Managing Restraints
Overview

• It is the policy of BHS to limit the use of restraints and seclusion to those situations where it is necessary to ensure the immediate physical safety of the patient, staff members, or other with appropriate and adequate clinical justification and to facilitate the discontinuation of restraint or seclusion as soon as possible based on an individualized patient assessment and re-evaluation.

• The restraint and seclusion process, when indicated, will be applied in a manner that protects the patient’s health and safety, and preserves the patient’s dignity, rights and well-being.
Overview

- Differentiate between indications for non-violent (medical) restraints and violent (behavioral) restraints.
- Determine when restraint orders should be initiated.
- Determine how and when restraint orders can be renewed.
- Identify proper documentation for patient’s in restraints.
- Recognize when it’s appropriate to release restraints.
- Identify other steps / processes that need to be taken when a patient is placed in restraints.
Restraints – Risks vs. Benefit

• There are risks involved in any physical intervention. Therefore, risks should always be considered when the danger presented by the patient’s behavior outweighs the risks of physical intervention.

• The initial assessment of each patient upon admission assists in obtaining information about the patient that could help minimize the use of restraint or seclusion as well as reduce the inherent risk to the physical safety and psychological well-being of the patient.
Clinical Justification?

• Before applying restraints, stop and think, do you have clinical justification for applying restraints?
• Is there a need for Medical restraints?
• Is there a TRUE need for Violent restraints?
• What is triggering the patient’s behavior and is it something that can be de-escalated?
Factors that could affect behavior

- Underlying medical, physical or emotional conditions
- Cognitive function
- Medications and their potential side effects
- Age, weight, developmental level or functioning
- Gender, culture, ethnicity
- History of abuse or trauma
- Prior experience with restraint or seclusion
- Behaviors of the staff
Physiologic causes that could affect behavior

- Hypoxia
- Hypoglycemia
- High fever
- Brain injury / tumor
- Dehydration
- Pain
- Sleep deprivation
- Meningitis
- Encephalopathy
- Alcohol withdrawal
- Drug toxicity
- Dementia
- Elimination needs
- Psychiatric disorders
Other precipitating factors that could affect behavior

- Loss of personal power
- Need to maintain self-esteem
- Fear
- Sense of failure
- Attention seeking
- Displaced anger
Attempt alternatives to restraints

- Restraints will not be used when less restrictive alternatives would be effective.
- You should consider and attempt as many alternative as possible before putting patients in restraints.
Strategies to use

• Identify behaviors, events, environmental & physiological factors that may trigger restraint use.

• Modify / eliminate identified triggers and attempt to de-escalate unwanted behaviors.

• Strategies that may be employed include, but are not limited to:
  – Promoting a safe environment
  – Promoting cognitive, psychological and physiological well-being
  – Promoting functional mobility
Promoting a safe environment

• Initiate falls precautions
• Use assistive devices for ambulation and / or bed mobility
• Place items closer to the patient
  – Bedside table, phone, call bell, bedside commode, etc.
• Bed-check alarm
• Low rise bed
• Adjust lighting / noise
• Place patient near the nurse’s station
• Remove tubes and lines a soon as medically indicated
Promoting cognitive, psychological and physiological well-being

• Orient patient to surroundings
• Ask the family to stay with the patient
• Eliminate unnecessary tubes / treatments as soon as possible
• Offer bathroom / beside commode frequently
• Periodic reassessment of medication / side effects
• Redirect patient’s focus
• Employ verbal de-escalation
• Clinical time out
• Quiet time
Promoting Functional Mobility

• Have patient wear his / her glasses, contact and / or hearing aids

• Perform strengthening activities
  – Up in chair, ambulate, range of motion

• Provide pain medication to maintain patient comfort
Rights to refuse treatment

• We must ensure that each patient’s right to be free from restraints is protected and must take actions to comply with requirements.

• Patients have the right to refuse treatment until and unless they are declared to be incompetent

• We cannot restrain a patient in order to force a treatment of test, such as a blood draw, etc.
When behavior escalates

Alternative methods to de-escalate situations aren’t always successful and sometime a patient’s behavior will continue to escalate. If this happens…

• Check your tone of voice and attitude
• Stay in control of your own behavior, don’t take the acting out personally
• Listen!
• Set limits
• Keep yourself safe!
Non-verbal communication & Safety

• Defensive positions:
  – Arms crossed
  – Minimal facial expressions
  – Little eye contact, downcast

• Positive positions:
  – Relaxed body and smiling
  – Good posture
  – Eye contact
## Patient / Staff Behaviors

