

DIVISION/DEPT.: PATIENT CARE
MANUAL NAME: HOUSEWIDE POLICY/PROCEDURE
TITLE: RESTRAINTS, USE OF
IDENTIFICATION CODE: PTCR61h
PAGE 1 OF 13



POLICY STATEMENT:

Patients at Children's Hospital & Medical Center will receive considerate and respectful care, free of unnecessary restraint. The hospital uses restraint only to protect the immediate physical safety of the patient, staff, or others. The use of restraint for purposes such as coercion, discipline, convenience, retaliation, or in response to staffing needs is not permitted.

PURPOSE:

To provide direction for the practitioner on the use of restraints to:

- Encourage the use of less restrictive interventions to prevent the use of restraint
- Minimize the use of restraints by ensuring that they are applied only when clinically necessary or indicated
- Assist with the selection of the least restrictive form of restraint that protects the physical safety of the patient, staff, and others
- Preserve the patient's physical and emotional well being
- Encourage discontinuation of restraints at the earliest possible, clinically appropriate time
- Ensure that all patients will be monitored by qualified staff during the use of restraints
- Assure that restraints are only applied by staff who have been trained and have demonstrated competency in their potential risks and safe use
- Assure that restraints are used in compliance with regulatory guidelines and applicable law
- Assure complete and accurate documentation regarding restraint use

DEFINITIONS

Licensed Provider is a provider licensed and recognized in Nebraska, including physicians, nurse practitioners, physician assistants and psychologists.

Physical Restraint is 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.

- Restraints for nonviolent behavior used in the provision of care, treatment, and services, are initiated for patients who cannot comprehend the consequences of their actions, jeopardizing the healing process. Examples include:
 - soft limb restraints or elbow splints ("welcome sleeves") used to prevent removal of tubes or devices or to prevent disruption of a procedure site
 - attaching hand mittens to the bed
 - mittens used in conjunction with wrist restraints
 - tight application of mittens immobilizing hands/fingers
 - bulky mittens that reduce the patient's ability to use their hands
- Enclosure beds are considered a nonviolent restraint when used to decrease the risk of harm related to patient's confusion, agitation or inability to comprehend the consequences of their actions. Examples of patients for whom the use of an enclosure bed would be considered a nonviolent restraint are children who have acute neurological changes at risk for harm to themselves when left in a regular bed.
- Restraint for violent or self-destructive behavior is initiated during an emergency or crisis situation when a patient's behavior becomes severely aggressive, violent or destructive, presenting an immediate, serious danger to his/her safety or to the safety of others. Examples include soft or hard limb restraints used to prevent the patient from harming themselves or others.

Chemical Restraint - Medications Used as Restraint: Medications given in addition to, or in replacement of, the patient's regular drug regimen to control extreme behavior during an emergency are also considered restraints.

The state of Nebraska defines chemical restraint as a psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms. Children's Hospital & Medical Center does not use medications for chemical restraint purposes.

Seclusion is defined as an involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion is not practiced at Children's Hospital & Medical Center.

DEVICES NOT CONSIDERED RESTRAINT AND EXCLUDED FROM POLICY

1. **Adaptive or Postural Support:** The use of devices to compensate for muscular or skeletal weaknesses generally used to assist the patient in sitting or standing and/or to avoid falling. Examples include Ankle Foot Orthoses (AFOs), hand splints, vests/jackets, wheelchair seatbelts, and standing boards.
2. **Forensic Restraints:** Those devices used by forensic personnel to prevent the patient from escaping, such as handcuffs, leg irons, flex cuffs or other special restraining devices. Refer to Administrative Policy: Forensic Personnel Within the Hospital.
3. **Procedural Immobilization:** Procedural immobilization includes standard practices that either temporarily limit or prevent mobility during a medical, dental, diagnostic, or surgical procedure. The device is removed when the procedure is completed. Examples include body restraint during surgery, papoose board use during circumcision, or device used to secure a child during x-ray.
4. **Protective Devices:** Devices used to promote the patient's safety that are not directly related to the patient's treatment or to severely aggressive/violent behavior. Examples include bed rails, bubble top cribs, helmets, IV arm boards, hand mittens that are not attached to the bed or immobilizing movement of fingers, safety enclosure beds, and highchair straps.
5. **Enclosure Bed** is not considered a restraint when used for patients with permanent developmental delays who have modifications to their home sleep settings to prevent the risk of physical harm (i.e. a mattress on the floor, a home enclosure bed, or a padded room). Information collected during the admission assessment will be used to determine when these protective devices are indicated. **A licensed provider order is required for enclosure bed, even when used as a protective device.**

