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Restraint Use

What staff need to KNOW for the safe use of restraints

Objective

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This training, in conjunction with annual hands on competency assessment, prepares the employee to safely implement the use of restraint only when the restraint becomes *absolutely necessary* to protect the *immediate* physical safety of the patient, staff or others.

What is a restraint?

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- Definition of a restraint includes:
  - 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.
  - A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and *is not a standard treatment or dosage for the patient's condition*.
- A restraint is used to protect the physical safety of the nonviolent or non-self-destructive patient, OR the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff or others when alternatives have failed.
- Restraints are never to be used as a form of coercion, discipline or retaliation.
- Restraints are never to be used for the convenience of staff.

Risks of Restraints

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- The use of restraints is highly controversial and presents an ethical dilemma between providing safe care with our values to provide humane and respectful care.
- The use of restraints has been linked to undesirable patient outcomes including post-traumatic stress disorder, delirium, higher rates of self-extubation, injury, prolonged length of stay and even death.

Restraint Alternatives

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- Due to the risk involved, every attempt to avoid use of restraint through trial of alternative measures is to be made.
- Identification of both staff and patient behaviors that trigger use of restraint is essential to help avoid use of restraint.
- Assessing the patient and attempting appropriate nonphysical and least restrictive interventions prior to application of restraints helps reduce risks.

To Avoid Restraint…

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Behavioral signals can provide awareness. Pay attention to cues that indicate distress or discontent.

- Significant changes in normal behavior or routines.
- Sudden changes in expression, physical activity, or posture.
- Dramatic increase or change in voice, volume, or tone.
- Expressions that communicate extreme anxiety or distress.
- Communications of despair and hopelessness.
- Body posture that is intimidating
- Verbal or physical threats.
- Looking for the cause and treating physical conditions such as delirium, hypoxia, lack of sleep, pain, and fever that may result in these behaviors may help avoid restraint use.

Staff Behavior Triggers

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- Moving quickly or abruptly toward a patient
- Using a punitive or threatening approach
- Shouting or using commands
- Touching a patient without warning or permission
- Failure to re-orient or explain interventions to patients
- Inadequate lighting
- Failure to respect privacy

Tips to Defuse Incidents

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Respect all individuals' personal space

- Space required to make us feel comfortable
- Increased anxiety when invaded
- Keep at arms length
- If contact needed, explain before doing
- If the person refuses:
  - Can it wait until they are calm?
  - Is someone else better suited to assist?
  - Is it a Medical necessity ?

Tips to Defuse Incidents

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Be aware of your own body position

- Avoid eye-eye, toe to toe
- Standing at an angle off to the side stance is less likely to invoke a challenging response

Be empathetic to others' feelings

- No judging
- Supportive presence conveys more than words

Keep nonverbal cues nonthreatening

- Non-verbal awareness increases with escalation of behavior and less tuned into words

Tips to Defuse Incidents

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- Set reasonable limits
  - Offer simple clear choice with consequences that are reasonable and enforceable
- Permit verbal venting when possible
  - Allows for outlet of energy
  - Peaks and valleys – Redirect during the “valley”
- Identify real reason for behavior
  - Often related to feelings of fear and helplessness
  - Listen for the *real* message
  - Restate the message to make sure you understand
- Stay composed – Don’t over react
- Physical techniques are a last resort.
  - Other possible alternatives are listed on the Vital Signs Flowsheet in the EMR.

Updating the Plan of Care

-if Restraint becomes necessary

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- Modify the patient's Plan of Care to include a time-specific goal for restraints removal.
- Document progress to goal of restraints removal *every shift* and modify the time-specificity as needed until restraints have been removed.

4 Types of Restraints

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- 1. <u>Physical Restraint:</u>
  Physical restraint is the bodily holding of a person with no more force than is necessary to limit the patient's movement.

- 2. <u>Mechanical Restraint:</u>
  Mechanical restraint occurs when a physical device or devices are used to restrain a person by restricting the movement of a patient or the movement or normal function of a portion of their body (ex: 4 point lock and key restraints).

- 3. <u>Chemical Restraint:</u>
  Chemical restraint occurs when a patient is given medication involuntarily for the purpose of restraining the patient.

- 4. <u>Seclusion:</u>
  The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.

What is Not a Restraint

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- Voluntary side rails (all 4 side rails up): A patient may request to have side rails for safety or a sense of security, the patient must be alert and oriented and this must be documented in the medical record.
- Side rails used to maintain a patient safely on a stretcher or on a bed during transport.
- Side rails and pads utilized for post-ictal patients.
- Side rails used while a patient is recovering from anesthesia.
- The use of IV arm boards.
- Geri-chair trays which can be easily removed by the patient, or being used for eating or activities.
- Protective equipment and adaptive support in response to assessed physical needs of the individual (for example, postural support, orthopedic appliances, and helmets).
- Therapeutic holding or comforting of children or adolescents, for pediatric behavior management methods.
- Forensic and correctional restrictions for security purposes.