<table>
<thead>
<tr>
<th>Patient Behavior</th>
<th>Effective Staff Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anxiety / Tension:</strong> Increased sensitivity and frustration. Apprehension.</td>
<td><strong>Supportive:</strong> Listen, stay calm, give them space, don’t get into an argument, uses non-judgmental, empathetic approach.</td>
</tr>
<tr>
<td><strong>Defensive / Disruptive:</strong> Loss of rationality; becomes belligerent and challenging</td>
<td><strong>Directive:</strong> Set limits on behavior. Calmly explain what you are / are not able to do. Consider calling security to assist in de-escalation.</td>
</tr>
<tr>
<td><strong>Loss of Control / Violence:</strong> Patient resorts to yelling, screaming or actual physical violence.</td>
<td><strong>Call code Green (55555):</strong> Security officers / code green team members have been trained in de-escalation and self-protection techniques. Follow direction of the security office. Put yourself near an exit.</td>
</tr>
<tr>
<td><strong>Tension reduction:</strong> Rationality regained</td>
<td><strong>Therapeutic rapport:</strong> re-establish communication.</td>
</tr>
</tbody>
</table>
If all else fails…

• Provide safe management of the patient in restraints
What is a restraint?

• Any method, physical or chemical or mechanical devise, material or equipment that immobilized or reduces the ability of a patient to move his or her arms, legs, body or head freely.

• Chemical restraints are NOT an approved form of patient management in the State of Texas and is prohibited.
Approved Restraints at BHS

• Wrist & ankle restraints, Mittens, Vests
• Side rails X 4
• Geri Chair, restraint chair
• Enclosed bed, restraining net
• Roll belt, elbow splints
Seclusion, Clinical Timeout & Quiet Time

• **Seclusion**: The involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behaviors.
  – This is NOT the same as a Clinical Timeout or Quiet Time.

• **Clinical Timeout**: The staff and patient collaboratively determine when the patient has regained self control and is able to return to the treatment area.

• **Quiet Time**: A procedure in which a patient, on the patient’s own initiative, enters and remains for a period of time in a designated area from which the patient is not prevented from leaving.
What is NOT a restraint?

• Voluntary mechanical support.
  – Examples: helmets, back, neck & leg braces, orthopedically prescribed devises, surgical dressings
• Age or developmentally appropriate protective safety interventions
• Forensic / correction devices used by law enforcement
• Protective devices
• Immobilization during medical, dental, diagnostic, surgical procedures
• Escort or brief physical prompt
• Assistance of a patient for activities of daily living
Special considerations

• Although all patients are considered at risk, populations at special risk require special attention in the care planning process.

• Some examples are:
  – Pregnant, respiratory problems, elderly, physically impaired, cognitively impaired, those with prior abuse cases
Two categories of restraints

1. Non-violent (Medical) Restraints

2. Violent (Behavioral) Restraints
Medical Restraint (non-violent)

• The use of a restraint to protect the patient from harm and support medical healing.

• Indications…
  – Interfering with medical interventional devices (tubes, drains, dressings, endotracheal tubes)
  – High risk for serious fall-related injury (on blood thinners, recent orthopedic surgery)
  – Interfering with surgical wound (picking at site in a manner that interferes with healing)
Ordering medical restraints

- Restraints MUST be ordered in Cerner
- The order should address:
  - Criteria that make the restraint necessary
  - Restraint type
  - Special considerations
- If restraints are applied without a physician order, a telephone order must be obtained either during the emergency application or immediately after the restraints have been applied.
- This telephone order must be authenticated by the physician within 96 hours.
Ordering restraints in Cerner
Continuation of medical restraints

• Medical restraints must be renewed on a daily basis.

• A face-to-face physical examination is required by the physician at least every calendar day to determine the clinical justification for the continued use of restraints.

• If it is deemed necessary to continue Medical restraints, the physician will need to complete a new order form.
Medical restraint orders

• PRN restraint orders are NOT accepted

• Restraints shall be discontinued at the earliest possible time, when the behavior or condition which was the basis for the restraint order is resolved.

