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Prevention of significant damage to the environment

**Restraints** are not used for:

Staff convenience

- Fall Prevention

Discipline of the patient

Patients whose clinical condition contraindicates the use of **restraints**

The use of **restraints** falls into two categories, behavioral or medical surgical. **Restraints** usage is classified as behavioral when the **restraints** are used to protect against injury to self or others because of an emotional or behavioral disorder. These standards apply anywhere in the facility. **Restraint** usage is classified as medical-surgical when they are used to support healing e.g., protecting IV or surgical sites, or to prevent disruption in treatment.

Sufficient personnel must be present while applying **restraints** to prevent injury to the patient or staff. The RN will assess the situation and determine the number of staff needed. The patient’s family/significant other is notified of the use of **restraints** in those situations where the patient has consented to have the family kept informed about care, treatment, and services.

Injuries to patients in **restraints** are reported to the Risk Management Department.

**SUPPORTIVE DATA:**

Physical **restraints** are defined as:

1. “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. OR
2. A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of
"click on the above click here to review the Holy Name restraint policy' movement and is not a standards treatment or dosage for the patient’s condition."

**Restraints** are used only when less restrictive forms or interventions are ineffective. **Restraint Alternatives** are available on all Adult Acute Care Units, except the Holy Name Pavilion. They include the following devices:

Self-Releasing Belts: They are used for patients who need a reminder to stay in the chair for safety reasons. They close in the front with a Velcro-closure and can be released without difficulty by the patient.

Hand Mitts, provided they are not tied down and do not restrict the patient’s arm movements or immobilize the patient’s hand or fingers.

The following may be used on both Acute Care Units and the Holy Name Pavilion:

Chair Wedges with non-skid sheets. These are used to tilt patient back in the chair and raise the feet off the floor. They deter movement out of the chair and help with positioning.

Chair Alarms may be used to alert staff to patients attempting to exit a chair unattended.

Use of side-rails providing that patient egress from bed is not obstructed (3 rails maximum, or 1 if bed only has 2 rails). This excludes the use of side-rails for seizure precautions. (Note see section on Side Rails)

Other Alternatives includes staff/environmental interventions, such as de-escalation techniques, soft music, family visits, structured activities, or behavioral management.

**PROCEDURE:**

**PHYSICAL RESTRAINTS:**

1. Except in an emergency, a patient will be physically restrained only after the Attending Physician or other licensed independent practitioner who has seen and evaluated the patient, and has written an order for restraint.
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The patient must be re-evaluated and, if necessary, the order must be rewritten every 24 hours and include indication for continued medical use. All orders are time limited with a maximum of 24 hours for medical/surgical indications and 4 hours for behavioral indications. They must include the type of and the purpose for which they are used. The use of PRN and Telephone Orders are prohibited.

2. In an emergency, the least restrictive restraint will be initiated by the Registered Nurse. The Attending Physician or other licensed independent practitioner will be notified immediately (within a few minutes) to obtain an order to continue restraints. The patient will be seen and evaluated by the

Attending Physician or other licensed independent practitioner within one hour and restraints will continue only with a written physician’s order. When the order expires, patients are reassessed by a physician or other licensed independent practitioner before the order is renewed.

3. If order for restraints is written by a physician designee or other licensed independent practitioner and not the attending physician, the attending physician must be notified within 12 hours.

4. Restraints are secured to the frame of the bed or chair out of the patient’s reach. Restraints are not secured to the side rails.

5. Soft padding is used underneath materials that can cause skin abrasions or tissue injury.

6. Every patient put into restraints will be assessed by an RN who will document the behavior/condition that justifies the need for restraint and lists the alternative interventions that have been tried. In an emergency situation, observation and assessment of the patient is done every 15 minutes until the patient is stable. Hourly observations are done thereafter.

The Charge Nurse directs the intervention of staff when restraints are applied.
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The patient’s mental and physical status is assessed and the need for restraint re-evaluated every hour for medical-surgical indications and every 15 minutes for behavioral indications.

7. Every two hours
   a. The patient is toileted with assistance if needed.
   b. Restraints are released to assess circulation and skin integrity.
   c. The patient is repositioned.
   d. ROM is provided to each extremity for 5 minutes.
   e. Skin care is performed.

8. Adequate nutrition and hygiene is provided according to the Standard of Care and documented in the Medical Record.

9. Ambulate at least every 4 hours if clinically feasible, or as ordered.

10. The restraint is discontinued as soon as is safely possible. When no longer necessary, i.e. the patient is non-combative and not agitated, the restraints may be removed based on the assessment of the registered nurse. Subsequent restraint usage regardless of time lapse requires a new physician order.

11. Patient wearing vests during the night (10:00 p.m. - 7:00 a.m.), for medical/surgical indications only, shall have the following interventions:
   a. Visual observation at least once an hour.
   b. Administration of fluids as ordered or needed by the patient.
   c. Toileting as needed.
   d. Release of restraints for repositioning and skin care at least every 2 hours.