Four Types of Orders

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restraints

Order	Co
Restraints	
Restraints, Continue (Continue Restraints) -	
Use only when patient is currently restrained and the order requires renewal.	
Restraints, Discontinue (Discontinue Restraints)	
Restraints, Notification & Approval, Post Non Violent (Post Non Violent Restraint Notification & Approval)	
Enter when restraints were applied and removed prior to an order being obtained.	

Orders Explained

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1. ***Restraints***: This order is for a new restraint application occurrence. This order needs to be placed for <u>every</u> new restraint use.
2. ***Restraints, Continue***: This order is for the patient who is already in restraints and needs the renewal order.
3. ***Restraints, Discontinue:*** This order is obtained when the restraints are removed.
4. ***Restraints, Notification & Approval, Post Non Violent***: Enter this order when the restraints were placed on patient and removed before receiving order.

What can I do before restraining ?
All Documentation should be on the Restraint Flowsheet .
This can be found on the Vital Signs Flowsheet.
These are interventions that should be attempted before resorting to restraint use.
Any and all of these (as appropriate based on assessment) should be attempted first.

atient Info | Documents | Flowsheets | Clinical Summary

COMPLETE PRIOR TO OBTAINING RESTRAINT ORDER

Restraint On

Reason for use

TIME COLUMN INDICATES WHEN RESTRAINT APPLIED

Restraint Off

Reason for removal

TIME COLUMN INDICATES WHEN RESTRAINT REMOVED

Safety Checks Non-Violent

Non-Violent/Non-Self-Destructive Patient: document every 1 hour

Safety Checks Violent

Violent/Self-Destructive Patient: document every 15 minutes

Patient/Family Education

Interventions attempted in the last 24 hour

Filter To:

- allow ventilation of feelings/ 1-1 session
- anticipate toileting and hydration needs
- bed alarm
- decrease environmental stimulus
- diversionary tactics
- diversionary techniques
- family presence and support
- medicate as appropriate
- modify environment (lighting,position, side rails, etc)
- optimize body position, balance alignment
- provide ambulation
- provide privacy
- relieve discomfort
- review medications/Pharmacist consult
- OT evaluation
- PT evaluation
- Pastoral Care referral
- Psych Nurse consult
- Social Work referral

OK | Cancel

Restraint Orders & Re-Order

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- *Orders must be placed on CPOE*
- *PRN ORDERS ARE NOT ACCEPTABLE*
- *Clinical justification for restraint must be documented by the MD*
- *If ALL restraints have been removed and reapplication is necessary, a new order is needed*

Restraint Order

Non-Violent and Non Self Destructive Patient

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- If the patient is attempting to interfere with treatment but has no significant change in condition, the nurse (RN, LPN, LNA) may proceed with applying restraints if other alternatives have failed and then notify the LIP/Provider and **obtain an order within 12 hours of restraint application.**

- Orders for the continued use of restraints must be obtained **every calendar day** that the patient remains in restraints.

For the Non-Violent and Non Self-Destructive Patient

(e.g. patient pulling at lines)

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- Used to protect the physical safety of the nonviolent or non-self-destructive patient when other alternative have failed.

- For example:
  - 89 year old, forgetful patient, Mr. Smith, has:
    - A tube feeding and Foley catheter, which he is frequently pulling at or attempting to remove
      - This is placing him at risk of physically harming himself.
        - » Therefore, this would be an indication for requesting a restraint for the ***non-violent patient***.

For the Non-Violent and Non Self-Destructive Patient (e.g. patient pulling at lines)

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- There must be **a new restraint order every calendar day** while the patient remains in restraints
- Safety observation and documentation is required **every 60 minutes** (licensed nursing personnel may perform – RN/LPN/LNA)
- RN assessment and documentation is required **every 2 hours** for:
  - continuation/discontinuation of restraint(s) or application of less restrictive devices based on patient's condition.

Restraint Orders

Violent and Self-Destructive Patient

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- In an emergent situation where patient is at imminent risk for harm, and all other interventions have failed:
  - nursing staff (RN, LPN, LNA) who have demonstrated competency may apply restraint device before obtaining order
- Face to face evaluation by the provider or a *trained* RN must take place **within the first hour** the patient is put into restraints **AND** then **every 8 hours** at a minimum thereafter for as long as patient is in restraints
  - a telephone order may be obtained by the RN between face to face evaluations

Restraints

For the Violent or Self-Destructive Patient

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- Behavior that jeopardizes the *immediate* physical safety of the patient, staff or others.
- Orders are for a **maximum of 4 hours** for patients 18 years and older.
- Orders are for a **maximum of 2 hours** for child and adolescents 9-17 years.
- Orders are for a **maximum of 1 hour** for children under age 9.

