

**Rhode Island Hospital
Standard Practice
Instruction Manual**

Subject:
Patient Restraint Policy

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Approved by:
Nursing Executive Committee;
Safety Committee; Structure
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Committee; Quality Monitoring
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I. PURPOSE:

The patient has the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff. Restraint is a potentially harmful procedure that is intended to be used only when less restrictive/intrusive measures have not succeeded or clearly are not likely to succeed in preventing injury to patients or others. Any application of restraint must involve consideration of the degree and likelihood of the harm that may be prevented by the restraint compared to the degree and likelihood of the harm produced by the restraint. A mechanism is provided for evaluation of restraint use to assure that the staff exhausts less restrictive measures, and uses staff, environmental interventions and structured activities appropriately, while demonstrating safe methods of application, assessment, monitoring, evaluation and reassessment of all restrained patients.

II. POLICY:

Rhode Island Hospital utilizes physical restraints, for adult and pediatric patients, for therapeutic reasons in two situations: use in medical and post-surgical care and emergency use in behavioral health care situations. The decision to use restraints is based on a comprehensive individual assessment of each patient at a specific time, and after less intrusive measures have failed. Restraints or seclusion should only be initiated after the assessment of the patient indicates that the risks associated with the use of restraints are outweighed by the risk of not using restraints. Restraint or seclusion should only be

considered a temporary means of intervention when the patient is in immediate danger of harming self or others.

GENERAL DEFINITIONS:

1. **Restraint:** any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. It is important to note that these requirements are not specific to any treatment setting, but to the situation the restraint or seclusion is being used to address. The reason for use, not the device, determines whether or not a device is considered a restraint. Therefore the policy does not apply to the following:

Exemptions: The following situations are not considered restraint under this policy.

- Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic or surgical procedures and the related post-procedure care processes (for example, surgical positioning, intravenous arm boards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients)
 - Adaptive support in response to assessed patient need (for example, postural support, orthopedic appliances, tabletop chairs)
 - Protective Helmets
 - Forensic and correction restrictions used for security
2. **Behavioral Health Restraint:** These standards apply to the use of restraint and/or seclusion for the patient with a primary or secondary psychiatric or behavioral disorder who is overtly aggressive and/or violent. The patient presents an immediate threat to the safety of him/herself and/or others.
 3. **Medical Restraint:** These standards apply to the use of restraint for a medical/post-surgical (non-psychiatric) patient who act out, either consciously or unconsciously, to interrupt critical therapeutic interventions or treatment, or may pose a safety risk to him/herself. This patient is not exhibiting violent and/or aggressive behavior.
 4. **Seclusion Room: (Adult Inpatient Psychiatric Units, and Hasbro Partial Hospital Program)** involuntarily confining an individual in the seclusion room where he/she is physically prevented from leaving. Locked seclusion is different from timeout, which means the restriction of a patient for any period of time to a designated area from which the patient is NOT physically prevented from leaving and for the sole purpose of reducing stimulus, providing the patient an opportunity to regain self-control. Patients in the seclusion room are always placed on Constant Observation. May only be used for violent or self-destructive behavior.

5. Chemical Restraint: medication used in addition to or in replacement of the patient's regular drug regimen to control extremely agitated and disruptive behavior during an emergency. Excluded from this definition are patients in detoxification or psychiatric treatment programs receiving PRN medications that are standard for the patient's medical condition and used to manage behavioral outbursts. Also excluded are intubated patients who are sedated as part of their treatment plan.
6. Safety Coat: (Adult Inpatient Psychiatric Units) involuntarily confining an individual in a full body restraint that restricts freedom of movement or normal access to one's body. This is a high-risk restraint and is only be used when other methods of managing the patient's behavior have been exhausted and proven unsuccessful (limit setting, behavioral contracts, room restriction, medications, seclusion room). Patients in the safety coat are always placed on Constant Observation.
7. Debriefing: A required therapeutic intervention after each behavioral restraint to provide staff and patients an opportunity to clarify the rationale for the decision to initiate restraint/seclusion, offer mutual feedback and promote more adaptive functioning. It includes the patient and, if appropriate, the patient's family, and staff involved in the restraint.
8. LIP: Licensed Independent Practitioner (LIP) is a physician or his or her designee, nurse practitioner, or physician's assistant who is clinically qualified and licensed in the State of Rhode Island to order restraint and conduct the required face-to-face assessment.

