**Policies & Procedures Behavioral Health**

**Glendive Medical Center**

**SUBJECT: RESTRAINT**

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**Written / Revised By: Trent Lear, LCSW, LAC, MAC Original Date: 09/10**

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**Approved By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recent Change Date: 04/11**

 **Parker Powell, CEO**

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**POLICY:**

Glendive Medical Center, Behavioral Health Services will promote the right of all patients to be free from restraint, limiting use of restraint and/or security room to clinically appropriate and justified situations. We will continuously review the use of restraints and reduce the risks associated with its use. Restraints will not be used as a means of coercion, discipline, convenience or retaliation by the staff, or in any manner that causes physical discomfort or injury to the patient. Less restrictive interventions will be considered prior to the use of a restraint, and restraint use will be time-limited and ended at the earliest possible time.

**PROCEDURE:**

Glendive Medical Center, Behavioral Health Services will follow all Glendive Medical Center policy and procedure for the use of seclusion; (Reference Glendive Medical Center policy and procedure SUBJECT: RESTRAINTS.), in addition to the following procedures:

1. Implementation of Restraints
	1. Once the decision to place the patient in four-six point restraints is made, nurse formulates a plan to implement restraints. The nurse gives specific instructions to treatment team members and informs the patient of the plan.
	2. Specific instructions include:
		1. The type of restraint is decided, with attending physician approval, using the least restrictive means possible.
		2. Restraints are administered in a designated security room.
		3. Searching the designated security room for removal of any harmful objects.
		4. Clearing area of other patients or potential obstacles before placing the patient in the security room.
		5. The nurse in charge will coordinate additional personnel to carry out the tasks as necessary. A "Code Tyson" may be called.
	3. The patient will relinquish all belts, sharps, and all potentially dangerous objects to the staff before the implementation of restraints. These objects may be removed by the staff, in the event of an uncooperative patient, with due regard to the patient's right to privacy. All patients in restraints will be placed in hospital scrubs clothing.
	4. When using locked restraints, secure the ends of restraints to the metal loops on the bed frame. Apply restraints firmly, but allow for limited movement of the legs and arms.
	5. The door to the security room will be locked for the duration of the restraint. An order for seclusion is obtained at the same time as the order for restraint. Only when one to one observation is ordered for the restrained patient is the door to the security room left open.
	6. In special situations (suicidal, self-injurious patient), nursing may judge it necessary to place the patient in restraints, without seclusion. In this case, one-to-one observation is maintained for the duration of the restraint without seclusion.
	7. Documentation of patient behaviors necessitating restraint and implementation of less restrictive interventions with patient response or lack of response to those interventions will be placed in the patient's computer record.
2. Care of the Patient in Restraints
	1. The nursing staff makes frequent contact with the patient in restraints, other than soft restraints, no less than every 15 minutes. Charting of patient behaviors and staff interventions will be done on the “Restraint/Seclusion Observation Record" or per Meditech automated forms. In the case of soft restraints, frequency of observation is determined per nursing judgment.
	2. When the patient is restrained on their back, they are under constant observation, as aspiration is a possible complication. Proper positioning of the patient is taught during annual training.
	3. The patient is checked every 15 minutes for circulation, skin integrity, and the need for fluids. Need for elimination is checked at least every two hours.
	4. The nursing staff frequently reassesses for termination of restraint, no less than every two hours. Documentation on the patient's clinical record describes the indications for initiation, continuance or termination of restraint in seclusion.
	5. The decision to continue restraints is never made for the convenience of the staff or because of inadequate staffing, or as a punitive measure. Every attempt is made to call in an additional staff as necessary to manage a higher level of Acuity.
3. Termination of Restraints
	1. Restraints may be terminated if:
		1. The patient can verbally contract to refrain from behavior necessitating the use of restraints, for example, hitting fists against door of seclusion room, and has demonstrated behavior consistent with verbal intent.
		2. The patient demonstrates a cessation of behavior necessitating restraints, despite an inability to verbalize. Examples include:
			* 1. Combative or intoxicated patient who falls asleep.
				2. An alert patient who becomes stuporous.
				3. An agitated patient who becomes calmed, but remains mute.
		3. Patients whose condition deteriorates rapidly need immediate release from restraints in order to provide management of the patient. Examples include:
			* 1. Patient becomes nauseated and complains of need to vomit.
				2. Demonstrated decreased circulation in a limb.
				3. Shortness of breath or chest pain where elevation of the upper body is necessary.
	2. Once the decision to terminate restraint is made, the nurse will formulate a plan to discontinue it. The nurse will give specific instructions to the treatment team members as well as inform the patient of the plan. specific instructions include:
		1. Removal of all restraints at once.
		2. Removal of one limb restraint at a time with appropriate treatment team supervision. At no time is a partially restrained patient left in the security room without one-to-one nursing observation. At no time is unused restraint left in the security room.
		3. Removal of restraints and continuance of seclusion.
4. Staff Education

A. All behavioral health staff will receive an annual review of the use of restraint/seclusion.