## Cabinet Peaks Medical Center

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| Originating Department: | Index: | |
| **Clinical Services** | CLIN-477 | |
| Affected Departments/Employees: | Original Effective Date: | Revised Date: |
| Acute Care, Emergency Services, Medical Staff | 07/17/08 | 10/09/18 |

**Restraint Management Protocol**

**Purpose:**

To ensure patient safety by defining the interdisciplinary team responsibilities and clinical management in the restraint of patients.

**Policy:**

Use of restraints must be implemented in accordance with safe and appropriate restraint techniques as determined by this policy and in accordance with state and federal law.

**Supportive Data:**

1. General Definitions:
   1. Patients have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the patient’s medical symptoms.
   2. All patients have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
   3. All patients have the right to be free from restraint or seclusion, of any form, imposed by staff as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
   4. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
   5. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
   6. The use of restraints or seclusion must be used in accordance with the order of a physician or other licensed independent practitioner (LIP) who is responsible for the care of the patient as specified under, and is authorized to order restraint or seclusion by hospital policy in accordance with state law.
   7. Medical staff and nursing leadership shall be involved in the development, review, approval and quality monitoring of protocols.
   8. This policy and procedure does not apply to forensic and correction restrictions used for security purposes. However, if the restraint or seclusion is related to the clinical care of an individual under forensic or correction restrictions, then the standards and this policy and procedure apply.
2. CMS Regulations:
   1. CMS restraint or seclusion regulations are not specific to treatment setting or diagnosis; the decision to use a restraint or seclusion is driven by a comprehensive individual patient assessment.
   2. CMS regulations apply to all uses of restraint and seclusion in all hospital care settings.
3. Categories of Restraint:
   1. There are two categories of restraints:
      1. Physical: Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient’s body that the individual cannot remove easily and that restricts freedom of movement or normal access to one’s body. In this context, easily remove means that the manual method, device, material or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff (i.e., bed rails are put down, not climbed over) considering the patient’s physical condition and ability to accomplish objective (i.e., transfer to a chair, get to the bathroom in time).
      2. Chemical: 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. “Standard treatment” includes:
         1. Medication that is used in accordance with FDA guidelines and manufacturer indications (including dosing parameters)
         2. Medication that is used in accordance with national practice standards
         3. Medication that is used based on the patient’s symptoms, overall condition and on the licensed independent practitioner’s knowledge of the expected patient responses
   2. Restraints do notinclude the following:
      1. Standard practices that include the limitation of patient mobility or temporary immobilization for medical, dental, diagnostic or surgical procedures and the related post-procedure care
      2. Methods to hold a patient during routine examination or procedure are not considered restraints as long as the patient’s right to refuse treatment is honored
      3. Orthopedically prescribed devices, dressings, or bandages
      4. Hand mitts unless they are pinned or otherwise attached to bedding using a wrist restraint in conjunction with the hand mitts; or if the mitts are applied so tightly that the patient's hands or fingers are immobilized; or if the mitts are so bulky that the patient's ability to use his/her hands is significantly reduced
      5. IV board to maintain IV access
      6. Therapeutic holding or comforting of children
      7. Mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility that would be possible without the use of such a device
      8. Methods used to permit the patient to participate in activities without the risk of harm
      9. Protective helmets
      10. The following devices used to prevent a patient from falling out of bed are not considered a restraint:
          1. If two to three (2-3) bed rails are raised and the patient is able to get out of bed
          2. If a patient is not physically able to get out of bed, regardless of whether the bed rails are raised or not, raising all four (4) bed rails
          3. If a patient is on seizure precautions, the use of four (4) padded bed rails
          4. The use of bed rails on a stretcher
          5. Age-appropriate cribs
          6. Exception: If a patient is physically able to get out of bed, and four (4) bed rails are raised to prevent the patient from getting out of bed, this is considered a restraint if the patient is not able to lower the bed rails without assistance.
   3. Seclusion: The involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