EQUIPMENT/FORM(S):

Elbow Splints
Soft or Hard Limb Restraints
Enclosure Bed
Hand Mittens
Restraint Flow Sheet (Nonviolent, Violent or Self-Destructive) in EPIC

STAFF EDUCATION AND COMPETENCY VALIDATION

Patients have a right to the safe application of restraint by trained and competent staff.

Physicians with admitting privileges and their collaborating licensed providers will be educated on the requirements for restraints by reviewing the policy and successfully completing a post-test at appointment and reappointment.

Nursing staff in Med Surg, SSU, NICU, PICU, and Emergency Department, along with Respiratory Therapists, and Rehab staff (physical therapists, occupational therapists, and speech therapists) working 50% or greater of their work hours in inpatient areas will be trained in orientation and demonstrate competency at a minimum on an annual basis by completing the on-line restraint training course and demonstrating proper application and removal of soft limb restraints used for non-violent or violent self-destructive restraint use.

Security Officers, and leadership staff (charge nurses, designated relief charge nurses, managers and educators) on 4MS, 5MS, 6MS, PICU and in the Emergency Department will be trained in orientation and demonstrate competency at a minimum on an annual basis by completing the on-line restraint training course and demonstrating proper application and removal of hard limb restraints used for violent self-destructive restraint use.

IMPLEMENTATION:

1. Physicians, APRN-NPs, PAs and RNs can make the decision that non-violent restraint is needed based on assessment.
2. Only those staff that are trained and competent in soft limb restraints can apply or remove soft limb restraints.
3. The RN caring for the patient in soft restraints is responsible for task delegation and supervision of other staff involved in the patient's care.
 - a. The application, release and removal of restraint cannot be delegated to those staffs that are not trained and competent in restraint.
4. Physicians, APRN-NPs, PAs, RNs, and Clinical Psychiatrists can make the decision that violent self-destructive restraints are needed based on assessment.
5. Only staff that are trained and competent in soft limb restraints can apply or remove a soft limb restraint used for violent self-destructive behavior.
6. Security Officers will be responsible in the application of hard restraints used for violent self-destructive behavior.
 - a. Only staff that are trained and competent in hard restraints can remove hard limb restraints.
7. The RN caring for the patient in violent self-destructive restraints is responsible for task delegation and supervision of other staff involved in the patient's care. If hard limb restraints are used, the RN will work with Security Officers, or those unit leadership staff that are trained and competent in hard restraints, to release the restraint for assessment and reapplication of restraint.
8. All other disciplines that have not been trained and demonstrated competency in restraint will not be involved in the application/removal of restraints. The patient's nurse will be contacted for the appropriateness of the planned intervention during the patient's time in restraint.

CAREGIVER ALERTS:

1. Standing orders, orders for PRN (as needed) restraint, restraint orders that are signed and held, and orders for restraints to be applied at a future date and/or time are not permitted.
2. A new order is required if at any time, the restraints are discontinued and then restarted.
3. Only Security Officers can apply hard restraints needed for a violent self-destructive patient in accordance with a provider order. Clinical staff will assist with the application. Patients in restraint for control of violent or self-destructive behavior will be monitored continuously.

PROCEDURE:

1. **Restraint Avoidance:**

Restraints should only be used when less restrictive interventions are not effective. Initiate appropriate alternate interventions prior to initiation of restraint whenever possible, including: distraction, redirection, diapering/clothing, swaddling, increased observations by staff, family, or other approved persons, change in treatment, or appropriate pain management. Information from the patient's assessment, as well as from the patient's family, should be utilized to determine the most appropriate techniques to use.
2. **Licensed Provider Assessment:**
 - a. **NONVIOLENT RESTRAINT:**
 - i. The Licensed Provider with restraint privileges must perform a complete assessment of the patient's situation regarding the need for restraint. Consider information obtained during the patient's initial assessment regarding any prior existing medical or psychological information that could place patient at increased risk during the use of restraint. The decision to use a restraint is not driven by diagnosis, but by a comprehensive individual patient assessment. For a given patient at a particular point in time, immediately prior to

writing a restraint order, this comprehensive individualized patient assessment is used to determine if there is a clinical justification that warrants the use of restraint. If the patient remains in restraint for more than 24 hours after the original order, the provider will re-evaluate the need for restraint on a daily basis until the restraint is discontinued.

