### PATIENT CARE STANDARD

<table>
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<th>TITLE:</th>
<th>RERAINT, BEHAVIORAL – VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR (ADULT &amp; PEDIATRIC)</th>
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| POLICY | 1. Prevent, reduce and eliminate the use of restraints by:  
   a. Preventing emergencies that have the potential to lead to the use of restraints, by utilizing de-escalation techniques and administering PRN medication as needed.  
   b. Using the least restrictive method  
   c. Limiting the use of restraints to emergencies where there is a risk of the patient harming himself/herself or others.  
   2. Protect the patient and preserve the patient’s rights, dignity and well-being during restraint use by:  
      a. Respecting the patient as an individual.  
      b. Maintaining a clean and safe environment  
      c. Encouraging the patient to continue to participate in own care.  
      d. Maintaining the patient’s modesty, preventing visibility to others, and maintaining comfortable body temperature.  
      e. Provide for safe application and removal of the restraint by qualified staff.  
      f. Monitor and meet the patient’s needs while in restraints.  
      g. Reassess and encourage release of restraints as soon as possible.  
   3. Leadership demonstrates its commitment to the aforementioned by providing and/or promoting:  
      a. Ongoing staff orientation and training.  
      b. Patient and family education, as appropriate.  
      c. The development and promotion of preventive strategies; and the ongoing assessment/reassessment of alternative measures.  
      d. The use of safe and effective alternative measures including adequate human resources when applicable.  
      e. Monitoring the use of restraints, for the purpose of reducing restraint use.  
   4. The hospital prohibits restraint that are imposed as a means of coercion, discipline, convenience, or retaliation by staff.  
   5. Exceptions to Behavioral Restraint Usage: The following are not governed by this policy: Handcuffs and other restrictive devices applied by law enforcement officials. These are considered forensic restrictions. |
**DEFINITIONS:**

**RESTRAINT:**
Use of a physical or mechanical device or chemical medication to involuntarily restrain the movement of the whole or a portion of a patient’s body for the reason of controlling his/her physical activities and is not a normal part of treatment. These can include soft extremity restraints, soft chest vests, mittens, side rails, medications, and hard extremity restraints. Excluded from the definition are any devices used for reasons of medical immobilization, adaptive support, or protection (as described below).

**MEDICAL IMMOBILIZATION:**
Mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures/tests that are considered a regular part of such procedure or test. These mechanisms usually include body restraint during surgery, arm board during intravenous administration or for use of restraint for post-operative/post-anesthesia care.

**ADAPTIVE SUPPORT:**
Mechanisms intended to permit a patient to achieve maximum normal body function. These mechanisms usually include orthopedic appliances, braces, wheelchairs, or other appliances or devices used to posturally support the patient.

**PROTECTIVE DEVICES:**
Mechanisms intended to compensate for a specific physical deficit or prevent safety incidents not related to cognitive dysfunction. These mechanisms usually include bed rails, tabletop chairs, protective helmets, and soft chest vests to prevent a cognitively intact patient from rolling out of bed at night.

**MEDICAL/SURGICAL RESTRAINTS:**
Any device used to restrict a patient’s movement or access to his body to prevent harm to self by interfering with medical treatment.

**BEHAVIORAL RESTRAINT:**
Any device (physical or chemical) used to restrict patient’s movement in response to sudden, unanticipated outburst of aggressive or destructive behavior that possess an imminent danger to self or others.

*Use of hard restraints or Posey Key Lock Belt constitutes behavioral restraints.*

**INITIAL ASSESSMENT:**

1. Identification of patients who are at risk for harming self or others.
2. Identify techniques, methods or tools that would help the patient control his / her behavior.
3. Evaluate for pre-existing medical conditions or any physical disabilities and limitations that would place the patient at greater risk during restraints, any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint is identified.
4. Behaviors that the patient is exhibiting in order to determine the need for the use of restraints.
5. The risks associated with the use of the restraint are outweighed by the risk of not using it.

6. **Assessment of potential causative factors:**
   a) Possible physiological sources of behavior:
      - Medication changes/drug interactions
      - Oxygenation levels
      - Sedation/anesthesia effects
      - Abnormal laboratory levels
      - Uncontrolled pain
      - Alcohol and/or drug intoxication or withdrawal
      - History of anxiety or mental health issues
   
   b) Other possible reasons for behavior changes:
      - Altered comfort
      - Loss of control in hospital
      - Fears and anxieties
      - Satisfaction with care
      - Environment