**Procedure:**

1. General Considerations:
   1. Any order for restraint shall be preceded by attempts and documentation that other, less restrictive measures have been found to be ineffective to protect the patient or others from harm.
   2. Restraint orders must be used in accordance with a written modification to the patient’s plan of care.
   3. Only those individuals that have completed the restraint management training may apply and provide care for patients requiring restraints.
   4. Appropriate staff must participate in the training offered and able to demonstrate competency in the physical application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint and seclusion:
      1. Before performing any actions in this policy
      2. As part of departmental orientation
      3. Subsequently on a periodic basis
   5. The attending provider must be consulted as soon as possible if the attending provider did not order the restraint.
   6. If a patient was recently released from restraint and exhibits behavior that can only be handled by the reapplication of restraint, a new order is required.
      1. Staff cannot discontinue an order and then re-start it under the same order
      2. Each episode of restraint use must be initiated in accordance with the order of a provider
      3. A temporary release that occurs for the purpose of caring for a patient’s needs (i.e., toileting, feeding, range of motion) is not considered a discontinuation of the intervention
2. Responsibilities of the Provider:
   1. When restraints are necessary, the provider is responsible for assessing the patient’s clinical condition and evaluating the factors that contribute to the behavior.
   2. Restraints require a provider’s order. The order must be written or entered into the Electronic Medical Record (EMR), or the verbal order signed within one (1) hour. Orders for restraint must specify:
      1. The reason (medical necessity and should indicate that restraint use is to improve the patient’s well-being) for the restraint
      2. The type of restraint
      3. The extremity or body part(s) to be restrained
      4. The duration (time frame) for restraint application and the date and time
      5. Any order for a restraint shall not be written as a PRN or standing order
   3. The use of restraints also requires the provider to document the following on the Provider Order/Progress Note:
      1. The behavior or reason for the use of restraints
      2. The intervention is clinically indicated
      3. Less restrictive alternatives were attempted and were not successful
   4. If a provider is not immediately available to give a restraint order, an RN may initiate restraint use based on patient assessment.
      1. The provider must give a verbal or written order immediately (within a few minutes) upon initiation of restraint.
      2. If the restraint order is given as a verbal order, the order must be written down by the RN and then read back to the provider giving the order.
      3. If the initiation of the restraint was due to a significant change in the patient’s condition the provider must be immediately notified by the RN.
   5. Non-violent/Non-self Destructive: Discontinue or renew the restraint order every 24 hours or sooner for the patient, after a clinical re-evaluation of the patient by a provider has been performed.
   6. Violent/Self Destructive: Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:
      1. Every 4 hours for adults 18 years of age older;
      2. Every 2 hours for children and adolescents 9 to 17 years of age; or
      3. Every 1 hour for children under 9 years of age; and
      4. After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other LIP who is responsible for the care of the patient must see and assess the patient.
   7. When restraint or seclusion is used, the patient must be seen (face-to-face) within one hour from the initiation of intervention by the provider. The evaluation and documentation must include:
      1. 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 to discontinue the restraint or seclusion
3. Responsibilities of Patient Care Services:
   1. The RN is responsible for:
      1. The patient assessment, the appropriate use of restraints, and determining the type of restraint
      2. Documenting the alternative measures that are less restrictive prior to initiating behavioral restraint and evaluation of the patient’s response
      3. The plan of care
   2. The RN may delegate the following to an appropriate staff member who has been specifically trained in the procedure(s):
      1. Obtaining the provider’s order
      2. The ongoing data collection and documentation
      3. Informing the patient and/or family the reason for the use of the specific restraint
      4. Including the patient and/or family in the plan of care
      5. Reassuring the patient and/or family that the restraint will be removed as soon as it is no longer necessary; encouraging them to express their concerns
   3. Notifying the provider and others as applicable, i.e. Charge Nurse, Patient Representative or Social Worker if the patient or family refuses to permit application of restraint (see CLIN-477-FB).
4. Procedure for Application (All Categories of Physical Restraints):
   1. Only trained personnel shall apply restraints
   2. Select the least restrictive restraint appropriate for the patient, keeping in mind the intent for its use. Ensure that it is the correct size and modified or padded as needed for patient comfort. Protective devices/restraints available at Cabinet Peaks Medical Center are as follows:
      1. Soft wrist/ankle
      2. Mittens
      3. Papoose board
      4. Halter-type (vest)
      5. Locking Restraints
   3. Important:Locking restraints may be used in the Emergency Department or Intensive Care Unit. Restraints with locking devices should not be used on the Acute Care Unit, but could be considered on a case by case basis.
   4. Position the patient to promote comfort, maintain proper body alignment, and prevent aspiration.
   5. Apply restraint while explaining the reason for application to patient and/or family members as feasible to decrease anxiety.
      1. Soft wrist/ankle: Do not interfere with flow of IV infusion or arterial line. Never use restraints proximal to an AV fistula or shunt.
      2. Halter type: Allow as much freedom of movement as possible while achieving the desired effect. Use pillows or rolled towels to assist in positioning to prevent pressure areas in immobile patients. Ensure application is comfortable and does not interfere with breathing.
   6. Secure restraint in such a manner that they are easily removed in the event of a fire or other emergency.
   7. Restraints designed for bed use should be secured to a movable portion of the bed frame. (e.g. the portion which elevates the head). NEVER secure the restraint to the mattress or fixed portion of the bed frame. Do not attach in the joints of the frame.
   8. Always use a quick hitch release when securing restraints.
5. Documentation of Initiation/Application:
   1. Reason for restraint
   2. Less restrictive alternative measures attempted
   3. Type of restraint applied
   4. Time and date restraint applied
   5. Physician order obtained
   6. Patient and/or family education
6. Procedures for Assessment, Intervention, and Documentation:

See the Restraint Assessment, Intervention, and Documentation attachment (CLIN-477-AA).

1. Reporting of Patient Deaths Associated with Restraint or Seclusion:

The hospital must report deaths associated with restraint or seclusion to its CMS Regional Office no later than the close of business the next business day following knowledge of the patient’s death.

1. Performance Improvement:

Cabinet Peaks Medical Center shall identify opportunities to reduce the risks associated with restraint use through preventive strategies, alternatives, and process improvement.

**Attachments:**

CLIN-477-AA Restraint Assessment, Interventions, and Documentation

**Forms:**

CLIN-477-FA Restraint Initiation Flow Sheet

CLIN-477-FB Refusal of Restraints Against Medical Advice

CLIN-477-FC Restraint Assessment Flow Sheet

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| **Rule/Cite/Tag:** | | | | | |
| CMS CAH Conditions of Participation (CoPs)§483.13 Tags C-0381 to C-0382  CMS Hospital Conditions of Participation (CoPs)§482.13 Tags A-0159 to A-0162, A-164 to A-0176, A-0178, A-0179, A-0184 to A-0188, A-0194, A-0196, A-0199, A-0200 to A-0202, A-0204 to A-208, A-0213, A-0214 | | | | | |
| **Medical Center Policy Cross Reference:** | | | | | |
| Nursing Flow Sheet (AC-100-FA) | | | | | |
| **List Historical Policy Version Dates:** | | | | | |
| Restraint Management (AC-10208.5) 05/21/14.  Restraint Management Protocol (AC-10208.6) 07/17/08, 10/15/09, 11/01/13. | | | | | |
| **Approved By:** | | | **Approval Date:** | | |
|  | ***See Hard Copy for Signature*** |  |  | 10/09/18 |  |
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