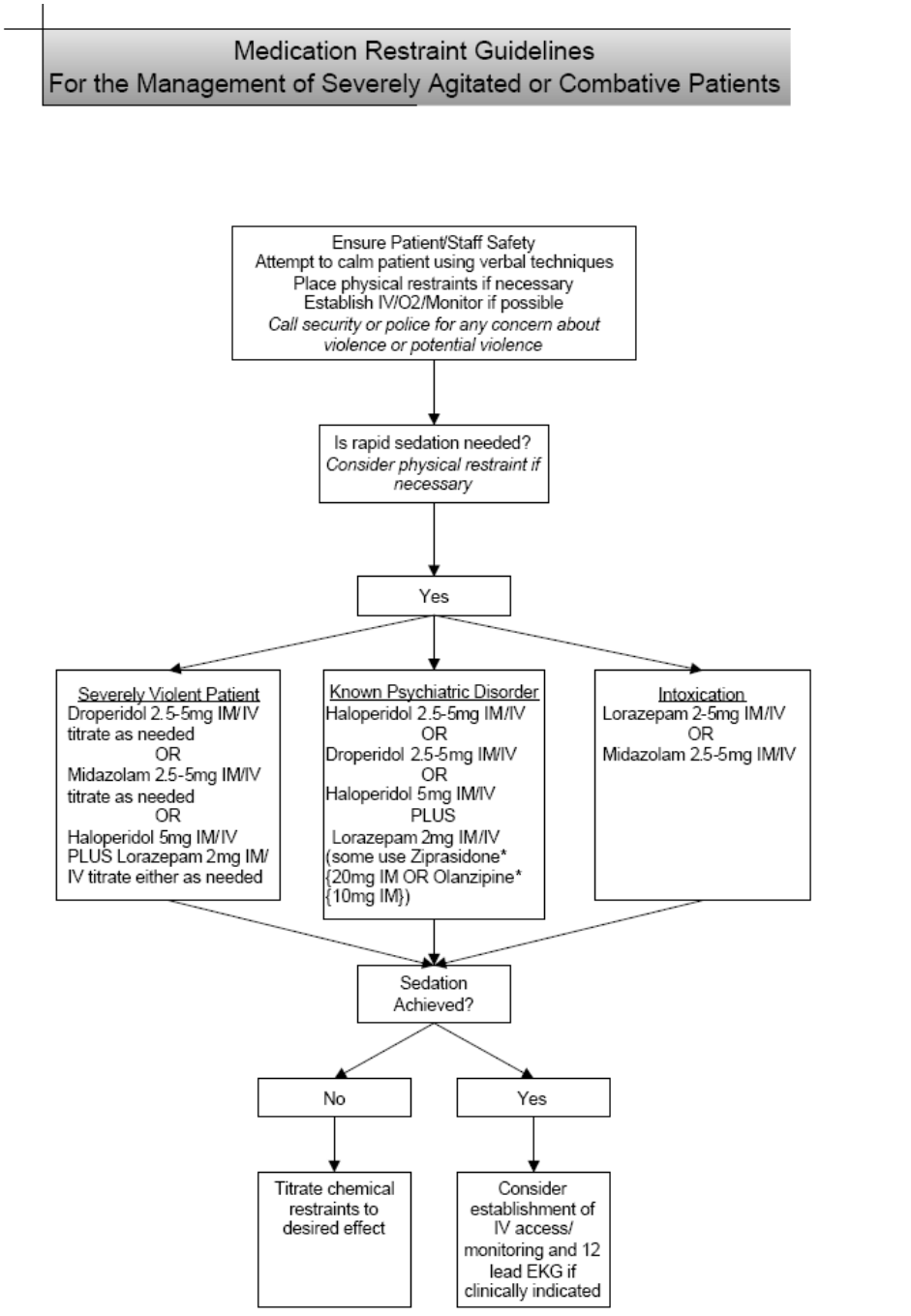
Attachment D –



* The safety of atypical antipsychotics in geriatric patients remains uncertain.
In elderly patients consider reducing the dose of any antipsychotic by half.

RELEASE CRITERIA: Verbalizes willingness to maintain safety, demonstrates ability to maintain safety, positive response to medications resulting in patient regaining control

N:\Working\Emergency\Medication Restraint Guidelines

Medication Restraint Guidelines 05.07.10.vsd

Attachment E –

ANNA JAQUES HOSPITAL

Violent, Self-Destructive, RESTRAINT Monitoring Record

Start Time:

Patient Label

Triggers:
What triggered the incident?

