RESTRAINTS: NON-VIOLENT or NON-SELF-DESTRUCTIVE BEHAVIOR-DRAFT

PURPOSE:

To outline the management of patients in restraints for non-violent or non-self-destructive behaviors.

SUPPORTIVE DATA:

Non-violent or Non-self-destructive behaviors may include any activity that may result in a serious or life-threatening event (e.g., dislodgement of a medically necessary device) and is due to the patient's lack of understanding of physical/cognitive limitations or detoxification.

Restraints are any method, 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, medication administration, and limit setting.

Types of restraints utilized are soft (limb holders/mittens), hard, elbow immobilizers, and cloth vest restraints. Soft limb holders are usually used, but hard restraints may be used for situations in which the limb holders are not sturdy enough to restrain the patient (e.g. the patient is very strong).

Medical immobilization during procedures (e.g., dental, medical, surgical, and diagnostic) that is considered a regular part of the procedure or treatment, does not require a physician order for restraints nor implementation of this protocol.

<u>Side Rails-Indication for provider order:</u>
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.

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.

PATIENT'S RIGHTS:

1. Explain to the patient/family upon application of restraints:
   - Reason for restraints
   - Conditions for release

RESTRAINT APPLICATION:

2. Ensure the restraint order is completed and specifies:
   - Time limitation (must be reordered by the end of the next calendar day)
   - Type and location of restraint (e.g., 2-point soft restraints)
   - Specific condition necessitating restraints

3. Notify provider of need for new order for:
   - New/different presenting condition
   - Expired order (if the condition necessitating restraints persists)

4. Apply restraints in an emergency (e.g., immediate risk of injuring oneself) under the direction of an RN – in the absence of a provider
   - A provider is notified, and an order is obtained as soon as possible, within 1 hour
   - A verbal order is read back to the provider to confirm the order
   - Upon entering verbal order, select under "Communication type" all the following:
     - "Phone with read back"
     - "Verbal with read back"
     - "Cosign required".
     - The selections routes restraint order to the ordering provider.

5. Assess/monitor and document the following upon application of restraints and a minimum of every 2 hours thereafter:
   - Restraint initiation behavior reasons (i.e. behavior necessitating initiation of restraints or continuation of restraints)
   - Restraint behavior description (description of behavior necessitating restraints)
   - Goal criteria for releasing restraints
   - Attempted alternative measure/ restraint discontinuation interventions
   - Response to alternatives (upon initiation only)
   - Restraint site evaluation (restraint type, location, and signs of injury related to restraints)

6. Assess and document the following upon application of restraints and a minimum of every 2 hours thereafter in addition to the items in #5
   - Neurovascular check
   - Restraint mental status assessment (level of consciousness, orientation assessment).
   - Restraint respiratory assessment

7. Provide for and document the following upon application of restraints and a minimum of every 2 hours thereafter:
   - Range of motion
   - Nutrition/hydration
   - Elimination
   - Hygiene
   - Patient position (repositioning)

8. Obtain vital signs (VS) per Unit Structure Standards.

9. Discontinue restraints when reasons for restraints are resolved regardless of the scheduled time limitation on physician order. A provider order to discontinue restraints is not needed in this circumstance.

SAFETY:

10. Restrain a patient in supine position only.
11. Use a minimum of two restraints (e.g. two arms, one arm/one leg on opposite sides). Exception: Just 1 restraint may be used in special circumstances, e.g. the patient has hemiparesis or has an amputated limb. Do not restrain legs only.

12. Ensure a restraint key is immediately accessible at all times (hard restraints).
13. Remove potentially dangerous items from patient/environment.
14. Position patient for eating/drinking and assist as necessary.
15. Ensure each restraint is clean, in working order, is secured, and fits properly.

PATIENT/CAREGIVER EDUCATION:

16. Assist in identifying behavior that necessitated restraints.
17. 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

18. Instruct to notify nurse/staff regarding:
    - Pain/numbness
    - Thirst/hunger
    - Need for elimination

REPORTABLE CONDITIONS:

19. Notify provider:
    - Upon initiation of restraints
    - When decision is made by the nurse to remove restraints
    - For significant change(s) in patient's condition

ADDITIONAL STANDARDS:

20. Refer to the following as indicated:
    - Artificial Airway - ICU
    - Confused Patient
    - Immobility
    - Intravenous Therapy
    - Pressure Injury Prevention and Wound Management Nursing Policy
    - Tracheostomy Tube – Acute Care Units

DOCUMENTA-TION:

21. Document in accordance with documentation standards.
22. Document the following elements:
    - Initiation of individualized Risk for 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 if EHR is not available.

Initial date approved:	Reviewed and approved by:	Revision Date:
03/01	Restraint Committee Professional Practice Committee Nurse Executive Council Attending Staff Association Executive Committee	03/14/05, 10/13, 04/16, 06/17, 08/19, 11/22, 07/23

REFERENCES:

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	Non-Violent/ Non-Self Destructive: Every 2 hours		X
Respiratory Rate			X
Restraint Site Evaluation		X Licensed or Unlicensed	
Learning Assessment	Once per shift	X	
Education Plan of Care	Once per shift	X	