

# Use of Non-Violent Restraints – System

## Introduction

### SCOPE

The policy applies to all SHS employees involved in direct patient care, and medical staff.

### Definitions

- Alternatives

Alternate method(s) or less restrictive interventions to help manage patient behavior or to protect the patient from harming others to avoid the use of restraints.

- Continuous Observation

Uninterrupted, ongoing in-person observation of the patient

- Licensed Independent Practitioner (LIP): Physician (MD, DO), Nurse Practitioner (NP)

- PA: Physician Assistant

- RN: Registered Nurse

- Non-Violent Restraint

A restraint applied as a protective intervention to support medical or surgical care and healing. In such cases protective interventions may be necessary. (soft wrist restraints or hand mitts)

- Physical Hold

Physically holding a patient during a forced administration of a psychotropic medication is considered restraint.

Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, hands, fingers or head freely.

- Prolonged Use

Non-violent restraints in use greater than 3 days. Exception to this is soft wrist restraints used to protect intubated patients.

- Treatment Without Consent:

Treatment or medications may be administered without consent to persons *in custody or committed* if a) immediate action is required to preserve the life or physical health of the person or b) because the person creates a substantial likelihood of immediate physical harm to the person or others in the facility, and c) it is not practical to obtain informed consent, as per OAR 309-033-0625. Holding a patient against their will to administer medication is a physical restraint and does require restraint standards to be initiated. Physical hold examples include but are not limited to holding a patient to administer medication or to allow for de-escalation.

- Violent/Self-Destructive Restraint:

Violent or self-destructive behavior is that which jeopardizes the immediate physical safety of the patient, a staff member or others; a restraint that fully immobilizes the patient is considered for violent use. (4 – point restraint – any restraint that immobilizes all extremities.)

## **Implementation**

### **POLICY**

1. To ensure patients have the right to be free from the use of restraints, unless medically necessary. Restraints will not be used for coercion, discipline, convenience or retaliation by staff.
2. To guide appropriate and safe use of restraints to:
  - a. Protect the health and safety of patients, visitors and staff members.
  - b. Preserve patients' rights, dignity, and well-being.
  - c. Base the use of restraints on the patient's assessed needs and after alternatives to restraints have failed.
  - d. Assure safe application and removal of restraints, including monitoring and reassessment of the patient.
  - e. Use must be in accordance with a written modification to the patient's plan of care.
3. To ultimately reduce and eliminate the use of restraints.

- a. Restraints may only be implemented by staff or security personnel trained in the application and discontinuation of restraints. Upon appointment, medical staff receives training regarding hospital policy.
4. Restraints may be initiated:
  - a. Only when clinically justified after a documented individual assessment, both physical and environmental to rule out any identifiable problems that may be causing behavioral changes and;
  - b. After alternatives to restraints have failed and;
  - c. The individual assessment concludes that for this patient at this time, the use of less intrusive measures poses a greater risk than the risk of using a restraint or seclusion
5. Orders: Non-Violent Restraints
  - a. The use of restraints must be in accordance with the order of a physician or other LIP who is responsible for the care of the patient. Physician Assistants/Residents may write orders if delegated by their supervising physician.
  - b. An order for restraints must be obtained prior to the application of restraints, except in emergent situations. An individual assessment must be documented by the LIP/RN and alternative methods to restraints must be documented.
  - c. An order for restraint use is never to be written as a standing or PRN order.
  - d. The order must include the clinical justification for application of a restraint(s) and the type of restraint(s) applied.
  - e. The attending physician or physician responsible for care and management of the patient must be notified at the earliest possible time if restraints are ordered by another LIP.
  - f. Non-Violent restraint order must be renewed at least every 24 hours if order to be continued.
  - g. If restraints are discontinued prior to the expiration of the order, a new order must be obtained prior to re-initiation of the restraints.
6. The ordering LIP does not have to be physically present to re-evaluate the need for continuing restraint use.
7. If soft restraints are used greater than 3 days, except on an intubated patient, the treatment team will review the plan of care.

8. Leg restraints shall never be applied without arm restraints. (If patient is in non-violent restraints and all extremities are immobilized then that is considered a violent restraint. Those standards need to be met.)
9. Restraint must be discontinued at the earliest possible time, regardless of the time identified on the order.
10. The standards do not apply to restraints during surgical procedures and the related post anesthesia care.
11. Hospitals must report deaths associated with the use of restraints directly to CMS in accordance with 42 CFR 482.13(g), the Conditions of Participation. Nurses must report to the Nursing Supervisor to ensure Unusual Occurrence Report, and the Nursing Supervisor will notify Hospital Leadership as soon as possible.
  - a. Hospitals must report the following deaths associated with restraint and seclusion directly to their CMS Regional Office no later than the close of business on the next business day following knowledge of the patient's death:
    - Each death that occurs while a patient is in restraint or seclusion, **excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion at the time of death;**
    - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion, **excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion within 24 hours of their death;** and
    - Each death known to the hospital that occurs 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, regardless of the type(s) of restraint used on the patient during this time.

