

Restraints and Seclusion



Pro-Tem Personnel

Guidelines for Staff Competency

OBJECTIVES:

During orientation, Pro-Tem Personnel employees will receive education regarding JCAHO and HCFA recommendations for the use of restraints/seclusion and requisite knowledge to facilitate skillful application of restraining devices.

Upon completion the employee will be able to:

- ❖ Describe the policy goals regarding restraints/seclusion to meet JCAHO recommendations
- ❖ Describe clinical justification and situations for use of restraints/seclusion
- ❖ Recognize the recommendations for time limits on the order, physician notification, and face to face evaluation
- ❖ Explain a basic understanding of the underlying causes of harmful behaviors that may be exhibited
- ❖ Understand that behaviors are sometimes related to medical conditions
- ❖ Describe the use of alternative interventions
- ❖ Demonstrate the initiation, safe application and removal of restraints to include monitoring and reassessment
- ❖ Recognize the signs of physical distress in patients who are restrained or secluded
- ❖ Describe criteria for termination of restraints and or seclusion
- ❖ Describe documentation practices as recommended for the medical record
- ❖ Describe the RN's role in patient/family education

INTRODUCTION

As health care professions, we have increased our awareness and emphasis on patient rights, individual care and ethical considerations. To that end, additional regulation regarding restraint practices has followed, most notable from **Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)**. To meet these regulations, organizations are examining ways to reduce restraint usage. The goal is to reduce the use of restraints by utilizing the least restrictive measure and only as long as necessary by utilizing a planned approach that assesses the continued necessity for their use. Another organization that mandated the monitoring and control of restraint usage is the **Health Care Financing Administration (HCFA)**, which mandates the Medicare and Medicaid program rules. These rules include that the patient has the right to be free from all restraints that are not medically necessary and that restraints may not be used as a means of coercion, discipline, convenience or retaliation by staff.

DEFINITIONS:

Physical Restraints – any manual method or physical/mechanical device that restricts freedom of movement or normal access to one’s body, material, or equipment that the patient cannot easily remove. Identified types of physical Restraints include:

- ❖ Vest
- ❖ Soft Wrist/Ankle
- ❖ Geri Chair
- ❖ Roll belt
- ❖ Leather

Chemical Restraints – drug used as a restraint; a medicine used to control behavior or to restrict the patient’s freedom or movement and is not a standard treatment for the patient’s medical or psychiatric condition. Identified types of chemical restraints include:

- ❖ drugs that control mood
- ❖ sedatives
- ❖ tranquilizers

Positioning or Securing Devices – used to maintain the position and/or immobility of a patient during surgery; not considered restraints.

Restrictive Devices Applied by Law Enforcement Officials – handcuffs and other restrictive devices applied by law enforcement officials for custody, detention, and public safety reason and is not involved in the provision of health care; not considered restraints.

Seclusion - involuntary confinement of a person in a room or area where the person is physically prevented from leaving.

Licensed Independent Practitioner (LIP) – an individual recognized by the State and the facility as having the ability under his/her license to independently order medications or restraints and seclusion. This includes Medical Doctors, Osteopath, Podiatrist or Dentist that are privileged and credentialed as a member of the medical staff. ARNP, CRNA, PA’s do not meet this definition in the state of Florida.

POLICY GOALS:

1. **To prevent, reduce and eliminate** the use of restraints or seclusion- proactive approach to prevent emergencies that have the potential to lead to the use of such, limiting use and using least restrictive method
2. **Protect the patient** and preserve the patient's rights
3. **Provide for safe application** and removal by qualified staff
4. **Monitor and meet the patient's needs** while in restraints
5. **Reassess and encourage release** as soon as possible.

Assessment of Risk Factors, Interventions and Alternatives to Restraint and /or Seclusion use:

Factors to consider as part of the assessment include, but are not limited to:

- ❖ Disorientation to person, place or time
- ❖ Memory disturbances
- ❖ Fluctuating levels of awareness
- ❖ Alteration in sleep/wake cycle
- ❖ Perceptual disturbance

The following causative factors should also be considered as part of the assessment:

- ❖ Pain or other physical discomfort
- ❖ Types and /or combinations of medications
- ❖ Types and/or combinations of treatment modalities
- ❖ Physiologic changes contributing to altered behavior such as alteration in oxygen perfusion, blood glucose levels, blood chemistry

Clinical Justification For Use of Restraint and/or Seclusion (HFCA Guidelines)