GENERAL PROVISIONS:

1. Alternatives to restraints: will be attempted and evaluated prior to implementing restraint or seclusion unless the circumstances are severe and warrant immediate intervention to protect the patient, staff or others. Refer to Appendix A for examples of alternatives. See Appendix A.
2. Least Restrictive Means:
 - a. Restraint shall not be used when less restrictive interventions would be effective.
 - b. When restraint is indicated, the least restrictive methods of restraint shall be chosen.
3. Indications: Restraint shall only be used for the protection of the patient, staff members, or others. Such indications shall be present and documented at the initiation of and throughout the episode.
4. Orders:
 - a. Restraint shall only be ordered by a LIP member of the medical staff. Certain situations may warrant initiation of restraint prior to obtaining an order.

- b. PRN restraint orders shall not be accepted and the ordering practitioner shall be contacted to clarify or discontinue the order.
 - c. The order shall specify the method of restraint and/or seclusion to be used. (Indications for the restraint may be documented in nursing or provider notes).
5. Early Release: Restraint shall be discontinued when the behavior or condition, which was the basis for the restraint order, is resolved, regardless of the duration of the enabling order.
6. Patient and Family Involvement: Efforts shall be made to discuss the issue of restraint, when practical, with the patient and the family around the time of use.
7. Locked Leather Restraints: Patients, who are in locked leather restraints and are transported from the Emergency Department, must be accompanied by Security Personnel who are in possession of the key to unlock the restraints. If the patient is to be admitted to a patient care unit, the security guard will assist in replacing the Emergency Department restraints with belted non-lock leather restraints on the unit. If a patient continues to require locked leather restraints, Security Personnel will remain with the patient at all times, until the patient's condition no longer requires locked restraints.
8. Report to Risk Management (ext. 4-8265) for follow-up any death or serious injury associated with the use of restraint or seclusion. This includes:
 - While the patient is in restraint or in seclusion
 - Within 24 hours after the patient has been removed from restraint or seclusion
 - Within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death

STANDARDS BY CATEGORY:

Medical Restraint

1. Indications:

Medical Restraint may be used for the following indications when less restrictive means would not be effective in protecting the patient:

 - a. The patient is pulling at tubes, lines, or dressings.
 - b. The confused patient is interfering with the provision of care.
 - c. The patient's actions are endangering themselves: for example, if the patient is thrashing around in bed or attempting to get out of bed in a way or under conditions where it might cause harm (including when such behavior is related to acute withdrawal syndrome).
2. Licensed Independent Practitioner Order:

- a. If the LIP is not available, a registered nurse may initiate restraint in advance of a LIP order
 1. If restraint was necessary due to a significant change in the patient's condition, the LIP shall be contacted immediately for an order.
 2. Otherwise, the LIP must be notified and a restraint order obtained within 12 hours of its initiation.
 - b. The LIP shall perform a face-to-face assessment of the patient within 24 hours of the initiation of the restraint, at which time he or she shall either discontinue or write an order for continuation of the restraint.
 - c. The LIP shall perform an in-person assessment of the restrained patient, no less often than once each calendar day, at which time restraint shall either be reordered or discontinued, as indicated. The LIP will document the evaluation of the patient's condition related to the restraint episode.
3. Patient Monitoring: The RN is responsible for the assessment of patient. The RN or a trained staff member can monitor the patient. At the initiation of the medical restraint the patient will be monitored no less than every two hours, and documented in the medical record.
- a. Type and location of the restraining device(s) shall be assessed and documented. Patients will be assessed while in restraints at least every 2 hours or more frequently as required by the patient's condition.
 - b. Rationale for restraint (observed condition or behavior) shall be assessed and documented at least every 2 hours.
 - c. Alternatives to less restrictive forms of restraint considered by the caregiver shall be documented at least every 2 hours.
 - d. Monitoring shall include range of motion; circulation, sensation, and movement; and toileting assistance at least every 2 hours, according to patient need.
4. Assessment for Discontinuance:
The time-limited order does not require applying the intervention for the entire period. The need for restraint should be frequently evaluated and ended at the earliest possible time based on the assessment and re-evaluation of the patient's condition as documented on the flow sheet. Time of discontinuance shall be written in the medical record. Examples of criteria for discontinuance would include documentation of the absence of behaviors/conditions that necessitated the restraint. A new restraint order must be obtained for any future episodes of restraint.