## PROCEDURE

1. Perform an individual assessment that includes the patient's behavior, physical status, and environment.
  - a. Utilize alternatives to restraint, i.e., companionship of family, friends or environmental adjustments. See Appendix B.
  - b. If these methods fail, then initiate the least restrictive method of restraint. (non-violent restraints include soft writs and / or hand mitts.)
2. Initiate the following precautions while applying and maintaining restraints:
  - a. Maintain respect for patient rights and dignity and provide for his/her privacy.
  - b. Apply restraints securely according to Lippincott policy "Limb Restraint Application."
3. Evaluate need for 1:1 patient observation for Non-Violent restraint.
4. Initial documentation after application of restraints:
  - a. Nursing assessment – including vital signs per patient condition
  - b. Individual assessment - if an assessment parameter cannot be met due to the patient's condition, document reason
  - c. Alternatives attempted and failed (Appendix B)
  - d. Initiate non-violent restraint care plan. Time and type of restraints applied
  - e. Patients response to education of discontinuation criteria
  - f. Patient and family notification/education regarding the use of restraints
  - g. Physician notification of restraint application
5. Ongoing documentation: refer to Appendix A for frequency and content of monitoring, intervention and documentation.
6. Release from restraints:
  - a. Consider restraint removal when:
    - Patient exhibits an appropriate cognitive and/or behavioral condition which allows them to participate in the plan of care.
    - Satisfactory alternative arrangements have been made to supervise the patient or other alternatives to restraints are now effective, e.g. sitter or companion.

- b. Based on reassessment and observed behaviors, nursing staff may release restraints before the time limit is reached. The team will slowly remove restraints all at the same time, under constant observation.
7. Continuously observe the patient during this period. If the behavior escalates, re-apply restraints and notify the LIP as appropriate. Obtain a new order.
8. Clean or dispose of restraints after each use. Disposable extremity restraints are placed in the regular trash when no longer needed.
9. Staff Training:
  - a. Direct patient care providers shall receive initial and periodic updates and competency training on obtaining orders, application and documentation of restraint use.
  - b. New medical staff will receive training upon orientation to the facility. Records of the training will be kept in their file.
  - c. Periodic review and updates will take place in medical staff meetings and reflected in the meeting minutes

## **Exceptions**

A physical restraint does not include devices such as:

- Orthopedically prescribed devices
- Surgical dressings or bandages
- Protective helmets
- Other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- Handcuffs or other restrictive devices applied by law enforcement officials (these still need to be monitored and observed for safety reasons by law enforcement)
- Padded side rails when put up for seizure precautions
- Special air mattress like beds with movement to prevent pressure ulcers (can put up all four rails)
- Side rails and lap belts while transporting a patient via wheelchair, stretcher, stroller, cart, or any other transportation vehicle.
- Crib tops, safety belts and side rails which are to be used as safety precautions considering the age and development of the child.

- Soft protective safety devices such as IV arm boards that may be used for the protection of the child.
- Swaddling/nesting an infant for comfort measures
- Postural support devices for positioning or securing
- If patient can lower side rails when he or she wants, this is not a restraint and should be documented on the patient's record.

## ■ Appendix A

<p><b>Patient displays behavior that is a concern and may interfere with safety, medical or surgical care and healing.</b></p> <ul style="list-style-type: none"> <li>Assessments by RN of behavior, physical status and environment completed and no cause for behavior identified.</li> </ul>		
<p><b>Apply least restrictive restraint appropriate with Physician Order</b></p>		
<p><b>Order for restraint that includes:</b></p> <ul style="list-style-type: none"> <li>Justification</li> <li>Type of restraint used</li> </ul>		
<p><b>Documentation:</b></p> <ul style="list-style-type: none"> <li><u>Initial Application</u> <ol style="list-style-type: none"> <li>Physician notification of restraint application</li> <li>Individual assessment - An assessment includes the patient's behavior, physical status, and environment to identify the possible cause of the patient's combativeness, or other harmful behavior.</li> <li>Alternatives attempted and failed (Appendix B)</li> <li>Vital signs per patient condition</li> <li>Initial non-violent restraint care plan</li> <li>Time of initiation and type of restraint applied</li> <li>Patient's response to education of discontinuation criteria explained</li> <li>Family notification regarding the use of restraints as appropriate</li> <li>Patient response to education</li> </ol> </li> </ul>		
<p><b>Evaluation/Intervention Documentation</b></p>		
<b>Time Frame</b>	<b>Discipline</b>	<b>Content</b>
At least every 4 Hours	RN/CNA	<ul style="list-style-type: none"> <li>Physical Comfort</li> <li>Fluids/Food</li> <li>Elimination</li> </ul>
	RN Only	<ul style="list-style-type: none"> <li>Range of motion</li> <li>Circulation/Skin integrity</li> <li>Mental status</li> <li>Patient reaction to intervention</li> </ul>
Every 24 hours	RN/LIP	<ul style="list-style-type: none"> <li>Renewal order must be obtained to continue restraint use</li> <li>If discontinued and reapplied a new order is required</li> <li>The ordering LIP does not have to physically present to re-evaluate the need for continuing restraint use</li> </ul>
Every 72 Hours	Treatment Team	<ul style="list-style-type: none"> <li>Review Plan of Care</li> </ul>

## **Appendix B**

### **LEAST RESTRICTIVE INTERVENTION ALTERNATIVES [include but are not limited to]:**

- Reorient/reassure patient
- Re-evaluate/disguise equipment
- Medication given
- Alarm
- Family/ friend at bedside
- Staff member at bedside
- Video monitoring (where available)
- Limit setting
- Discuss stressors
- Redirect/distract patient
- Pharmacy consult requested
- Decrease stimuli
- Offer comfort measures
- Identify alternative coping
- Identify precursors to episode