- ❖ **Acute medical Surgical Care** – when restraint is applied to ensure that an IV line or tube etc, will not be removed by the patient who is temporarily or permanently mentally incapacitated to prevent injury
- ❖ **Behavioral Health Care** – when restraints or seclusion are used to manage behavior as an emergency when the patient displays destructive, aggressive behavior which places the patient or others in imminent danger

The application of restraints is not solely dependent on whether they are plied for Medical-Surgical Care or Behavioral Health –but that because of the inherent risks of restraints-- the strictest standards should be implemented as policy in the facility. Restraints will be used only in situations where the patient is demonstrating observable behaviors that indicate he/she is at risk of injuring himself/herself or others.

Situations would include:

- ❖ Harmful to self or others as evidenced by hitting, pulling hair, striking or biting or self-mutilation and appropriate alternative measures have been attempted.
- ❖ Threatens placement and/or patency of necessary therapeutic lines/tubes, interfacing with necessary medical treatment and appropriate alternative measures have been attempted.

- ❖ Unable to follow directions to avoid self-injury, (such as climbing out of bed or wandering) and appropriate protective alternative measures have been attempted.

PROCEDURE:

The physician's/LIP's order must specify

- ❖ Restraint type
- ❖ Justification
- ❖ Date and time ordered
- ❖ Duration
- ❖ **NO PROTOCOLS or PRN ORDERS ARE ACCEPTED**

An exception to obtaining a physician's order may occur if the physician is unavailable and the patient presents immediate danger to self and others and all other alternatives and less restrictive measures are determined to be ineffective. The trained RN may apply a restraint and notify the physician/LIP within 30 minutes to obtain the verbal order.

ALWAYS CHECK THE FACILITY POLICY FOR:

- ❖ specific time frames for physician notification and face to face assessments (**some facilities may use the ED physician for consults for face-to-face**)
- ❖ specific procedures for implementation and assessment from qualified staff (**in many facilities restraints must be obtained from the supervisor-they are not readily available on the units**)
- ❖ documentation of restraints (**most facilities will have specific restraint flow sheets and quality improvement forms**)

The Strictest Interpretation of the Guidelines include:

1. The physician must be notified within a certain time frame- i.e. **30 minutes**
2. The physician must make a face to face assessment of the patient **within one hour**
3. The treating physician must be consulted as soon as possible
4. Orders are limited to
 - ❖ 4 hours for adults up to maximum of 24 hours
 - ❖ Two hours for patient age 9 –17
 - ❖ One hour for patient's under age 9

Seclusion and Restraint may not be used simultaneously unless:

- ❖ The patient is continually monitored face-to-face by an assigned staff member
- ❖ Staff uses both video and audio equipment continually to monitor the patient and the monitoring is in close proximity to the patient

When the order for restraints/seclusion expires, a qualified trained individual in the organization who has been authorized for this function will conduct a face-to-face assessment to make the decision for release. If the patient is not ready for release, the staff member will re-evaluate the plan and notify the physician/LIP to obtain a verbal order. Renewal may be done by phone not to exceed a total of 8 hours for ages 18 and older and 4 hours for ages 17 and younger.

Monitoring, Assessing and Care of the Patient in Restraints/Seclusion:

- ❖ Increased need for monitoring and assessment to assure safety, that less restrictive methods are used when possible, and that use is discontinued ASAP
- ❖ Assess immediately after application to ensure properly and safely applied as to not cause harm
- ❖ Patient needs should be continuously monitored by an assigned staff member and assessed by a registered nurse at least **every 15 minutes** to include:
 - Signs of injury
 - Nutrition/hydration
 - Circulation and range of motion
 - Hygiene and elimination
 - Vital Signs
 - Physical and psychological status and comfort
 - Readiness for release

Discontinuing Restraint and/or Seclusion Prior to the Expiration of the Order

Any patient who is requiring restraint and/or seclusion should be continuously monitored and evaluated for appropriateness of early release (Facility will state in policy) A Registered Nurse with established competencies must assess.

Improvements are based upon:

- ❖ Improvements mental status
- ❖ Patient's agreement and compliance with instructions
- ❖ Improved ability to transfer or ambulate without risk of injury
- ❖ Less restrictive measures are effective
- ❖ Patient's lines are discontinued or no longer required

DOCUMENTATION:

Each Facility will have it's own documentation forms.