_____
_____
_____
_____

Check those that apply below

Other interventions attempted:

- ❑ Ask HALTT (are you Hungry, Angry, Lonely, Thirsty, Tired?)
- ❑ Sensory Interventions
- ❑ Activity Change
- ❑ Separate from Situation
- ❑ Offer Quite Space
- ❑ Offer PRN Medication
- ❑ One-on-one intervention
- ❑ Other

_____
_____

Considerations:

- ❑ Medical Problems
- ❑ Disabilities

❑ **Physical Restraints**
❑ **Medication Restraints**
Time: _____
Medication: _____
_____
Dose: _____
Rate: _____
RN Signature_____

DOCUMENTATION TO OCCUR EVERY 15 MINUTES BY TRAINED STAFF PERSON. DOCUMENTATION BY RN MUST OCCUR AT LEAST EVERY 30 MINUTES

Time_____ Date _____	Time _____ Date _____	Time _____Date _____	Time _____Date_____
Vital Signs/Care(Chemical & Physical	**Vital Signs/Care(Chemical & Physical**	**Vital Signs/Care(Chemical & Physical**	**Vital Signs/Care(Chemical & Physical**
BP _____ Pulse _____	BP_____ Pulse _____	BP_____Pulse_____	BP _____Pulse_____
Temp _____ Resp_____	Temp _____ Resp _____	Temp_____Resp _____	Temp_____Resp _____
Describe Skin Condition_____	Describe Skin Condition_____	Describe Skin Condition _____	Describe Skin Condition _____
_____	_____	_____	_____
Offered or Provided (O or P):_____	Offered or Provided (O or P):_____	Offered or Provided (O or P): _____	Offered or Provided (O or P): _____
Fluids/Food _____	Fluids/Food_____	Fluids/Food _____	Fluids/Food _____
Toileting _____	Toileting _____	Toileting _____	Toileting_____
Hygiene help _____	Hygiene help _____	Hygiene help_____	Hygiene help _____
Extremity Circulation & ROM Check Physical	**Extremity Circulation & ROM Check Physical**	**Extremity Circulation & ROM Check Physical**	**Extremity Circulation & ROM Check Physical**
Left Arm _____ Right Arm	Left Arm _____ Right Arm	Left Arm _____Right Arm	Left Arm_____Right Arm
Left Leg _____ Right Leg	Left Leg_____ Right Leg	Left Leg_____Right Leg	Left Leg _____Right Leg
Neck/Head Position: _____	Neck/Head Position:_____	Neck/Head Position: _____	Neck/Head Position: _____
Current Condition	**Current Condition**	**Current Condition**	**Current Condition**
Maintaining Control** _____	Maintaining Control** _____	Maintaining Control** _____	Maintaining Control** _____
Calm** _____ Sleeping** _____	Calm** _____ Sleeping**_____	Calm**_____Sleeping**_____	Calm**_____Sleeping**_____
Agitated _____ Trashing_____	Agitated _____ Trashing _____	Agitated_____Trashing _____	Agitated_____Trashing _____
Crying_____	Crying_____	Crying _____	Crying _____
Threatening:	Threatening:	Threatening:	Threatening:
Suicide _____ Homicide _____	Suicide _____ Homicide _____	Suicide _____Homicide_____	Suicide _____Homicide_____
Self-Abuse _____ Assault _____	Self-Abuse _____ Assault _____	Self-Abuse _____Assault _____	Self-Abuse_____Assault _____
Other _____	Other_____	Other_____	Other _____
***Requires justifying continuation*	***Requires justifying continuation*	***Requires justifying continuation*	***Requires justifying continuation*
Signature _____	Signature _____	Signature _____	Signature_____
Title _____	Title_____	Title_____	Title _____
Release Readiness	**Release Readiness**	**Release Readiness**	**Release Readiness**
**Justify continuation:_____	**Justify continuation:_____	**Justify continuation: _____	**Justify continuation: _____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Release: ❑ Yes ❑ No	Release: ❑ Yes ❑ No	Release: ❑ Yes ❑ No	Release: ❑ Yes ❑ No
RN Signature _____	RN Signature _____	RN Signature _____	RN Signature_____

RELEASE CRITERIA: Verbalizes willingness to maintain safety, demonstrates ability to maintain safety, positive response to medications resulting in patient regaining control.

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