12. Patients will participate with staff in a debriefing about restraint or seclusion for behavioral health reasons as soon as possible after the episode but no longer than 24 hours after the restraints or seclusion are discontinued. Families are included in the debriefing when appropriate. This will be documented in the medical record.
SIDE RAILS
The use of side rails to prevent the patient from exiting the bed is considered a restraint, e.g. disoriented elderly patients as it restricts the patient’s freedom to exit the bed.

“A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds.” If a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four-side rails is not considered a restraint as the side rails have no impact on the patient’s freedom of movement.

The use of raised side rails on a stretcher is not considered restraint but a prudent safety intervention as there is an increased risk of falling from a stretcher due to its narrow width, and mobility.

LOCKED RESTRAINTS:
The use of locked or buckle type vinyl restraints is limited to patients whose behavior poses a serious threat to them, the environment, or treatment and who can not be maintained by cloth restraints. The key is always readily available to staff in the event of an emergency. The patient’s mental and physical status and need for continued use of the restraints is assessed every fifteen minutes. The locked restraints are removed as soon as the patient’s condition no longer warrants their use. The patient must be reassessed by the physician or other licensed independent practitioner every 4 hours and a new order written if restraint use is continued.

These restraints are maintained in the Emergency Room and on Holy Name Pavilion. They are cleaned after each patient use following manufacturer’s instructions.

PERFORMANCE IMPROVEMENT:

There is a planned and systematic approach to identify opportunities to reduce restraint use. Aggregate data is collected on the following:

Number of orders
Date and time of episode
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All staff involved with the initiation, maintenance or discontinuation of restraints will be trained to identify and utilize alternatives to restraints, how to recognize signs of physiological and/or psychological distress, how to respond to physical distress in a restrained patient, and what behavioral changes would indicate that restraints may no longer be necessary.

Physicians or other licensed independent practitioner should have a working knowledge of the Use of Restraints policy.

DEATH OF A PATIENT IN RESTRAINTS:

All deaths that occur in the hospital that are associated with the use of seclusion or restraints are reported immediately to the Unit Director, Senior Vice President for Patient Care Services, Vice President of Professional Services, Legal Affairs, and Risk Management.

The RN will notify the Unit Director, Clinical Coordinator or Nursing Supervisor of each patient death and indicate whether or not the patient was in restraints at the time of death.

The Unit Director, Clinical Coordinator or Nursing Supervisor will review the chart or the Restraint log in RUMBA to determine if the patient was in restraints or seclusion within the past 7 days.

The Unit Director, Clinical Coordinator or Nursing Supervisor will complete the Restraint Death Report on the Intranet. The Risk Management Coordinator will notify CMS by the close of the next business day and document this information.

The hospital is responsible for reporting the following information to the Center for Medicare and Medicaid Services no later than the close of business on the next business day:

a) Each death that occurs while a patient is in restraint or seclusion
b) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
c) Each death know to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that the use of restraint or the placement in seclusion contributed indirectly or directly to the patient’s death. Reasonable to assume in this context includes
"click on the above click here to review the Holy Name restraint policy' but is not limited to deaths related to restrictions of movement for prolonged periods of time, or death related to chest compressions, restriction of breathing or asphyxiation.

The completed form will be printed out and forwarded to Medical Records for inclusion in the patient’s chart.

**DOCUMENTATION:**

At minimum, documentation should include:

a) The condition or symptoms that warranted the use of restraints
b) Patients response to restraints and/or rationale for continued use
c) Indication that the restraint used is the least-restrictive intervention that protects the patient’s safety

The Nursing assessment and use of alternatives is documented on the Restraint Assessment Flow Sheet for medical/surgical indications, or on the Restraint/Seclusion Assessment Flow Sheet for behavioral indications. Release of restraints and patient care are documented on the Restraint Assessment Flow Sheet or the Restraint/Seclusion Assessment Flow Sheet. Restraint-free periods are documented on this form and on the Patient Care Notes. In addition, the RN will document an assessment of the patient’s behavior at least once every 8 hours on the Patient Care Notes.

An Interdisciplinary Plan of Care specific to restraints will be initiated on application of restraints. The plan of care will be reviewed and updated daily.

The date and time of any death is noted in the chart as well as the date and time of notification of CMS.

**REFERENCES:**

New Jersey Department of Health, Sub-chapter 18.4, Hospital Licensing Standards
October 17, 2008

New Jersey Department of Human Services, Division of Mental Health Services, Administrative Bulletin 3:21,
"click on the above click here to review the Holy Name restraint policy' Seclusion and Restraints in the Continuum of Care, September 26, 2008

Joint Commission Comprehensive Accreditation Manual for Hospitals: Provision of Care and Treatment: PC.03.02.01-PC.03.02.11


Federal Register, Vol.71, No. 236/December 8, 2006/Rules and Regulations

Center for Medicare and Medicaid Services: Memorandum Summary Revised Restraint and Seclusion Interpretive Guidelines Standards 482.13 (e) May 30, 2008

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