• Temporary releases that occur for the purpose of patient care are not considered a discontinuation of a restraint.
Medical Restraint documentation

- Monitor patient in restraint at least every two hours or more frequently according to patient’s need
- Document in Cerner
  - Mental status
  - Anxiety
  - Behavior
  - Circulation
  - Skin integrity
  - Respiratory status
  - Cardiac status
  - ROM each restrained limb
  - Bathroom privileges
  - Meals
  - Hydration
Since Nutrition / Hydration and Hygiene / Elimination are combined in charting fields, you will need to enter a COMMENT to specify what was offered or declined for the following assessments:

- Bathroom privileges
- Meals
- Hydration
- Hygiene
Violent Restraints

• The use of restraint for behavioral emergencies; demonstrated outburst of severely aggressive behavior that poses and imminent danger to the patient or others.
Ordering Violent restraints

- Restraints MUST be ordered in Cerner
- The order should address:
  - Restraint type
- If restraints are applied without a physician order, a telephone order must be obtained either during the emergency application or immediately after the restraints have been applied.
- This telephone order must be authenticated by the physician within **48 hours**.
Ordering Violent restraints

- **The following form is a downtime form** and is intended to be used for one episode (the time period from the initiation of restraint or seclusion until the release of the patient).
  - The left side of the order form is for the original order (may be written or telephone order).
  - The right side is to be completed if a continuation of Violent restraints is necessary (must be written by the physician).
  - After this form is used, a new order form will need to be completed and will be considered a new restraint episode.
Order form

This form is to be utilized during Cerner downtime.

<table>
<thead>
<tr>
<th>ORIGINAL Behavioral Emergency Restraint Order</th>
<th>CONTINUATION Behavioral Emergency Restraint Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original order may be Telephone Order</td>
<td>Continuation order must be a written physician order</td>
</tr>
</tbody>
</table>

**SECTION 1: CRITERIA THAT MAKE RESTRAINT NECESSARY**
- Behavior is violent or self-destructive and de-escalation techniques have been ineffective.

**SECTION 2: RESTRAINT TYPE**
*only select restraints appropriate to patient at this time*
- Upper Extremities (Wrists)
- Lower Extremities (Ankles)
- Restraint Chair
- Restraining Net
- Physical Hold
- Mittens
- Vest
- Seclusion

**SECTION 3: TIME LIMIT**
ORDER IS VALID FOR NOT MORE THAN...
- 4 hours for ages 18 +
- 2 hours for ages 9-17 years
- 1 hour for patients under the age of 9
- 15 minutes for physical hold

Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

**SECTION 4: AUTHENTICATION**
**TELEPHONE ORDER FROM...**

(Physician name)  (Nurses Signature/Title)

Nurses Emp#:  Date:  Time:  

NO Telephone orders can be accepted for continuation of restraints. Order must be written by a physician member of the staff.

**SECTION 4: AUTHENTICATION**
**TELEPHONE ORDERS MUST BE AUTHENTICATED IN FULL WITHIN 48 HRS**
Notification process

• The Chief Nursing Office or designees and Unit manager / director (or House Officer) shall be notified immediately of any instance of initiation of Behavioral Restraints or Seclusion.
• A comprehensive face-to-face assessment **MUST** be conducted by a physician, LIP or RN with documented competency to perform a face-to-face assessment, **within one hour** of initiation or restraint or seclusion.

• **Face-to-face:** Describes a contact with a patient that occurs in person. Face-to-face does not include contact made through the use of video or telecommunication conferencing or technologies, including telemedicine.

This form will be utilized during Cerner downtime.
Continuation of restraints

• Pay attention to the time limits for Violent restraints!

<table>
<thead>
<tr>
<th>Age</th>
<th>Time limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 + years</td>
<td>4 hours</td>
</tr>
<tr>
<td>9 – 17 years</td>
<td>2 hours</td>
</tr>
<tr>
<td>Under 9 years</td>
<td>1 hour</td>
</tr>
<tr>
<td>*Physical hold</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

• Before the original order expires, the RN will evaluate the patient face-to-face and determine if there is continuing existence of a behavioral emergency.
• If so, the RN must contact the physician.
• The physician will conduct a face-to-face evaluation before the original order expires in order to issue an order that continues the use of the restraint or seclusion.
Violent restraint orders

- PRN restraint orders are NOT accepted

- Restraints shall be discontinued at the earliest possible time, when the behavior or condition which was the basis for the restraint order is resolved.

- Temporary releases that occur for the purpose of patient care are not considered a discontinuation of a restraint.

- Restraints must be discontinued if a patient falls asleep while in restraints.
A physician or LIP* must conduct an in-person exam daily and document the reason for continued restraints.

The documentation can be completed in Cerner or on this form...as long as the 4 points are documented somewhere.

* LIP = Licensed Independent Provider

This form will be utilized during Cerner downtime.