BEHAVIORAL HEALTH RESTRAINT AND SECLUSION

1. Requirements for All Settings
 - a. Initiation of Restraint: A registered nurse may initiate restraint or seclusion in advance of the LIP order;

1. As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, the registered nurse shall consult with the physician who is primarily responsible for the ongoing care of the patient, or, his or her LIP designee, about the patient's physical and psychological status and obtain an order (verbal or written).
2. The initial and all subsequent restraint orders shall expire in:
 - 1 hour or less for patients 8 years of age or younger,
 - 2 hours for patients from 9 to 17 years, and
 - 4 hours for patients 18 years of age and older.
- b. One-Hour Face-to-Face Assessment: the LIP performs a face-to-face assessment of the patient's physical and psychological status within 1 hour of the initiation of the restraint. The LIP will document the evaluation of the patient's condition related to the restraint episode.
- c. Ongoing Face-to-Face Assessment: a LIP shall conduct an in-person re-evaluation at least every:
 1. 8 hours for patients 18 years or older and
 2. 4 hours for patients 17 years of age or younger
- d. Continuous, In-Person Observation
 1. Monitoring of patients in restraints or seclusion is done through continuous in-person observation by a staff member.
 - Exception: After the first hour, a patient in seclusion without restraint may be continuously monitored using simultaneous video and audio equipment, if available, and if consistent with the patient's condition and wishes.
 2. If the patient is in a physical hold, a second staff person shall be assigned to observe the patient.
 3. A patient in seclusion is immediately placed on constant observation. Should the patient require a safety coat, the safety coat is applied in the seclusion room and the patient is immediately placed on constant observation with the seclusion room door open. A restraint and seclusion may not be used simultaneously.
- e. Assessment:
 1. Patients, at the initiation of restraint or seclusion, and no less than every hour thereafter, will be monitored for response to restraint, mental status, and physiological response, as warranted by the patient's immediate condition. This will be documented in the medical record.
 - Physical and psychological status and comfort
 - Response to restraint

- Signs of any injury associated with applying restraint or seclusion
 - Skin integrity, CSM, ROM, and level of consciousness
 - Readiness for discontinuation of restraint or seclusion release
2. Patient monitoring shall be done no less that every 15 minutes and should include the following, unless it is inappropriate for the type of restraint or seclusion employed. This will be documented in the medical record. The RN is responsible for the assessment of patient in restraints. The RN or a trained staff member can monitor the patient.
 - Nutrition and hydration
 - Vital signs
 - Hygiene and elimination
 - Comfort
 3. At the initiation of the restraint or seclusion episode, the patient is made aware of the behavior that must be demonstrated in order for the restraint or seclusion episode to be discontinued. The criteria for removal of the patient from a restraint or seclusion episode is individualized and directly associated with the maladaptive behavior that necessitated the higher level of the patient's restriction. Upon placement of the patient in restraint or seclusion, the staff member leading the restraint or seclusion will inform the patient of the behavior that will relieve the restraint or end the seclusion episode and the time frame within which this will be evaluated. Restraint or seclusion is discontinued as soon as the patient meets their behavior criteria. The time of discontinuance is documented in the medical record.
- f. Leadership Notification of Continued or Repeated Restraint: the nurse manager and/or designee shall immediately be notified of any instance in which a patient
 1. Remains in restraint or seclusion for more than 12 hours or
 2. Experiences two or more separate episodes of restraint and/or seclusions of any duration within 12 hoursThereafter, the nurse manger shall be notified every 24 hours if either of the above conditions continues.
 - g. Debriefing: as soon as possible, but no longer than 24 hours, after the conclusion of each restraint episode, the patient and, if appropriate, the patient's family, participate with staff members who were involved in the episode in a debriefing. Staff shall use the currently approved debriefing form(s), which shall guide the content of that debriefing.

MONITORING:

Patients in restraints must be monitored for the following parameters.

<u>Monitoring and Intervention Requirements:</u>	<u>Leather Restraints</u>	<u>Medical Restraints</u>	<u>Vest</u>	<u>4 Bed Side rails</u>	<u>Locked Seclusion</u> <i>Inpatient Psych Units/Hasbro Partial Only</i>	<u>Safety Coat</u> <i>Inpatient Psych Units/Hasbro Partial Only</i>	<u>Chemical Restraint</u>
Constant Observation	• CO				•CO	•CO	
Restraint released and then reapplied (q 4 hours when asleep)	•q1h	•q2h					
Circulation, Sensory, Motor check	•q1h	•q2h				• q1h	
Offered food/water/toilet (while awake).	•q1h	•q2h	•q2h	•q2h	• q1h	• q1h	
Behavior/pt. response to restraint	•q1h	•q2h	•q2h	•q2h	• q1h	• q1h	• q1h
Position (while awake)	•q1h	•q2h	•q2h		•q1h	• q1h	

TRAINING OF STAFF

Hospital and medical staff members shall receive training in the following subjects, as it relates to duties performed under this policy. Such training shall take place during departmental or medical staff orientation (before the trainee is asked to implement the provisions of this policy) and shall be repeated periodically as indicated in the hospital’s training plan, which is based on the results of quality monitoring activities. Individuals trained shall exhibit their knowledge of the subject matter through the consistent implementation of the matters taught. The training programs may also include return demonstration of post-training tests at the discretion of the trainer.

