

# Use of 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.

- Chemical Restraints: See Appendix C

- Continuous Observation

Uninterrupted, on-going 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

Violent or self-destructive restraints in use greater than 24 hours

- Specially Trained RN or PA: RN or Physician's Assistants identified to perform face to face evaluations and who have completed the required training

- 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**

Samaritan Health Services is committed to create an environment that minimizes circumstances that give rise to the application of restraint and the use of seclusion for patients and maximizes safety when utilization is necessary.

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:
  - Protect the health and safety of patients, visitors and staff members.
  - Preserve patients' rights, dignity, and well-being.
  - Base the use of restraints on the patient's assessed needs and after alternatives to restraints have failed.
  - Assure safe application and removal of restraints, including monitoring and reassessment of the patient.
  - Use must be in accordance with a written modification to the patient's plan of care.
  - Restraint and seclusion cannot be used simultaneously. Patients require face-to-face observation while in violent restraints and that cannot be accomplished if patient is in seclusion.
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.
- b. After alternatives to restraints have failed and;
- c. The individual assessment concludes that for this patient at this time, the use of less restrictive measures pose a greater risk than the risk of using a restraint.

5. Orders: Violent or self-destructive restraint use:

- a. The use of restraint must be in accordance with the order of a physician or other LIP who is responsible for the care of the patient.
- b. An order for restraint use must be obtained prior to the application of restraints, except in emergency\* situations.

\*(In emergency situations, an order must be obtained during the emergency application of the restraint, or immediately after the restraint has been applied.)

- 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 restraint is ordered by another LIP.
- f. Violent or self-destructive restraint order renewal is based upon the age of the patient.

6. A physician, LIP or specially trained RN or PA must see the patient face-to-face within 1 hour after the initiation of restraints regardless if the restraints are discontinued prior to that time to evaluate:

- a. Patient's immediate situation
- b. Patient's reaction to the intervention
- c. Patient's medical and behavioral condition: and
- d. The need to continue or terminate the restraint, and
- e. Evaluation of history, drugs/medications and recent labs

7. Orders are limited to: (See Appendix A)

4 hours for adults 18 years and older

Pediatric Limits

2 hours for children and adolescents 9-17 years of age

1 hour for children under 9 years of age

8. Time limits on the length of each order only apply when restraint is used to manage violent or self-destructive behavior. The limitation of the order above identifies critical points at which there is mandatory contact with a LIP or specialized RN or PA responsible for the care of the patient.

When the original order is about to expire, the patient must be reassessed by the RN or PA who will then contact the LIP to obtain direction as to whether to renew the order (for up to 4 hours, 2 hours, or 1 hour based upon age of the patient and regulation) or other treatment options.

9. The restraint order may be renewed in accordance with these limits for up to a total of 24 hours.
  - a. After each 24 hours of continuous restraint, and prior to further extension of the restraint, an examination and second opinion must occur by a second physician.
  - b. If a patient needs to remain in restraint beyond 24-hours after the original order, a face-to-face assessment by a LIP must occur before a new order for the continued use is written.
10. If the restraint is discontinued prior to the expiration of the order, a new order must be obtained prior to re-initiation of restraint. The new order requires another 1-hour face-to-face evaluation and the same renewal timelines for up to 24 hours.
11. Adequate numbers of staff are scheduled to maintain safety of the patient and staff members. 1:1 staff is provided for face-to-face observation whenever a patient is placed in violent/self-destructive or 4-point restraints for the duration of time the patient remains in restraints. (See Appendix A)
12. 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.)
13. Restraint must be discontinued at the earliest possible time, regardless of the time identified on the order.
14. The standards do not apply to restraints during surgical procedures and the related post anesthesia care.
15. If there is prolonged use of violent/self-destructive restraints and continued use is required, the plan of care will be reviewed by the treatment team to identify possible actions to reduce or eliminate the use of restraints.
16. Hospitals must report deaths associated with the use of restraint directly to CMS in accordance with 42 CFR 482.13(g), the Conditions of Participation for each site. Nurses must report to the Nursing Supervisor to ensure completion of an 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.
17. Restraint Log – Available through EMR for quality review.

## PROCEDURE

1. RN performs an individual assessment that includes the patient's behavior, physical status, and environment to identify the possible cause of the patient's combativeness, or other harmful behavior.
  - 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. Obtain Physician order unless emergent, then order must be obtained after initiation based on patient condition.
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. Utilize sufficient number of trained personnel for applying violent, self-destructive restraints.
  - c. Apply restraints securely according to Lippincott policy "Limb Restraint Application".
3. Initiate 1:1 direct patient observation if violent, self-destructive restraint is used.
4. Initial documentation after application of restraints:
  - a. Individual assessment – if an assessment parameter cannot be met due to the patient's condition, document reason
  - b. Alternatives attempted and failed (See Appendix B)
  - c. Vital signs per patient condition
  - d. Initial violent restraint care plan

- e. Time and type of restraints applied
  - f. Patient's response to education of discontinuation criteria
  - g. Family notification regarding the use of restraints as appropriate
  - h. Physician notification of restraint application (need for 1-hour face to face)
5. Ongoing assessment and documentation: refer to Appendix A for frequency and content of evaluations, interventions and documentation.
6. Release from restraints:
- a. Consider restraint removal when:
    - The patient's behavior has de-escalated to the point that the patient is no longer an imminent danger to self or others.
    - Satisfactory alternative arrangements have been made to supervise the patient or other alternatives to restraints are now effective, e.g. sitter or companion.
    - Patient exhibits an appropriate cognitive and/or behavioral condition which allows them to participate in the plan of care.
    - Based on reassessment and observed behaviors, nursing staff may release restraints before the time limit is reached. The staff will slowly remove restraints while patient is under constant observation.
7. Continuously observe the patient during this period.
8. Once the assessment is complete and the restraints have been removed, any subsequent behaviors/actions escalating warranting restraint use, notify the LIP to obtain a new order.
9. Clean or dispose of restraints after each use. Neoprene restraints are cleaned by staff using approved cleaner. If visibly soiled send to laundry or contact EVS for cleaning.
10. Staff Training:
- a. Direct patient care providers should receive initial training and periodic updates including 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 be reflected in the meeting minutes.
  - d. Some Registered Nurses and Physician Assistants in specific roles can be identified and receive specialized training to perform face-to-face evaluations.
11. Restraint utilization and documentation data will be reviewed quarterly.

