RESTRAINTS/SECLUSION: VIOLENT or SELF-DESTRUCTIVE BEHAVIOR

PURPOSE: To outline the management of patients in restraints/seclusion for violent or self-destructive behavior.

SUPPORTIVE DATA: Violent or self-destructive behavior is defined as a severely aggressive or self-destructive behavior that places the patient or others in immediate danger.

Restraints are any method of physical, mechanical or medication that immobilizes or reduces the ability of a patient to move his or her extremities, torso or head freely.
Restraints may lead to serious adverse physiological and psychological effects. Restraints are applied only after less restrictive measures have been considered/implemented and have been found ineffective to protect the patient or others from harm. Less restrictive measures include, but are not limited to: Close monitoring, PRN medication administration, de-escalation of aggression, and limit setting.

Restraints type definitions:

- Physical: The use of a manual hold to restrict freedom of movement or normal access to all or part of a person's body
- Mechanical: A mechanical device attached to the person's body that cannot be easily removed that restricts freedom of movement e.g., soft (limb holders/mittens), hard restraints, elbow immobilizers, and cloth vest restraints
- Seclusion: Involuntary confinement of a patient alone in a room or area in which the patient is physically prevented from leaving
- Medication: A drug or medication used as a restriction to manage the patient's behavior or to restrict a patient's freedom of movement and is not a standard treatment for a patient's medical or psychiatric condition

- Side Rails: Indication for provider order. Placing all four bed side rails in raised position that impedes an ambulatory patient from getting out of bed is considered a restraint and would require a provider order. No provider order is required to have all four side rails in the raised position when used for non-ambulatory patients for safety reasons such as being at risk of falling out of bed.

The assistance of the Behavioral Response Team (BRT) may be requested when other interventions have been determined to be ineffective.

When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff member or others, the patient must be seen face to face by the physician/Licensed Practitioner/(LP)/Licensed Resident Physician within one hour after the initiation of the intervention.

For the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) a directly-supervised temporary release of restraints or seclusion is not considered a discontinuation of the use of restraint or seclusion episode. As long as the patient remains under the direction of a licensed (RN) supervision, the restraint is not considered discontinued because the staff member is present and is serving the purpose as the restraint or seclusion.

Once the licensed (RN) determines that the patient meets release criteria, there is no medical need or reason to apply restraints or seclusion the restraints must be discontinued and the provider must be notified. In the event the patient requires restraints in the future the RN must obtain a new restraint or seclusion order and implement a new restraint plan of care.

PATIENTS RIGHTS:

1. Explain to the patient/family upon application of restraints/seclusion:
   - Reason for restraints/seclusion
   - Behavioral expectations/conditions for release

RESTRAINT APPLICATION:

2. Ensure the restraint order is completed and specifies:
   - Time limitation
     - 1 hour for ages under 9
     - 2 hours for ages 9 to 17
     - 4 hours for ages 18 and older
   - Type **and location** of restraint (e.g., 2 or 4-point hard)
   - Specific behavior necessitating restraints/seclusion

Note: Orders may be renewed according to the time limits for a maximum of 24 consecutive hours. After 24 hours, the provider must see and assess the patient before writing a new order.

3. Notify provider for need for new order for:
   - New/different presenting behavior
   - Expired order if the behavior(s) necessitating restraints persist
4. Apply restraints in an emergency (e.g., immediate risk of injury to self or others) under the direction of an RN – in the absence of a provider
   - A provider is notified and an order obtained as soon as possible, within 1 hour after initiation of restraints/seclusion
   - A verbal order is read back to the provider to confirm the order.
   - Upon entering verbal order, select all the following under "Communication type":
     - "Phone with read back"
     - "Verbal with read back"
     - "Cosign required"
     - The selections routes restraint order to the ordering provider.