b. **VIOLENT OR SELF-DESTRUCTIVE RESTRAINT:**

- i. The Licensed Provider with restraint privileges must conduct an in-person face to face physical and behavioral assessment of the patient within 1 hour of the initial restraint order to control violent or self-destructive behavior. This assessment will include an evaluation of the patient's immediate situation, patient's reaction to the restraint intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint. If a patient's violent or self-destructive behavior resolves and the restraint intervention is discontinued before the provider arrives to perform the face to face evaluation, the provider is still required to see the patient face to face and conduct the evaluation within 1 hour after the initiation of the intervention. If the patient remains in restraint for the management of violent or self-destructive behavior 24 hours after the original order, the provider must see the patient and conduct a face to face re-evaluation before entering a new order for the continued use of restraint.

3. Restraint Orders

a. **NONVIOLENT:**

- i. If the need for restraint is identified, a Licensed Provider with restraint privileges may order restraints. The Licensed Provider will provide information on the patient's physical and psychological condition, and will direct the staff in the following:
 1. The type and number of restraints to be used
 2. The limb(s) to be restrained
 3. The duration of the order if shorter than the maximum allowed
 4. Ways to help the patient regain control in order for restraint to be discontinued
- ii. If the ordering Licensed Provider is not the attending physician, the ordering provider (e.g. APRN-NP, PA, consulting psychiatrist or psychologist) will notify the attending physician of restraint initiation.
- iii. Orders entered in the EMR in accordance with this policy to address a patient's medical care related safety needs that are evidenced by nonviolent behavior are considered in full force and effect for up to 72 hours from when the initial order was entered in the EMR. If the patient remains in restraint for more than 72 hours, then a new order must be entered in the EMR.
- iv. A temporary release of nonviolent restraint that occurs for the purpose of caring for a patient's needs (including range of motion, food/nutrition, elimination, and hygiene) by an adult caregiver is not considered a discontinuation of restraint. The caregiver's supervision serves the same function as the restraint, and therefore does not require a new order. If a parent/guardian will supervise the patient without staff in attendance, staff will educate parent/guardian how to supervise the patient using the Restraint Teaching Sheet.
- v. A new order is required if at any time, restraints are discontinued and then restarted.
- vi. An order for an enclosure bed used as a nonviolent restraint is required by the provider upon initiation and will serve as the active order until the enclosure bed is discontinued.

b. **VIOLENT OR SELF DESTRUCTIVE:**

- i. If the need for restraint is identified, any Licensed Provider with restraint privileges may order restraints. The Licensed Provider will provide information on the patient's physical and psychological condition, and will direct the staff in the following:
 1. The type and number of restraints to be used
 2. The limb(s) to be restrained
 3. The duration of the order based on age parameters
 4. Ways to help the patient regain control in order for restraint to be discontinued

- ii. If the ordering Licensed Provider is not the attending physician, the ordering provider (e.g. APRN-NP, PA, consulting psychiatrist or psychologist) will notify the attending physician of restraint initiation.
- iii. An order for restraint must be obtained by the Licensed Provider during the emergency application of restraint or immediately after (within 20 minutes of) the restraint being applied.
- iv. Restraint order must be renewed based on the following timeframes (up to a maximum of 24 hours):
 1. 4 hours for adults 18 years of age or older
 2. 2 hours for children and adolescents 9 to 17 years of age
 3. 1 hour for children under 9 years of age
- v. The administrative coordinator and clinical manager or Director of the area are to be notified of situations in which restraint use is extended beyond 12 hours or the patient experiences two or more separate episodes of restraint within 12 hours.
- vi. A new order is required if at any time, restraints are discontinued and then restarted.

