



POLICIES AND PROCEDURES MANUAL

Hospital Department

Supersedes:

Section: Nursing

Subject: Restraints

Number: NUR 01_052

Attachments: Attachments A, B, C, D, E

Date Effective: 5/2010

Date Reviewed: 1/22/2013

Purpose

The Bellevue Medical Center adheres to the philosophy of recognizing and respecting patient's rights to receive appropriate and safe care while preserving the dignity, rights and well being of patients and staff. Bellevue Medical Center respects the patient's right to be free of restraints of any form that are not deemed medically necessary and maintains the goal of limiting the use of restraint to the shortest time possible while providing a safe environment of care for all. The purpose of this policy is to provide guidelines directing the clinically appropriate use of Non-violent (medical) and Violent (behavioral) restraints.

Applicable Definitions

- A. BMC-Bellevue Medical Center
- B. Rights-each patient has the right to receive care in a safe setting. The safety of the patient, staff, or others forms the basis for initiating and discontinuing the use of restraint or seclusion. Each patient has the right to be free from all forms of abuse and corporal punishment. Each patient has the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may not be used unless the use of restraint or seclusion is necessary to ensure the immediate physical safety of the patient, a staff member, or others. The use of restraint or seclusion must be discontinued as soon as possible based on an individualized patient assessment and scheduled re-evaluation.
- C. Restraints- Physical restraints are 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. Medical restraint is a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Chemical restraints are any drug used for discipline or convenience and not required to treat medical symptoms. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or 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).
- D. Non-violent/Non-Self Destructive/Medical Restraint-The application of a device for the purpose of safety of the patient to allow the patient to heal from a medical condition or to participate in a treatment program for a medical condition i.e. tube and line protection.
- E. Behavior root cause: what is the reason for the patient's behavior? Examples may include hunger, thirst, pain, boredom, bowel or bladder needs, hot or cold (uncomfortable) or perhaps a medication reaction. See Attachment A for additional information.
- F. Personal restraint-The application of physical force without the use of any device for the purpose of restraining the free movement of a patient's body.
- G. Violent/Self Destructive/Behavioral restraint the application of restraint for the protection of the patient against injury to self or others because of emotional or behavior disorder/s.
- H. Seclusion-is the involuntary confinement of an individual in a room or area alone for any period of time, from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior
- I. Alternative interventions-measures which modify the environment that enhance interpersonal interaction or provide treatment so as to minimize or eliminated the problems or behaviors which place the patient at risk. See Attachment A for additional information
- J. Least Restrictive Interventions-measures that permit the maximum amount of freedom of movement consistent with goals to provide patient safety and protection from injury
- K. Medical Record-Electronic Medical Record/Electronic Health Record and associated down-time paper support forms
- L. LIP-Licensed Independent Practitioner including a physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care as defined in the Medical Staff By Laws, Rules and Regulations

- M. Exclusion Restraint clarification: devices and methods typically used in medical/surgical care are not considered restraints such as orthopedically prescribed equipment, surgical dressings or bandages. Protective helmets or 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 participated in activities without the risk of physical harm are not restraints
1. Side rails will not be considered a restraint when:
 - a. The structure of the bed from the mattress to the floor is at an unsafe elevation.
 - b. When the side rails are being used to assist with maintaining postural support
 - c. The side rails are in sections and all but one section is raised and if the patient is able to easily get out of bed if they wish
 - d. The side rails contain the patient's controls for calling the nurse, adjusting the bed, controlling the TV, etc.
 2. Side rails will be considered a restraint when the intent is to keep the patient in bed and all four side rails are elevated
 3. The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices used for custody, detention, and public safety reasons that are applied by law enforcement would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients; the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to these patients.