1. Licensed Independent Practitioners who order restraint or seclusion shall be trained in the requirements of this policy and shall demonstrate a working knowledge of this policy through ongoing compliance.
2. Hospital staff members who assess patients for restraint or who apply restraint shall receive training in the following:
 - a) Techniques to identify staff and patient behaviors, conditions, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. (I.e. excessive environmental stimuli, alcohol withdrawal, psychiatric emergencies, unfamiliar surroundings, medication, etc.).
 - b) The use of non-physical intervention skills. (I.e. reassurance, active listening, explanation of care, frequent or constant observation).

- c) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition after other alternatives have been unsuccessful.
- d) The safe application and use of restraints, including training in how to recognize and respond to signs of physical and psychological distress (I.e. skin, circulatory or respiratory compromise). Personnel authorized to initiate seclusion and /or safety coat will receive unit level education regarding their safe application and use.
- e) Clinical identification of specific behavioral changes that indicate the restraint or seclusion is no longer necessary.
- f) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy.
- g) Certification in cardiopulmonary resuscitation.
- h) The underlying causes of threatening behaviors exhibited by the patients. For example, a patient may exhibit an aggressive behavior that is related to a patient's medical condition and not related to his or her emotional condition (I.e. threatening behavior that may result from delirium in fevers or other medical conditions).
- i) How staff behaviors can affect the behaviors of the patients. (I.e. the value of gaining control over the situation, approaching the patient calmly, confidently, and in a firm manner etc.)
- j) De-escalation, medication, self-protection, and other techniques, such as timeout for personnel in high risk areas. See Appendix B.
- k) Recognize how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a patient reacts to physical contact. Utilize behavior criteria for discontinuing restraint or seclusion and help patients in meet these criteria.

Appendix A Alternatives to Restraint

Alternatives to restraints can include:

- 1) Frequent observation
- 2) Placing a patient in an observable room/area
- 3) Encouraging family to monitor patient and maintain safety
- 4) Diversion
- 5) Use of bed alarms
- 6) Modifying the environment
- 7) Toileting the patient on a regular basis
- 8) When possible, engaging the patient in activities.

When a patient **pulls tubes/dressing/devices**, alternatives include:

- 1) Changing continuous to bolus feedings
- 2) Covering abdominal tubes with binders or extra dressing
- 3) Considering the removal of the device
- 4) Placing the device out of patient's vision and/or reach, if possible
- 5) Teaching the patient to become more comfortable by guiding them through touching the device, etc.

When a patient is **agitated**, alternatives include:

- 1) Reducing stimulation
- 2) Diversion
- 3) Redirection
- 4) Increasing frequency of observation
- 5) Use of medications; etc.
- 6) Therapeutic dialogue to see what is agitating the patient

When a patient is **confused and escalates easily**, alternatives include:

- 1) Ignoring negative behavior
- 2) Reinforcing positive behavior
- 3) Directing activity to promote comfort (e.g. music, reading, spending more time with the patient, etc)

When a patient **wanders**, alternatives include:

- 1) Frequent observation
- 2) Surveillance by family
- 3) Providing diversion
- 4) Redirection

When a **child or adult patient with delayed development** is out of control, alternatives include:

- 1) Constant supervision
- 2) Instructing family/qualified adult on monitoring the patient
- 3) Providing diversion

Appendix B

De-escalation techniques

De-escalation techniques center around one on one communication with the patient. Allowing your patient to verbalize their feelings and the use of active listening may diffuse an aggressive patient. Other techniques useful in managing aggressive behavior include calling a “time out” and offering relaxation, exercise, and other diversionary activities. Other strategies include:

- Listening to your patient
- Distraction
- Focusing your patient on something positive
- Changing the subject
- Giving your patient choices
- Offering your patient alternatives
- Setting limits on your patient’s behavior

Verbal phrases that are useful in the de-escalation process and often help your patient feel they are being truly heard include:

- “Tell me what the biggest problem is right now.”
- “I really want to help.”
- “I am listening.”