## Exceptions

### EXCEPTIONS or "what is not a restraint"

#### A. 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)
- 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 in the patients record

## ■ Appendix A

**Patient displays behavior that poses immediate danger to themselves or others and may interfere with safety, medical or surgical care and healing**

- Assessments by RN of behavior, physical status and environment completed and no cause for behavior identified.

**Apply restraint with Physician Order** (May initiate if emergent prior to order)

**Order for restraint that includes:**

- Justification

Type of restraint used (4 point)

**Within 1 hour of initiation, there must be a face-to-face evaluation by a physician or LIP.**

**Orders are limited to:**

- 4 hours for adults (18 and older)
- 2 hours for children and adolescents (9 – 17 years of age)
- 1 hour for children under 9 years of age

**Documentation:**

- Initial Application
  1. Physician notification of restraint application
  2. 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.
  3. Alternatives attempted and failed (Appendix B)
  4. Vital signs per patient condition
  5. Initial violent restraint care plan
  6. Time of initiation and type of restraint applied
  7. Patient's response to education of discontinuation criteria explained
  8. Family notification regarding the use of restraints as appropriate
  9. Patient response to education



### Evaluation/Intervention/Documentation

Evaluation results for the patient during the designated time frames are to be considered to meet patient care needs and comply with the plan of care. Documentation of the evaluation and intervention is completed after each time frame.

<b>Time Frame</b>	<b>Discipline</b>	<b>Intervention</b>
Continuous Observation	RN/CNA	<ul style="list-style-type: none"> <li>• Performed continuous in person observation by an assigned staff member</li> <li>• RN ONLY - Readiness to remove restraints</li> </ul>
Every 15 minutes	RN/CNA	<ul style="list-style-type: none"> <li>• Safety and comfort check.</li> </ul>
One-hour face-to-face Evaluation (within 1 hour of initiation)	LIP or Special trained RN/PA only	Evaluation of Patient's Immediate <ol style="list-style-type: none"> <li>a) Medical Condition</li> <li>b) Behavioral Condition</li> <li>c) Condition review include history</li> <li>d) Patient Reaction to Intervention</li> <li>e) Need to continue</li> </ol>
Every 2 Hours	RN/CNA	<ul style="list-style-type: none"> <li>• Physical comfort</li> <li>• Fluids/Food</li> <li>• Elimination</li> </ul>
Every 4 Hours	RN	<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>
Daily Care	RN/CNA	<ul style="list-style-type: none"> <li>• VS to meet patient care needs and comply with plan of care</li> <li>• Hygiene</li> </ul>
Every 24 Hours	Treatment Team	<ul style="list-style-type: none"> <li>• Review Plan of Care</li> </ul>
24 hour Face-to-Face evaluation	Physician or LIP	<ul style="list-style-type: none"> <li>• Must repeat the 1-hour face-to-face evaluation for prolonged use prior to 24 hours</li> <li>• Prior to further extension of the violent restraint, an examination and second opinion must occur by a second physician</li> </ul>

## **Appendix B**

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

- Reorient/reassure patient
- Re-evaluate/disguise equipment
- Medication given
- Alarm
- Family/Friend at bedside
- Staff member in attendance
- Limit setting
- Discuss stressors
- Redirect/distract patient
- Pharmacy consult requested
- Decrease stimuli
- Offer comfort measures
- Identify alternative coping
- Identify precursors to episode

## ■ Appendix C

### Chemical Restraints:

A chemical restraint is defined as a drug or medication that is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement.

A chemical restraint does not include medications used as a standard treatment for a patient's medical or psychiatric condition, such are excluded from the standards for chemical restraint use.

A standard treatment is defined as a medication used to address a patient's medical or psychiatric condition and include but are not limited to the following:

1. The medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer, for the indications it is manufactured and labeled to address, listed dosage parameters, etc.
2. The use of the medication follows national practice standards established or recognized by the appropriate medical community and/or professional medical association or organization.
3. The use of the medication to treat a specific patient's clinical condition is based on that patient's target symptoms, overall clinical situation, and on the MD/DO's or other LIP's knowledge of that patient's expected and actual response to the medication.
4. An additional component of "standard treatment" for a medication is the expectation that the standard use of a psychotherapeutic medication to treat the patient's condition enables the patient to more effectively or appropriately function in the world around him or her than would be possible without the use of medication. Psychotherapeutic medications are to enable, not to disable. If a psychotherapeutic medication reduces the patient's ability to effectively or appropriately interact with the world around him or her, then the psychotherapeutic medication is not being used as a "standard treatment" for the patient's condition.

Examples of standard treatment:

- Clinical treatment of patients who are suffering from serious mental illness and who need appropriate therapeutic doses of psychotropic medication to improve their level of functioning.
- Appropriate doses of sleeping medication prescribed for patients with insomnia.
- Anti-anxiety medication that is prescribed to calm a patient who is anxious.