Policy

Restraints or seclusion may only be used and implemented when the least restrictive methods have been employed and have been determined to be ineffective for preventing patients from harming themselves (self-destructive/ violent/ behavioral); other patients; staff members: or when restraints are needed to prevent the patient from interfering with necessary medical regimens (non-self destructive/non-violent/medical). Clinical assessment will occur prior to the use of restraints. The type of restraint employed will be based solely on patient assessment and need and will not be used for any other purpose, such as coercion, discipline, convenience or retaliation by staff. When using restraints, BMC staff will adhere to and be guided by applicable Joint Commission and CMS standards; organizational policies as well as applicable State and federal laws.

1. Training-New RN staff members will be educated to implement restraint and seclusion with safe and appropriate restraint and seclusion techniques as determined by this policy in accordance with State law. RNs that initiate or terminate restraint will be specifically trained to do so during orientation and before participating in the application of restraint. Ongoing education of existing employees will be done as needs are identified and will emphasize prevention, alternative measures and protecting vulnerable patient populations on a periodic basis, typically during facility annual training events. Only RNs who prove competency in orientation, complete mandatory education and competency, have demonstrated knowledge in the use of first aid techniques and are current in BLS certification may make decisions about, implementing, and discontinuing restraint use. Personnel training will be documented in staff records to demonstrate competency and successful completion of training. Staff education and competency will focus on:
 - a. Strategies and techniques used to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of restraint or seclusion
 - b. Use of nonphysical intervention skills
 - c. Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition
 - d. Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
 - d. Safe and appropriate restraint and seclusion techniques including the application and use of all types of restraint used in the hospital, including training in how to recognize and respond to signs or physical and psychological distress.
 - e. Clinical identification of specific behavioral changes that indicate that 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 identified with the in-person evaluation conducted within one hour of initiation of restraint or seclusion
 - g. Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation
 - h. RN education will include assessment/evaluation and documentation in the patient medical record on the following:

- i. Restraint Alternative options
 - ii. Skin under restraint intact
 - iii. Adequate Circulation to immobilized limb
 - iv. Range of Motion needs
 - v. Elimination needs met
 - vi. Food/Fluids needs met
 - vii. Behavior
 - viii. Least restrictive restraint
 - ix. Need for restraint assessed
 - x. Reason for restraint documented every shift and when restraint use changed
 - xi. Who Education about restraint was given to
 - xii. Restraint type documented every shift and when restraint type/location changed
- i. RN education will include training on how to individualize the patient Care Plan to reflect restraint components reflecting the written modification to the patient's plan of care
 - j. RN education will include Patient Education Points and instruction on how to access and use available resources to help educate patients and families when restraints are needed and used
2. Only physicians/LIPs who are privileged to practice at BMC and who have had education at orientation, have a working knowledge of and have acknowledged reviewing the Restraint use policy may order restraint interventions. Physicians will receive and acknowledge the medical staff's policy on the use of restraint and sign the attestation. Documentation of policy acknowledgment/education will be maintained by the Medical Staff Office. See Attachment E
 3. Various agencies must be informed when patients die in restraint or who were restrained within one week (special focus on patients in restraints within 24 hours) of death in restraints. Quality Management (in addition to Unit Manager/Leads/House Supervisors) must be informed of all patients who died within 24 hours of removal of restraint. Quality Management (in addition to Unit Manager/Leads/House Supervisors) will also be notified of any death that occurred within one week after restraint where it is reasonable to assume that use of restraint contributed directly or indirectly to a patient's death. Provide details (within 24 hours) of any deaths in these categories of interest to the Quality Management department using Fax (402-763-3195) or scan /email details to the Quality staff. Contact Quality Management (402-763-3700) with questions. Staff will record the date and time the death was reported to CMS when it is reasonable to assume that use of restraint contributed directly or indirectly to a patient's death