**PROCEDURE:**

**Use of Least Restrictive Interventions (Alternative Measures)**

1. Alternative measures are to be considered prior to application of restraint devices
   a. **Examples of alternative measures are found in appendix A.**
   b. Patients will have routine PRN medications ordered and used by nurses at all appropriate junctures. The routine PRN is our first line of care to prevent escalation and prevent decompensation.
   c. Occasionally, patients’ conditions will escalate to potentially dangerous levels despite the judicious use of routine use of PRN medication and professional staff de-escalation techniques. In this instance, “Emergency Medications” are often needed in addition to the already scheduled PRNs. **There are several scenarios that can occur in this instance:**
   1) The physician is called for an order for Emergency Medication (PO or IM) and such is offered to the patient with a professional show of force and concern. If the patient accepts this emergency medication with physical restraint used, then there is no “restraint” in effect. In these cases, an emergency medication for a one time dose only is ordered. **These medications are prescribed for their appropriate clinical condition treatment and are not chemical restraints by definition.**

   Definition: Chemical Restraint is a drug that is not an expected standard treatment or dosage for the patient’s condition.
### Restraints

a. **Obtain order.** Note: many types of emergencies can occur, and staff are expected to effectively respond. In some emergency situations, the need for a restraint intervention may occur so quickly that an appropriate order cannot be obtained before the application of restraints. In **these emergency situations**, the intervention is authorized by the RN and the order from the MD must be obtained either during the emergency application of the restraint, or immediately after the restraint has been applied.

b. **Document order** on the MD order sheet for behavioral restraint packet.

c. **Explain to patient and/or significant other the necessity of restraints.**

d. A staff member will continuously monitor the patient for the duration of Behavioral Restraint.

e. **Assessment is determined by condition of the patient but is to be visually performed at least every 15 minutes by an RN for behavioral restraint.**

f. Adhere to the documentation component of policy utilizing the RN monitoring and assessment tool in the packet.

g. **Assess every 15 minutes the following:**
   1) Airway & Respiratory status
   2) Skin color
   3) Circulation, movement and sensation
   4) Responsiveness
   5) Nonverbal cues
   6) Suicidal/ homicidal ideation
   7) Intent to harm others
   8) VS
   9) Patient readiness for release from restraints

h. **Assess every 2 hours for the following:**
   a) Hydration and nutritional needs
   b) Hygiene and toileting needs
   c) Range of motion performed: release one restraint at a time, beginning with the ankles.

### Initiation and Renewal of Orders for Behavioral Restraints:

a. Physician Orders for Behavioral restraints include:
   1) Date and time restraint initiated
   2) Type of restraint & number of limbs to be restrained
   3) Length of time restraint to be utilized
   4) Reason or clinical justification for restraint
   5) Criteria for release
   6) Physician name
**PROCEDURE CONTINUED:**

b. Behavioral restraint orders and face to face assessment:
   1) A new restraint order must be obtained for each restraint episode.
   2) The restraint order will be obtained within 1 hour of application or sooner based on patient’s condition.
   3) Within one hour, a face to face evaluation is conducted by the Physician to assure patient safety, rule out possible underlying factors that might be contributing to the patient’s behavior, to assess the patient’s physical and psychiatric condition, and to decide whether restraint continues to be necessary.
   4) Orders for behavioral restraints are limited to:
      1. 4 hours for patients 18 years of age and older.
      2. 2 hours for children and adolescents ages 9-17.
      3. 1 hour for children under age 9.

c. The Physician reorders restraint for each age group at interval listed above.

4. **Discontinuing Restraint prior to Expiration of the Order:**
   a. Any patient who is requiring restraint will be continuously monitored and evaluated for appropriateness of an early release ASAP. Such improvements may be based on:
      1) Improved mental status.
      2) Patient’s ability to demonstrate safe behavior.
      3) Less restrictive measures are effective.
   b. Registered Nurse (RN) must assess whether the patient qualifies for an early release to assure appropriateness for the continued need. This assessment is conducted at least every 15 minutes.
   c. If the restraint is discontinued prior to the expiration of the original order, and reinitiating of restraint is indicated, a new order must be obtained and a face-to-face assessment completed.

5. **Staff Education and Competency**
   a. All staff applying restraining devices receive instruction and demonstrate competency in the safe application of restraints and subsequent monitoring of restrained patients. The staff has received training in techniques and alternative methods for handling behavior, symptoms, and situations.

6. **Debriefing**

   **Patient**

   A patient debriefing is conducted at the time of release from restraints. This is documented on the patient debriefing section contained in the Restraint (Behavioral) packet. This debriefing identifies, from the patient’s perspective, what the patient and staff could have done differently that may have assisted in avoiding the use of restraint. Use this information to update the Plan of Care as applicable.
### TITLE: RESTRAINT, BEHAVIORAL – VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR (ADULT & PEDIATRIC)

#### PROCEDURE CONTINUED:

7. **Risk Management Reporting:**
   - Any death or injury that occurs while a patient is restrained or where it is reasonable to assume that the patient’s death is a result of restraint must be reported immediately to Risk Management and the facility’s administrative staff (Administrator on Call), who will initiate referral to the appropriate agency.