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### Continuation of violent restraints

<table>
<thead>
<tr>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment must be conducted before order expiration</td>
<td>If physician delegates the in-person assessment to a LIP, findings must be discussed with physician prior to physician writing a continuation order for BE restraint/seclusion</td>
</tr>
</tbody>
</table>

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### Patient's Immediate Situation:

- Patient's immediate situation:
  - What accounted for the need for seclusion or restraint?
  - What interventions were tried prior to seclusion or restraint?
  - Did the patient cause any injury to himself or anyone else during the restraint or seclusion?
  - What has the patient been told he/she must do to decrease or discontinue the restraint or seclusion?

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### Patient's Reaction to the Restraint or Seclusion:

- Patient's reaction to the restraint or seclusion:
  - How is the patient observed to be experiencing the seclusion or restraint?
  - Is the restraint or seclusion assisting or de-escalating harmful behavior?

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### Patient's Medical and Behavioral Condition:

- Patient's medical and behavioral condition:
  - Conduct a behavioral assessment (i.e., appearance: behavior, awareness: mood/afflict, perception: judgment/speech).
  - Review patient's history and note how it may impact this seclusion or restraint.
  - Review medications administered recently.
  - Review recent lab results.
  - Evaluate other causes of behavior such as: drug interaction, electrolyte imbalance, hypoglycemia, etc.
  - Review vital signs, quality of respirations/circulation.

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### Need to Continue or Discontinue the Restraint or Seclusion:

- Need to continue or discontinue the restraint or seclusion:
  - Has the patient complied and responded positively to this intervention?
  - Is there any progress toward the desired goal for the patient?
  - Are any restraints be discontinued?

Restraint or seclusion must be discontinued when the patient is no longer exhibiting violent behavior (e.g. when calm, sober, etc.).
Behavior restraints documentation

- Monitor patient in restraint every **15 minutes** or more frequently according to patient’s need.
- Document in Cerner.

<table>
<thead>
<tr>
<th>Violent (Behavioral) Restraint</th>
<th>Frequency</th>
<th>Fields / forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental status, anxiety, behavior</td>
<td>15 minutes</td>
<td>Behavior, Anxiety, Attitude</td>
</tr>
<tr>
<td>Respiratory status, circulation, skin</td>
<td>15 minutes</td>
<td>Distal limb assessment, Skin, Resp Rate</td>
</tr>
<tr>
<td>integrity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac status</td>
<td>hourly</td>
<td>HR and BP</td>
</tr>
<tr>
<td>ROM each restrained limb</td>
<td>hourly</td>
<td>Exercise/ROM</td>
</tr>
<tr>
<td>Bathroom privileges</td>
<td>2 hours</td>
<td>Hygiene/Elimination</td>
</tr>
<tr>
<td>Meals</td>
<td>meal/snack intake</td>
<td>Nutrition/Hydration</td>
</tr>
<tr>
<td>Hydration</td>
<td>2 hours</td>
<td>Nutrition/Hydration</td>
</tr>
<tr>
<td>Hygiene</td>
<td>daily bath</td>
<td>Hygiene/Elimination</td>
</tr>
</tbody>
</table>
| Room safety                               | 2 hours         | Right click Safety field and add note: "Room free of hazards"
| Steps toward release                      | 2 hours         | Release attempts                                     |
| Readiness for release                     | 2 hours         | Under Restraint Education topics, select “release criteria” |
| Transfer of responsibility                | every change of | In I&C/INET Bedside Hand-Off, select Yes for shift/caregiver “Verification of Receiving Person”, then right click on that response, select “Add Comment” and enter “Reviewed restraints”.
| Debriefing                                | Once, ASAP after | Debriefing form (include in paper chart)             |
| initiation                                |                 |                                                    |
Personal Hold
(Physical Restraints)

• Any manual method by which a person holds or otherwise bodily applies physical pressure that immobilizes or reduces the ability of the patient to move his or her arms, legs, body, or head freely.

• Holding a patient can be just as restrictive and potentially dangerous as restraining methods using devices.

• Physically holding a patient during a forced psychotropic (or other) medication procedure is considered a physical restraint.

• No prone or supine holds.

• Must have a continuous observer who is not physically applying the restraint.
Qualified sitters

• A qualified sitter will be assigned after the house officer is notified of a patient being placed into violent restraints.
  – This is someone that has been trained and proves competence. This cannot be a family member or non-clinical employee.