Procedure

1. Non-violent/non-self destructive/medical restraint use
 - a. Ordering process
 - i. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN)
 - ii. An order for the LIP is required when restraints are used. In the absence of the LIP, a verbal/telephone order may be entered into the Medical Record. The LIP is responsible for a face-to-face patient evaluation and for signing the order within 24 hours of medical restraint application. The attending physician will be consulted as soon as possible if the attending physician did not order the restraint or seclusion. See Attachment B.
 - (1) Face-to-face evaluation and assessment by the LIP of the patient include:
 - (a) Identification of potential risk for the patient's behaviors; staff concerns for safety; risk to the patient staff and others that necessitated the use of restraint.
 - (b) Identification of interventions that were implemented prior to the use of restraint.
 - (c) Evaluation of failed measures that were implemented.
 - (d) Documentation that the patient and/or family were provided with an explanation for the reason for restraint.
 - (e) Documentation the patient and/or family were provided with teaching on the restraint.
 - (f) The criteria for release from restraint.
 - iii. The LIP may continue the use of restraints beyond the initial 24 hr period if deemed medically necessary and justified. The renewal order is to be issued and signed no less often than once every calendar day and is to be based on the examination of the patient by the treating LIP
 - iv. After completing a behavior root cause review, the LIP will be contacted as soon as possible when RN staff establish the medical necessity to use restraint for patient safety, no later than the end of the RN's shift on which the restraint was initiated. The restraint

use will then be entered as a telephone order from the LIP, who is responsible for the face-to-face evaluation and signing the order within 24 hours.

- v. Documentation of restraint and seclusion in the medical record will include the following:
 - (1) Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior
 - (2) A description of the patient's behavior and the intervention used
 - (3) Any alternatives or other less restrictive interventions attempted
 - (4) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion
 - (5) The patient's response to the interventions(s) used, including the rationale for continued use of the intervention
 - (6) Individual patient assessments and reassessments
 - (7) The intervals for monitoring, if outside standards noted below
 - (8) Revisions to the plan of care
 - (9) The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion
 - (10) Injuries to the patient
 - (11) Death associated with the use of restraint or seclusion
 - (12) The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion
 - (13) Notification of the use of restraint or seclusion to the attending physician
 - (14) Consultations
- b. The use of least restrictive measure to prevent restraint use is to be documented in the Medical Record at least every shift including the points noted in Attachment D.
- c. Efforts will be taken to protect patient privacy and confidentiality, i.e. covering restraints from view when transporting the patient.
- d. Documentation of the use of restraints will be recorded in a daily log, readily accessible to interested parties. The log will be electronically derived from the Medical Record system. Paper record logs will be used when the Medical Record system is not able to produce the electronic log, i.e. down-time. Quality Management will episodically independently audit restraint logs and use, and will report policy compliance to involved parties.
- e. Restraints may be removed for routine cares or treatments, providing adequate staff members are present to maintain patient safety when the restraints are off. Reapplication of restraints after cares are provided is covered under the existing restraint order.
- f. The RN will discontinue the restraints when the clinical justification/need for restraint is no longer present, regardless of the length of time identified on the order
- g. When non-violent, medical use restraints are needed, assessment and care performed will be document at least every two hours in the Medical Record and will include consideration of variables such as patient condition, cognitive status and other relevant factors.
 - i. Observation and assessments will include, but are not limited to:
 - (1) Placement of restraint
 - (2) Skin condition under restraint prior to and during restraint use
 - (3) Circulation of immobilized limb/s
 - (4) Patient condition, orientation status and comfort
 - ii. Provision of Care will include, but is not limited to:
 - (1) Active and/or passive range of motion
 - (2) Change of position
 - (3) Hygiene and elimination needs are addressed
 - (4) Food and fluid intake offered and assessed
 - iii. The need for restraint continuation is reassessed
- h. Documentation of the Plan of Care related to the use of restraints will be included in the Medical Record and updated and individualized for each patient when each restraint is used.
- i. Termination: Restraint may only be used while the unsafe condition continues. RNs who have had the education and have competency to recognize when the patient is no longer a threat may terminate restraint use earlier than indicated by the order based on their assessment of the patient condition or when attempted alternative measures are successful. Documentation of the decision process will be included in the Medical Record and will include documentation that the patient's behavior is no longer a threat to self, staff member or others.
- j. Should an unsafe condition re-emerge non-refractive to alternative measures, a new order for restraint must be obtained as per the processes identified above.