5. Assess and document the following upon application of restraints or seclusion, a minimum of every 2 hours (Every hour under age of 9) or more frequently based on patient's condition:
   - Restraint initiation behavior reasons (i.e. behavior necessitating initiation of restraints or continuation of restraints)
   - Behavior description (description of behavior necessitating restraints)
   - Goal criteria for releasing restraints
   - Attempted alternative measures/Restraint discontinuation interventions
   - Response to alternative measures (upon initiation only)

6. Assess and document the following upon application of restraints and a minimum of every 2 hours (Every hour under age of 9) or more frequently based on patient's condition in addition to the items in #5
   - Neurovascular check
   - Restraint Mental status assessment (level of consciousness, orientation assessment, affect/behavior)
   - Restraint Respiratory assessment

7. Provide for and document the following upon application of restraints or seclusion and a minimum of every 2 hours (every hour under the age of 9) or more frequently based on the patient's condition:
   - Range of Motion
   - Nutrition/Hydration
   - Elimination
   - Hygiene
   - Patient position (repositioning)

8. Monitor and document the following upon initiation of restraints or seclusion, every

15 minutes thereafter or more frequently based on patient's condition:
- BH Patient activity (e.g. awake, eyes closed)
- Restraint site evaluation (restraint type, location, and signs of injury related to restraints)
- Respiratory rate

9. Obtain vital signs per Unit Structure Standards.
10. Provide continuous in-person observation or provide observation through the use of both video and audio equipment in close proximity to the patient.
11. Discontinue restraints/seclusion when reasons for restraints/seclusion are resolved at the earliest possible time regardless of the scheduled expiration of the order. A physician/LP order to discontinue restraints is not needed in this circumstance.

SAFETY:

12. Restrain a patient in supine position only.
13. Use a minimum of two restraints (e.g. both arms, one arm/one leg on opposite sides). Do not restraint legs only.
14. Ensure a restraint key is immediately accessible at all times.
15. Remove potentially dangerous items from patient/environment
16. Reposition one restraint at a time utilizing a minimum of two staff members.
17. Protect patient from extreme changes in ambient temperature or environmental conditions (e.g., overheated rooms).
18. Position patient for eating/drinking and assist as necessary.
19. Ensure each restraint is clean, in working order, and fits properly.

PATIENT/FAMILY TEACHING:

20. Instruct and document on the following:
    - Restraint policy
    - Reason for use of restraints (Behaviors/issues that necessitated restraints/seclusion)
    - Restraint release criteria (Conditions for release)
    - Plan of care
21. Instruct to notify nurse/staff regarding:
    - Pain/numbness
    - Thirst/hunger
    - Need for elimination
22. Include family (if available/appropriate), with patient's consent, in treatment plan.

REPORTABLE CONDITIONS:

23. Notify provider:
    - Upon initiation of restraints
    - When the decision is made by nursing to remove restraints
    - For significant change(s) in patient's mental or physical condition

ADDITIONAL STANDARDS:

24. Refer to the following as indicated:
    - Agitated Patient
    - Confused Patient
    - Immobility
    - Pressure Injury Prevention and Wound Management Nursing Policy
    - Suicidal Patient
    - Violent Patient

DOCUMENTATION:

25. Document in accordance with documentation standards
26. Document the following elements:
    - Initiation of individualized Risk Injury related to Restraints Interdisciplinary Plan of Care (IPOC)
    - Assessment, monitoring, learning assessment, and education via "Task list" in

electronic health record (EHR), or on appropriate flowsheet when EHR is not available.

Initial date approved:	Reviewed and approved by:	Revision Date:
07/23/01	Restraint Committee Professional Practice Committee Nurse Executive Council Attending Staff Association Executive Committee	07/05, 10/13, 06/17, 08/19, 11/22, 07/23

REFERENCE: Los Angeles General Medical Center Policy #903: Restraints/Seclusion

Component	Frequency	Responsibility	
		Licensed	Unlicensed
Restraint episode Activity Type	Every 2 hours	X	
Restraint Discontinuation Interventions		X	
Goal Criteria for Releasing Restraints		X	
Neurovascular Check		X	
Restraint Mental Status		X	
Restraint Respiratory Assessment		X	
• Activity • ROM • Positioning • Nutrition/Hydration • Elimination • Hygiene	Every 2 hours	X Licensed or unlicensed	
BH Restraint Activity	Violent/Self-Destructive: Every 15 minutes	X Licensed or Unlicensed	
Respiratory Rate		X Licensed or Unlicensed	
Restraint Site Evaluation		X Licensed or Unlicensed	
Learning Assessment	Once per shift	X	
Education Plan of Care	Once per shift	X	