Documentation should include:

- ❖ Circumstances leading to use
- ❖ Consideration or failure of less restrictive measures
- ❖ Rationale for type utilized
- ❖ Notification of patient's family/significant other when appropriate
- ❖ Written orders for use
- ❖ Behavior criteria for release of restraint or seclusion
- ❖ Each verbal order received from a physician/LIP
- ❖ Monitoring and assessments
- ❖ Any injuries sustained and treatment of such
- ❖ Any deaths

PERFORMANCE IMPROVEMENT:

The goal of performance improvement process is to identify and understand the root cause for the use of restraints.

All facilities will incorporate restraint/seclusion use as a performance improvement activity to identify needs and opportunities related to:

- ❖ Less restrictive devices
- ❖ Staff education and training
- ❖ Reduction in the number of episodes
- ❖ Reduction in the amount of time for each episode

See Sample form attached.

PATIENT FAMILY EDUCATION:

Restraint procedures should be performed in a manner that does not violate the patient's rights. Where appropriate, the patient/and or family should assist in the identification of techniques that may help the patient control his/her behavior.

Before applying restraints the RN will provide the family with an explanation of restraint utilization and the reason for restraints. Unsuccessful interventions should also be discussed.

See attached example of family literature

Sample Letter to Families
PATIENT AND FAMILY EDUCATION FOR RESTRAINTS

On occasion, some of our patients may experience a temporary episode of confusion which may lead to agitation and/or self-destructive behavior. Conditions that may contribute to confusion are:

1. Medication side effects
2. Hearing loss
3. Vision loss
4. Oxygen deprivation
5. Fluid imbalance
6. Change in surroundings
7. Infections
8. Decrease of blood flow to brain/arteriosclerosis
9. Psychiatric illness such as schizophrenia
10. Personal losses/grief reactions
11. Withdrawal from medications

During these temporary episodes the Physician and Nurses may identify the need for safety devices or utilize seclusion to safely care for you or your family member. These devices may be in the form of safety vests, belts, or wristlets. While safety devices are in place you or your family member will be observed frequently by nursing personnel to assist you/family member with your/their care. You/your family member will be offered food, fluids, toileting while restrained and anything else you/your family member may need.

As you/their condition improves, you/your family member will be assessed for the continued need for a safety device. Your safety and emotional needs are always a primary concern for us while you are with us at Aventura Hospital and Medical Center.

ALTERNATIVES NURSES SHOULD TRY BEFORE THEY RESTRAIN

1. Identify physiological changes causing behavior changes.
2. Consult with the patient's family on methods of calming the patient.
3. Work with doctor to remove tubes, lines, dressings, etc., as soon as medically possible.
4. Cover IV sites with surginet, stockinet, or kerlix for protection.
5. Cover PEG tube with abdominal binder.
6. Bed alert.
7. Offer toileting frequently when restless and assure the bowel program has been effective.
8. Talk soothingly.
9. Try bath, shower, ambulation, rocking chair, and/or wheelchair ride in the hall.
10. Camera monitor.
11. Consider a family member or sitter at bedside.
12. Modify the patient's environment to minimize clutter.
13. Reduce stimuli by dimming lights, cutting down on noise, and visitors.
14. Provide distractions, soothing music, relaxation videos, TV, magazines, books, or soft object to handle.
15. Pain relief, comfort measures.
16. Massage.
17. Active listening, attention to feelings and concerns.
18. Pastoral counseling.
19. Exercise, PT/TO.
20. Social activity.
21. Outlets for anxious behavior, especially structured activity.

Restraints can also cause serious harm if they are over used or used carelessly.

Research on restraints has demonstrated that very serious consequences can result from their use. These include physical and psychological harm such as: loss of dignity, violation of individual rights, and even death. In 1992, the Food and Drug Administration (FDA) issued a safety alert to all hospitals documenting over 100 deaths associated with the use of physical restraints.

Injuries

Improperly restrained patients can:

- Get tangled in straps and choke.
- Struggle to get free and have broken bones, cuts, concussions or other injuries as a result.

Medical Complications

- Keeping the body or limbs in the same position can cause:
- Poor circulation
- Incontinence
- Constipation
- Weak muscles and bones
- Pressure sores

Mental and Emotional Problems

Restrained or secluded patients often feel humiliated or imprisoned. They may become:

- Depressed
- More agitated
- Uninterested in eating
- Unable to sleep
- Unwilling to socialize

Assessing the patient is the first step in using restraints and seclusion properly. The staff's goal should be to find the safest, least restrictive way to care for the patient.