2. Violent, self-destructive, behavioral restraint use
 - a. Therapeutic interventions to de-escalate the situation will be instituted as soon as possible when displays of agitation, irritability or aggressiveness are exhibited by the patient. If the patient's behavior continues or deteriorates to the point of presenting a danger to self or others, other de-escalating measures have failed, or the patient is unable to demonstrate a clear understanding of the consequences of their behavior, the use of violent/self-destructive/behavioral restraint should be considered.
 - b. Ordering Process
 - i. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN)
 - ii. An order for the LIP is required when restraints are used. In the absence of the LIP, a verbal/telephone order may be entered into the Medical Record. The LIP is responsible for a face-to-face patient evaluation and for signing the order within age specific time frames. The attending physician will be consulted as soon as possible if the attending physician did not order the restraint or seclusion. See Attachment C.
 - (1) Face-to-face evaluation and assessment by the LIP of the patient include:
 - (a) Identification of potential risk for the patient's behaviors; staff concerns for safety; risk to the patient staff and others that necessitated the use of restraint.
 - (b) Identification of interventions that were implemented prior to the use of restraint.
 - (c) Evaluation of failed measures that were implemented.
 - (d) Documentation that the patient and/or family were provided with an explanation for the reason for restraint.
 - (e) Documentation the patient and/or family were provided with teaching on the restraint.
 - (f) The criteria for release from restraint.
 - (2) Adults (18 years and older): 4 hour time limit. Initial face-to-face evaluation and documentation of the findings to be completed by LIP within one hour of restraint application.
 - (a) Re-evaluation and assessment of the need to continue the behavioral restraint is to be documented by the treating LIP or as a verbal/telephone order by the RN every four hours for adults (18 years and older).
 - (3) Children ages 9-17: 2 (two) hour time limit. Initial face-to-face evaluation and documentation of the findings to be completed by LIP within one hour of restraint application.
 - (a) Re-evaluation and assessment of the need to continue the behavioral restraint is to be documented by the treating LIP or as a verbal/telephone order by the RN every 2 (two) hours for children ages 9-17.
 - (4) Children under 9 (nine) years: 1 (one) hour time limit. Initial face-to-face evaluation and documentation of the findings to be completed by LIP within one hour of restraint application.
 - (a) Re-evaluation and assessment of the need to continue the behavioral restraint is to be documented by the treating LIP or as a verbal/telephone order by the RN every 1 (one) hours for children under 9 (nine) years.
 - iii. The LIP may continue the use of restraints beyond the initial 24 hr period if deemed medically necessary and justified. The renewal order is to be issued and signed at age specific intervals and will be based on the examination of the patient by the treating LIP at least every 24 hours.
 - iv. After completing a behavioral root cause review, the LIP will be contacted as soon as possible (with the goal of one hour) notification when RN staff establishes the behavioral necessity to use restraint for patient safety, no later than the end of the RN's shift on which the restraint was initiated. The restraint use will then be entered as a telephone order from the LIP, who is responsible for the face-to-face evaluation and signing the order within specified time frames.
 - v. Documentation of restraint and seclusion in the medical record will include the following:
 - (1) Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior
 - (2) A description of the patient's behavior and the intervention used
 - (3) Any alternatives or other less restrictive interventions attempted