Restraints

For the Violent or Self-Destructive Patient

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- Provider orders are for a **maximum of 4 hours** for adult patients- must be **re-ordered every 4 hours**
- Safety observation and documentation is required **every 15 minutes** (licensed nursing personnel may perform – RN/LPN/LNA)
- RN assessment and documentation is required **every 2 hours** for:
  - continuation/discontinuation of restraint(s) or application of less restrictive devices based on patient's condition
- Patients in 4 point restraints must be on **Continuous 1:1 Observation**
  - these patients are at highest risk for injury in restraints

Applying 4 Point Restraints

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- *Call Code Grey* and "all clear" as appropriate (Dial 2111)
- Designate one staff member or leader to direct the procedure
- A staff member will be assigned the restraint of a specific limb
- Remove harmful objects from self
- Confirm patient identification by use of two identifiers.
- Apply restraints as directed by the leader per policy
  - a patients in 4 point restraints is on Constant 1:1 Observation

Removing 4 Point Restraints

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- Assess that clinical criteria for removal of restraints has been met.
- Release restraints as follows:
  1. one arm/leg and observe behavior for up to 15 minutes
     a) *two opposite limbs are kept restrained*
  2. then, if appropriate: release opposite arm/leg and observe behavior for up to 15 minutes
  3. then, if appropriate remove remaining 2 restraints
     a) *Never leave a patient in one restraint*
- *An RN will assess the appropriateness of the release of each restraint.*
- Document removal of restraints in the Restraints Management section of the Vital Signs Flowsheet in the EMR.

Removal of Restraints

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- Continued need for restraint should be assessed consistently.
- Restraints should be removed as soon as an alternative intervention is clinically appropriate or as soon as the behavior that warranted restraint use has ceased.
- For patients in any distress, restraints should be immediately removed and clinically appropriate care provided.

Monitoring of Patient in Restraints

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- Patients in restraint require close monitoring and assessment to ensure their safety and needs are met.
  - Monitoring includes and is not limited to: physical and psychological well being, mental status, respiratory and circulatory status, skin integrity, vital signs and clinical condition.
  - Needs include and are not limited to: food and hydration, elimination, comfort and positioning, hygiene, interaction, and clinical care.
- Provide first aid if needed based on assessment.
- Monitoring is documented in the Restraints Management section of the Vital Signs Flowsheet of the EMR.

Education

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- Education should always be provided to patients and families on use of restraints, alternative measures and monitoring while in use.
- Education is documented in the Restraints Management section of the Vital Signs Flowsheet in the EMR.

Record all nursing documentation

RESTRAINT MANAGEMENT SECTION
OF THE VITAL SIGNS FLOW SHEET

Date Range

From: 04-23-2013
Yesterday

To: 04-24-2013
Today

Filter
- [ ] Default to summary
- [ ] Show abnormal only
- [ ] Suppress blank rows and cols
- [ ] Show ml/Kg
- [x] Show cancelled columns

- [ ] Retain selections for next patient

Flowsheet Selection

- D100
  - Flowsheet
    - 01. Vital Signs Progressive...
    - 02. Intake & Output Flowsheet
    - Diabetes Flowsheet

	04-24-2013 12:53
Restraint Management	
Interventions attempted in the last 24 hours prior to restraints COMPLETE PRIOR TO OBTAINING RESTRAINT ORDER	allow ventilal decrease en
Restraint On Reason for use TIME COLUMN INDICATES WHEN RESTRAINT APPLIED	attempts to ii
Restraint Off Reason for removal TIME COLUMN INDICATES WHEN RESTRAINT REMOVED	
Safety Checks Non-Violent Non-Violent/Non-Self-Destructive Patient: document every 1 hour	completed
Safety Checks Violent Violent/Self-Destructive Patient: document every 15 minutes	
Patient/Family Education	Patient/Fami

Record Safety Checks, Education, and Nursing Assessment/Interventions

RESTRAINT MANAGEMENT SECTION OF THE VITAL SIGNS FLOW SHEET

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	12:53
TIME COLUMN INDICATES WHEN RESTRAINT REMOVED	
Safety Checks Non-Violent Non-Violent/Non-Self-Destructive Patient: document every 1 hour	completed
Safety Checks Violent Violent/Self-Destructive Patient: document every 15 minutes	
Patient/Family Education	Patient/Fami
Assessment/Intervention(RN doc at min every 2 hrs)	
Reason for continued need	attempts to ii
Type of Restraint	soft;
Circulation	warm/pink/c
Emotional Status	agitated
LOC	confused
Response	no changes
Interventions	fluids encour
CoSignature	

Death in Restraints

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Restraint related deaths are to be reported to the CMS Regional Office in Boston, MA no later than close of business the next business day under the following circumstances:

- *Death that occurs while a patient is in restraint*
- *Death that occurs within twenty-four hours after the patient is removed from restraint*
- *Death known to the hospital that occurs within one week after use of restraint where it is reasonable to assume that the use of restraint contributed to the patient's death.*

Actions for Death in Restraint

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- Notify Nursing Administration (Nursing Coordinator off shifts, weekends, and Holidays) of Reportable Death Occurrence.
- Complete and submit "HOSPITAL RESTRAINT/ SECLUSION DEATH REPORT WORKSHEET" to Nursing Administration.
- Nursing Administration will notify the CMS Regional Office.
- Document in the patient's Medical Record the date and time that the death was reported to CMS.
- Once worksheet faxed by Nursing Administration, it will then be placed in the patient record.

Policy

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- Please review and be familiar with CMC s policy on safe use of restraint which can be found in Policy Stat on the CMC Intranet.
  - Policy titled "*Restraint(s) Use Guidelines*"

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Thank you