CalvertHealth®

Restraint & Seclusion

Policy GA-066

Restraint & Seclusion

To delineate the proper use of Restraints and Seclusion and the care of the patient while in Restraints or Seclusion, please refer to Policy GA-066

CHS Is Committed To:

- Preventing, reducing, and striving to eliminate the use of restraints/seclusion
- Preserving the individual's safety and dignity when restraints are used
- Using alternative measures such as PREFERRED INTERVENTIONS
- Facilitating discontinuation of restraints as soon as possible
- Limiting use of restraint for emergencies when imminent risk of harm to self or others
- Patients, 12 years of age and under are NOT permitted in violent restraints.

Restraint & Seclusion

We do not use medications to restrain patients. A medication is considered a restraint if it meets one or more of the following criteria:

- Restricts patient's freedom of movement
- Is not a standard treatment for a patient's condition
- Is not a standard dosage for patients' condition

If the medications used are to treat a symptom that will improve the patient's ability to function and interact with the environment, it is not considered a restraint.

Patient Rights Regarding Restraints

Patient has the right to:

- Be free from restraints of any form that are not medically necessary or necessary to protect their safety and safety of others
- Treatment that least restricts their liberty
- Be educated regarding use of restraints
  - Reason initiated
  - Alternatives attempted
  - Behavior required for removal
- Temporary use of restraints when deemed necessary by LIP and other techniques have failed
- Fifteen minute 1:1 observation while in four-point restraints
- Not be restrained in prone position
- Not be restrained if under 13 years of age

Risks Associated with Restraint

The Joint Commission has reported sentinel events resulting in death or severe injury secondary to restraint use.

Other risks associated with restraint use include but are not limited to:

- Increased agitation
- New onset pressure injuries
- Pneumonia
- Nerve injury

Alternatives to Restraint

Nursing staff and medical providers should always attempt alternative interventions (and document those interventions) before deciding to place a patient in restraints. These include:

- Patient trying to pull out IV:
  - Cover IV with gauze
  - Place IV poles out of patient's view
- Patient trying to pull out indwelling urinary catheter:
  - Consider having the patient wear pajama bottoms or sweatpants
  - Consider discontinuing catheter and starting bladder training program
- Patient who is a fall risk:
  - Move close to nurses' station or hallway
  - Try distractions including coloring, folding clothes, music, watching TV, games, etc.
- Patients showing Agitation, Anger, & Aggression:
  - Focus your attention on the patient and let them know you are interested.
  - Project calmness: move and speak slowly, quietly encourage patient to talk and listen patiently.
  - Give patient choices and offer alternatives
  - Avoid confrontational poses (hands on hips, waving hands or pointing fingers)

Restraint & Seclusion

Restraints are:

- Geri chairs that restrict patient movements and cannot be easily removed
- Side rails used to prevent patient from exiting a bed
- Physical holding for forcing medications
- Physical escort to include light grasp that patient cannot escape
- Physical restraints including limb restraints, roll belt, padded and aqua mitts

Restraints approved for use at CHS are in order of least to most restrictive:

1. Padded Mitts
2. Aqua Hand Mitts
3. Soft Limb Restraints
4. Locked Limb Restraints
5. Seclusion (ONLY on Level 5)

Decision for Restraint/Seclusion

- Restraint and/or seclusion require a provider order and are a provider/nurse decision based on patient assessment to include:
  - Pain Management
  - Nutrition
  - Toileting Needs
  - Medications
- Patient assessment should take into consideration **Medical Conditions** that could be contributing to the behaviors being displayed.
- It is important to remember that restraining cognitively impaired individuals can worsen their behaviors.

Non-Violent Restraint

Non-Violent Restraints are used for non-violent or non-self-destructive patients who are interfering with the healing process or compromising life support.

These behaviors include:

- Confusion or disorientation with risk for injury
- Inability to follow directions regarding treatment or safety

Orders for Restraint:

- A restraint order will be obtained from a provider prior to initiation of restraints or in emergency situations, within minutes of restraint initiation.
  - Telephone orders must be countersigned within 24 hours of obtaining the order.
  - The order is never to be written as a standing order or on an "as needed" basis.
  - The order for restraints expires every 24 hours (24 hours from the time the restraint was first initiated).
  - The provider must do a reassessment of the patient, in person, to determine the need for restraints at least every 24 hours. Patient assessment by a provider identifies changes in the patient's behavior or condition which determines readiness for restraint release.

- There are **NO PRN RESTRAINT ORDERS**. Providers must evaluate via face-to-face assessment within 24 hours and every 24 hours thereafter.
- Orders must be renewed every 24 hours and a restraint note must be completed every 24 hours.
- A new order for restraint or seclusion must be obtained when either is discontinued prior to provider order expiration.

Violent Restraints/Seclusion:

Violent Restraints are used for patients demonstrating violent or destructive behaviors to self or others. These behaviors include severe agitation, combativeness, threatening staff/ patients/other and threatening self-abuse.

Seclusion only occurs in Behavioral Health setting.

Initiation of Violent Restraint/Seclusion:

- The Nurse may initiate restraint in an emergency situation based on clinical evaluation of the patient.
- Within minutes of the restraint application, the nurse will need to consult with the attending provider or his/her designee to obtain an order for the seclusion/restraint.
- A provider will do a face-to-face evaluation within one hour of the placement of restraints/seclusion to evaluate the patient's immediate situation, patient's reaction to the intervention, patient's medical and behavioral condition and need to continue or terminate the restraint or seclusion.
- Orders for violent restraint/seclusion and re-assessment of the need for violent restraint/seclusion are limited to the following durations:
  - If the patient is released prior to one hour of initiation of restraint, the face-to-face evaluation is still required.
  - When the original order for restraint/seclusion expires and the patient is not ready for release from restraint/seclusion, a new order from the attending provider or their designee is required.

Discontinuation Violent Restraint/Seclusion

Patients in restraints will be continually assessed for the readiness to discontinue restraints. The licensed nurse may discontinue use of restraints if the patient's behavior meets the release criteria prior to the expiration of the provider's order.

- If the patient falls asleep in seclusion, the door must be unlocked and opened within the nearest 15 minutes of monitoring.
- If the patient falls asleep in restraints, restraint(s) are removed.
- The Staff Debriefing form will be completed with all staff involved following the event.

Documentation and Re-assessment

- Use Restraint Flow Sheet when patient is placed in restraints
- If the patient is released within one hour of initiation of restraint, the face-to-face evaluation is still required
- Every 2 hours (or more frequently as necessary):
  - Reassess need for restraint
  - Document patient observations
- Assessment should include:
  - Skin integrity and circulation
  - Behavior exhibited
  - Hydration and nutritional needs
  - Hygiene and toileting needs
  - Range of motion
  - Patient dignity and rights maintained
- Update Patient care plan to reflect restraint use

Age	Duration	LIP Evaluation and face to face reassessment
18 and up	4 hours	8 hours
13 to 17	2 hours	4 hours
Children under 13 may not be placed in restraint		