- (4) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion
 - (5) The patient's response to the interventions(s) used, including the rationale for continued use of the intervention
 - (6) Individual patient assessments and reassessments
 - (7) The intervals for monitoring, if outside standards noted below
 - (8) Revisions to the plan of care
 - (9) The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion
 - (10) Injuries to the patient
 - (11) Death associated with the use of restraint or seclusion
 - (12) The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion
 - (13) Notification of the use of restraint or seclusion to the attending physician
 - (14) Consultations
- c. The use of least restrictive measure to prevent restraint use is to be documented in the Medical Record at least every shift including the points noted in Attachment D.
 - d. Efforts will be taken to protect patient privacy and confidentiality, i.e. covering restraints from view when transporting the patient.
 - e. Documentation of the use of restraints will be recorded in a daily log, readily accessible to interested parties. The log will be electronically derived from the Medical Record system. Paper record logs will be used when the Medical Record system is not able to producing the electronic log, i.e. down-time. The record will be sent to Quality Management and saved on the facility shared secure drive, accessible to involved parties. Quality Management will episodically independently audit restraint logs and use, and will report policy compliance to involved parties.
 - f. Restraints may be removed for routine cares or treatments, providing adequate staff members are present to maintain patient safety when the restraints are off. Reapplication of restraints after cares are provided is covered under the existing restraint order.
 - g. The RN will discontinue the restraints when the clinical justification/need for restraint is no longer present, regardless of the length of time identified in the order
 - h. When violent/behavioral use restraints are needed, assessment and care performed will be document at least every 15 minutes in the Medical Record and will include consideration of variables such as patient condition, cognitive status and other relevant factors.
 - i. Observation and assessments will include, but are not limited to:
 - (1) Placement of restraint
 - (2) Skin condition under restraint prior to and during restraint use
 - (3) Circulation of immobilized limb/s
 - (4) Patient condition, orientation status and comfort
 - ii. Provision of Care will include, but is not limited to:
 - (1) Active and/or passive range of motion
 - (2) Change of position
 - (3) Hygiene and elimination needs are addressed
 - (4) Food and fluid intake offered and assessed
 - iii. The need for restraint continuation is reassessed
 - i. Documentation of the Plan of Care related to the use of restraints will be included in the Medical Record and updated and individualized for each patient and each restraint is used.
 - j. Termination: Restraint may only be used while the unsafe condition continues. RNs who have had the education a have competency to recognize when the patient is no longer a threat may terminate restraint use earlier than indicated by the order based on assessment of the patient condition or when attempted alternative measures are successful. Documentation of the decision process will be included in the Medical Record and will document that the patient's behavior is no longer a threat to self, staff member or others.
 - k. Should an unsafe condition re-emerge non-refractive to alternative measures, a new order for restraint must be obtained as per the processes identified above.

References

- A. State Operations Manual Appendix A interpretive Guidelines-Hospitals. Retrieved December 10, 2012, from CMS Web site: <http://www.cms.hhs.gov>
- B, Joint Commission, Comprehensive Accreditation Manual for Hospitals-The Official Handbook, Restraint Standards, Refreshed Core, retrieved December 10, 2012 from <http://e-dition.jcrinc.com/Frame.aspx>

- C. American Psychiatric Associate, American Psychiatric Nurses Association and National Association of Psychiatric Health Systems. Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health. Retrieved December 10, 2012 from <http://www.naphs.org/rscampaign/Learning.pdf>
- D. Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation; Final Rule from the Federal Register Online via the Government Printing Office [www.gpo.gov] Vol. 77 , No. 95 / Wednesday, May 16, 2012 viewed December 10, 2012 from <http://www.gpo.gov/fdsys/pkg/FR-2012-05-16/html/2012-11548.htm>
- E. 2012 Joint Commission and CMS Crosswalk: Comparing Hospital Standards and CoPs. Publisher: Joint Commission Resource 2011

Department Approval

Signed | s |: N/A

Title:

Department:

Administrative Approval

Signed | s |: Lisa Walters

Title: Director of Nursing

Alternative Interventions to Restraints

Purpose

The purpose of this attachment is to identify possible behavior root causes and defines alternatives available to help avoid the inappropriate use of restraints.