• A sitter of the same gender as the patient will remain on continuous face-to-face observation (except in a case of sexual assault by a person of the same sex).
Physical hold scenario

• A violent patient in the Emergency Department is attempting to leave the hospital. An Emergency Detention order has not yet been obtained. As patient attempts to leave, the physician asks the Security Guard to prevent the patient from leaving. The Security Guard holds the patient by the arm and leads him back to his room. Does this require a restraint order?
Physical Hold Scenario – Answer

• YES. This is a Physical Hold which requires a restraint order that may be initiated only at the direction of the nurse or physician. The patient’s nurse will be responsible for obtaining a physician order for the Physical Hold.
Debriefing – Behavioral restraints

• Following an episode of behavioral emergency restraints or seclusion, staff will conduct or attempt to conduct a debriefing.

• Staff members and supervisors will debrief together as a support mechanism and to identify successes, problems, or necessary modifications as soon after the episode as is practicable in light of facility operation.

• The patient does not need to be included in the debriefing, but the reason must be documented in the patient’s medical record. (i.e. Discharged from facility, does not have cognitive capacity)

• The debriefing is conducted utilizing the currently approved BHS Behavioral Restraint Debriefing Form, which will guide the content of that debriefing.

• The debriefing form is a part of the medical record and a copy will also be forwarded to the facility CNO.
# Debriefing – form

**BEHAVIORAL RESTRAINT STAFF DEBRIEFING**

<table>
<thead>
<tr>
<th>Date Restraint Initiated:</th>
<th>Time Initiated:</th>
<th>Time Removed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Debriefing:</td>
<td>Time of Debriefing:</td>
<td></td>
</tr>
</tbody>
</table>

**Staff present at restraint initiation**

<table>
<thead>
<tr>
<th>Print Name:</th>
<th>Title:</th>
<th>Emp #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Staff, Supervisors, or Others Participating in Debriefing**

<table>
<thead>
<tr>
<th>Print Name:</th>
<th>Title:</th>
<th>Emp #:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**What led to the incident?**

1. 
2. 
3. 
4. 
5. 

PATIENT NAME: __________________________ AGE: _______ DOB: _______

SEX: ___________________________ PATIENT LABEL: ___________________________

MEDICAL RECORD #: __________________________ ACCOUNT #: __________________________
Emergency Medical Condition

- If the patient experiences an emergency medical condition while in restraint or seclusion, the staff member providing continuous monitoring (or another individual) must release the patient of restraint or seclusion as soon as possible, as indicated by the emergency medical condition, and the medical condition assessed and treated.
Recognizing Signs of distress

- Difficulty breathing
- Increased heart rate or respiratory rate
- Increased agitation
- Undesired change in blood pressure
- Change in level of consciousness
- Impaired circulation / injury to extremity
Responding to emergency condition

- Call for help or activate RRT or Code Blue, depending upon the extent of the distress
- Remove restraints / release physical hold
- Evaluate need to institute CPR
- Ensure the patient’s airway is patent
- Evaluate need for supplemental oxygen
- Other interventions as needed
Reporting Death or Serious Injury

- Hospital Personnel will contact the facility house Officer whenever:
  - A serious injury occurs to a patient while in restraints / seclusion
  - A patient dies while in restraints / seclusion
  - A patient dies within 24 hours of the removal from restraint or seclusion
  - A patient dies within 1 week after restraint or seclusion where it is reasonable to assume that use of restrain or placement in seclusion contributed directly or indirectly to the patient’s death.
In the case of ....

- In case of **serious injury** the House Office will notify the CNO or designee and:
  - Complete an occurrence report
  - Notify risk management

- In case of **death** the House Office will notify the CNO or designee and:
  - Complete a Mortality Occurrence Report
  - Complete the CMS worksheet
  - Notify Risk Management
Appropriate application of restraints

- Mittens
- Wrist
- Posy
Mittens

• Hand covering gloves that are secured around the wrist or lower arm.

• May be used to allow full use of the arm or may be secured to the bed frame to be more restrictive.
Wrist / Ankle Restraints

• Should be loose enough to insert two fingers between the restraint and the patient’s extremity.

• Should be able to feel pulse upon check, to ensure that restraint is not too tight.

• Remember to remove every 2 hours for range of motion and a skin integrity check.
Vest Restraints

- Vests must fit properly to ensure they do not ride up on the patient’s neck, causing choking.
- Shoulder straps, which are included with the vest, must NEVER be used – choking deaths have occurred related to their use.
- Must be secured using a quick release knot.
Reminders...

• Never position a patient in restraints in the prone (face-down) position.

• If a patient has a high risk for aspiration, position on their side, rather than supine.

• Do not secure all restraint ties on one side of the bed.
Restraint free care!
That’s what everyone wants!