#### NOTIFY PHYSICIAN/MANAGEMENT OF:

1. Changes in patient condition
2. Necessity for additional medications.

#### PATIENT/FAMILY EDUCATION:

Instruct the patient/family/caregiver regarding (note the family/caregiver should be notified of restraint use):

- Reason for restraint, including alternatives tried.
- Use of call light.
- Expected care.
- Identification of possible patient and family participation in the care process that could limit or halt the use of restraints.

#### DOCUMENTATION:

Utilize packet of Restraint Orders, Behavioral

#### REFERENCES:

JCAHO
Title 22

#### CROSS REFERENCES:

Patient Care Standard for: Restraints, Medical Non-Violent, Adult and Pediatrics

Administrative Policy For Handling Incarcerated, Legal Or Forensic Patients

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<tr>
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<th>Written by:</th>
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<tr>
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<td>Approval Date:</td>
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<td>Approved by:</td>
<td>Shelly McGriff, Chief Nurse Executive</td>
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APPENDIX A

EXAMPLES OF ALTERNATIVE MEASURES

Physiological Measures:

- Routinely take the patient to bathroom or bedside commode.
- Assess the patient’s comfort level and give care as needed. For example do they need a position change? Do they want to get up in a wheelchair, or be put back to bed? Does the patient need pain medication? Is the patient too hot/too cold?
- Assess the patients’ physical care needs. For example, is the patient hungry or thirsty?
- Insure adequate hydration
- Increase frequency of observation
- Reorientation
- Bed in lowest position
- Minimize obstacles to mobility
- Noise reduction
- Toilet every 2 hours while awake and every 4 hours during the night
- Adjust master treatment plan

Psychosocial Measures:

- Orient or reorient the patient to person, place or time.
- Encourage verbalization of feelings.
- Validate the patient’s feelings.
- Acknowledge the patient’s tension and be physically available to initiate therapeutic interventions in potentially stressful situations.
- Instruct the patient in relaxation techniques and/or deep breathing exercises.
- Be physically available to patients during periods of increasing tension.
- Respect a patient’s need for personal space.
- Offer television, books, and / or “busy work”.
- Set consistent limits on type and degree of aggression that is tolerated. Review consequences if behavior is not controlled.
- Pay attention to threats of physical aggression.
- Recognize the need for clear-cut staff and/or patient boundaries.
- Determine and anticipate the need for medications.
- Avoid sudden movement around a potentially violent patient.
- Allow the patient to participate actively in their care to decrease frustration.
- Keep the patient well informed of their treatment to reduce fear.
APPENDIX A (Continued)

EXAMPLES OF ALTERNATIVE MEASURES

- Speak to the patient in a calm reassuring voice.
- Always treat the patient in a dignified and respectful manner.
- Determine if medication intervention is necessary. Check PRN medications available and discuss symptoms and behavior with the patient’s physician as needed.
- Explain procedures carefully and assess understanding.
- Attempt to redirect agitated patients to another topic. For example reminiscence is often effective with cognitively impaired patients.
- Put the patient on a higher level of observation with regular checks to provide for safety and increase staff contact.
- Play soothing music.
- Assess whether television has a calming or agitating effect of the patient.
- Sit the patient close to the nursing station. Assess whether this has a calming or agitating effect.
- Provide the patient with a safe therapeutic activity that is diverting.
- Use verbal redirection techniques.
- Use de-escalation techniques such as non-violent crisis prevention.
- Provide clock in room; provide calendar in room
- Review medication and management
- Isolate the situation
- Adjust master treatment plan

**Environmental Measures:**
- Place the patient in a room closer to the nurses station
- Use appropriate lighting.
- Modify the environment to reduce sensory stimulation
- Create a safe, protective environment by removing potentially hazardous articles.
- Assure the call bell is within reach and night light on,
- Orient the patient frequently to his or her surroundings
- Place personal items within reach
- Place the bed in low position if possible
- Provide non-slip/grip footwear
APPENDIX B

ASSAULT RESPONSE DECISION TREE

Is this behavior dangerous?

NO

Will the treatment plan solve this problem?

YES

Use the treatment plan.

YES

NO

Is there an immediate danger of injury?

NO

Will routine back-up plans solve this problem?

YES

Use routine back-up plans.

YES

NO

Is serious injury being threatened?

YES

Do we understand why this is happening?

YES

Identify function of behavior & make adjustments in approach per treatment plan?

NO

Can we talk the attacker into stopping the attack?

YES

Use verbal crisis intervention.

NO

Will the attacker stop if we briefly avoid the attack?

YES

Use evasive self-defense.

NO

Will we have to restrain this person from hurting self or others?

YES

Use physical intervention, containment, restraint.

YES

Do we have enough trained staff to restrain this person with minimum risk to the person and the staff?