Behavior Root Causes

Appropriate interventions should be initiated based on the true cause of the behavior. Examples of potential behavior issues may include:

Hunger	Environmental changes	Bowel or bladder needs
Thirst	Uncomfortable-cold or hot	Medication reaction or changes
Hypoxia	Intoxication	Abnormal lab values
Pain	Post traumatic brain injury	Substance withdrawal
Infection	Sleep deprivation	Boredom

Alternative Interventions to help improve behavior: (some may require LIP order)

Examples may include:

- Patient and/or family education
- Reality orientation
- Assist the pt to the bathroom/offer bathroom breaks at frequent intervals
- Call light within easy reach
- Reposition (i.e., up in chair, side vs. back, most comfortable option)
- Implement DT Protocol (WAS) for substance abuse issues
- Medical interventions to correct underlying medical concerns (i.e. abnormal labs, etc)
- Offer supervised ambulation/exercise
- Closer observation (i.e., move patient to room closer to the nursing station; have the patient sit in a recliner at the nurse's station, etc.)
- Provide diversional activities (i.e., TV, music, activities involving hands such as folding wash cloths, playing with a deck of cards and reading materials, etc.)
- Provide comfort measures
- Offer food/fluids often
- Offer warm blankets or remove layers if too warm
- Family observation/sitter/companion (discuss options with the family)
- Wrap catheter insertion site with tube gauze allowing access for visibility
- Secure the tubing along the extremity to prevent the tube/line from dangling. This measure may reduce the visibility and decrease the patient's tendency to pull at the tubing. This may work for both central and peripheral lines.
- Keep the IV or tube feeding pole behind the patient and out of his/her visual field
- Make a vest from large tube gauze or use mesh T-shirt and apply over the patient's chest to prevent him/her from pulling out a central line.
- Use an abdominal binder to cover a PEG, g-tube or JP bulbs
- Bed alarm and/or chair alarm
- Oxygen (if hypoxic or medically indicated) to help brain function
- Environmental modification (i.e., lighting, remove clutter, bring familiar items from home, etc)

Non-Violent (Medical) Restraints

Physician Restraint Order Summary

Non-Violent (Medical) Restraints

- Patient behavior-Patient is pulling tubes/lines, interfering with dressings, wounds, devices
- Alternatives attempted: redirection, diversion activities, PRN medications, etc.

Physician Present

1. Physician assess and documents the need for restraints
2. MD enters order in One Chart for Non-Violent restraints

Physician NOT Present

1. RN orders restraints and contacts the Physician within one hour of restraint application to obtain a verbal/telephone order for restraint
2. Physician conducts **Face-to-Face** evaluation within **24** hours covering
 - a. Review of systems (medical reason for behavior? i.e. electrolyte imbalance, hypoxia, etc.)
 - b. Review of most recent lab values
 - c. Mental examination
 - d. Determination if restraints are still required
 - e. Restraint order renewed as indicated for a further **24** hours

Restraint Orders Will Include

1. Reason for restraints
2. Type of restraints
3. Patient reaction to restraints
4. Time limited order
 - **24-Hours ONLY for initial order**
 - The renewal order is to be issued and signed no less often than once every calendar day and is to be based on the examination of the patient by the treating LIP

The physician must complete and document a Face-to-Face Evaluation of the patient every 24 hours to continue the use of restraints

***Restraints cannot be ordered on a PRN basis. No exceptions.**

Violent (Behavioral) Restraints

Physician Restraint Order Summary

Violent (Behavioral) Restraints

- Patients' Actions-violent, aggressive toward self or others
- Alternatives attempted and documented i.e. de-escalation, PRN medications, redirection, reduction of environmental stimulus
- Alternatives Failed-Consider use of Restraints for protection of self/others*

Physician Present

1. Assess and document the need for restraints
2. MD enters order in One Chart for Violent restraints

Physician NOT Present

1. RN orders restraints and notifies Physician within **one** hour of restraint application
2. Physician conducts **Face-to-Face** evaluation within **one** hour covering
 - a. Review of systems (medical reason for behavior? i.e. electrolyte imbalance, hypoxia, etc.)
 - b. Review of most recent lab values
 - c. Mental examination
 - d. Determination if restraints are still required
 - e. Restraint order renewed as indicated

Restraint Orders Will Include

1. Reason for restraints
2. Type of restraints
3. Patient reaction to restraints
4. Time limited order
 - a. Adult greater than 18 years – four (4) hour time limit
 - b. Age 9-17 years – two (2) hour time limit
 - c. Less than 9 years – one (1) hour time limit

Restraints must be renewed within the time frame allocated per order

The physician must complete and document a Face-to-Face Evaluation of the patient every 24 hours

***Restraints cannot be ordered on a PRN basis. No exceptions.**

1. Contact your Unit Educator to review precise steps for correct "One Chart" documentation.
2. Forms for use during electronic record "Down Time"
 - a. Emergency Department –ED Daily Restraint Log
 - b. Other departments – ICU/MS Daily Restraint Log



Date:

Demographics / Sticker	Age	Restraint type V=Violent / NV= Non-violent/ Medical	Date	Start time	End Time	Ordered by:	Renewal needed ? Y / N	Time order needed
				Start	End			
				Renew Start	Renew End			
				Renew Start	Renew End			
				Renew Start	Renew End			
				Start	End			
				Renew Start	Renew End			
				Renew Start	Renew End			
				Renew Start	Renew End			
				Start	End			
				Renew Start	Renew End			
				Renew Start	Renew End			
				Renew Start	Renew End			

ED Daily Restraint Log

AM SBAR 7 A - 7 P RN Lead/7P-7A Lead
/

PM SBAR 7P- 7A RN Lead/7A-7P Lead
/

Date: _____	0700 - 0659	<p>Medical/Non-Violent Restraints need to be (initial order within one hour of application) reordered q 24 hours & documented q 2 hours. Behavioral /Violent restraints need to be (initial order within one hour of application wth MD face-to-face) reordered every 4 hours (with bedside evaluation) & documented q 15 mins.</p> <p style="color: blue; text-align: center;">Any documentation missed puts BMC out of compliance with regulations. Scan to "Restraints" every morning.</p>
<input type="checkbox"/> No restrained patients		

Patient Sticker	Restraint Order Current & Ordered	Time / Date renewal needed	Rt	POC Complete		Educ. Done		Q 2 hours/ 15 min Monitor/ Doc		DC'd (date & time)	Restraint Comments (Medical/Non Violent vs Behavioral/Violent- Behavioral use dedicated check list)
	Y / N	Time(s)		D	N	D	N	D	N		RN on shift.
Example	Y	10/22 800 (1200) (1600)	X	X	X	X	X	X	X	na	Medical- Next shift updated to when order expires D-RN _____ N-RN _____
											D-RN _____ N- RN _____
											D-RN _____ N-RN _____
											D-RN _____ N-RN _____
											D-RN _____ N-RN _____

 Scanned to Restraint Q: drive

 Copy to Quality Management



ATTACHMENT E

MEDICAL STAFF RESTRAINT USE ATTESTATION STATEMENT

The Bellevue Medical Center and their Medical Staff are required by federal regulations to ensure that their medical staff members are educated about the appropriate use of restraints and seclusions for the safety of our patients. Enclosed you will find a policy that outlines the philosophy, policies and procedures related to restraint use at Bellevue Medical Center.

Please read the policy and complete this attestation statement.

Return your signed attestation. You may contact Medical Staff Services at 402-763-3022 (or 3023), with any questions.

I hereby certify that I have read, understand and will follow the Restraint use policy of the Bellevue Medical Center.

Signature

Date

Printed Name