4. Restraint application

a. NONVIOLENT:

- i. Apply soft limb restraint by sliding sleeve on to appropriate limb taking care to ensure that anatomical position of limb is correct. Tighten restraint on limb so that at least 2 fingers can be inserted under the restraint to prevent constriction. Secure restraint to bed frame (not to side rails) using quick release tie. Confirm that skin integrity, skin color, temperature, and sensation are appropriate.
- ii. Apply enclosure bed by placing the patient in the bed, and zipping the bed enclosures.

b. VIOLENT OR SELF DESTRUCTIVE:

- i. In an emergency application situation, the RN can apply soft limb restraints to control violent or self-destructive behavior based on assessment of the patient.
- ii. If soft limb restraints are needed for a violent self-destructive patient based on assessment, apply the restraint by sliding sleeve on to appropriate limb taking care to ensure that anatomical position of limb is correct. Tighten restraint on limb so that at least 2 fingers can be inserted under the restraint to prevent constriction. Secure restraint to bed frame (not to side rails) using quick release tie. Confirm that skin integrity, skin color, temperature, and sensation are appropriate.
- iii. If hard limb restraints are needed based on assessment, Security Officers will be responsible for application of these restraints. Clinical staff will notify Security of the need to apply hard limb restraints.
- iv. Twice as Tough (TAT) hard limb restraints will be applied in accordance with the manufacturer's guidelines.
 1. To apply TAT wrist restraints (the blue cuffs):
 - Begin by ensuring the lock on the connecting strap is unlocked. The strap will be locked to the bed prior to placing the patient's wrists in the cuffs.
 - Bring the end of the long connecting strap down through the inside of the side rails so it does not interfere when the side rails are raised.
 - Wrap the connecting strap under a moveable part of the bed frame on the inside of the frame.
 - Thread the end of the strap over the top of the frame making a loop around the frame.
 - Bring the strap up and thread through the lock (the strap will now be on the outer part of the bed frame).
 - Click the lock shut.
 - Apply the cuff to the patient's wrist. Wrap the neoprene piece (the blue

side should be positioned against the skin) around the wrist.

- Attach the black hook and loop pieces together, followed by the blue hook and loop pieces. Be sure to overlap at least one inch. Slide one finger (flat) between the cuff and the inside of the patient's wrist to ensure proper fit. The cuffs must be snug enough to prevent escape, but not interfere with circulation.
 - Bring the end of the limb cuff strap (the short strap) over the top of the cuff through the two "D" rings.
 - Bring the strap back over the first ring and between the two "D" rings. Insert two fingers under the cuff strap and pull tight but not so snug as to not interfere with circulation.
 - Repeat on the other side.
 - To unlock, insert the posey key into the lock and turn it counter clock wise.
2. To apply TAT ankle restraints (the red cuffs):
- Begin by ensuring the lock on the connecting strap is unlocked. The strap will be locked to the bed prior to placing the patient's ankles in the cuffs.
 - Bring the end of the long connecting strap down through the inside of the side rails so it does not interfere when the side rails are raised.
 - Wrap the connecting strap under a moveable part of the bed frame on the inside of the frame.
 - Bring the strap up on the outside of the frame and thread through the lock.
 - Click the lock shut.
 - Apply the cuff to the patient's ankle. Wrap the neoprene piece (the red side should be positioned against the skin) around the ankle.
 - Attach the black hook and loop pieces together, followed by the red hook and loop pieces. Be sure to overlap at least one inch. Slide one finger (flat) between the cuff and the inside of the patient's ankle to ensure proper fit. The cuffs must be snug enough to prevent escape, but not interfere with circulation.
 - Bring the end of the limb cuff strap (the short strap) over the top of the cuff through the two "D" rings.
 - Bring the strap back over the first ring and between the two "D" rings. Insert two fingers under the cuff strap and pull tight but not so snug as to not interfere with circulation.
 - Repeat on the other side.
 - To unlock, insert the posey key into the lock and turn it counter clock wise.
3. Security Officers and a staff member on the unit trained and competent in violent self-destructive restraint will have a TAT restraint key to unlock, adjust, or remove the restraints.

5. Restraint Monitoring

a. NONVIOLENT:

- i. Patients in Nonviolent Restraint will be assessed by the RN every two hours for:
 - 1. Psychological Status
 - 2. Signs of compromised circulation and range of motion in extremity(s) restrained
 - 3. Skin Integrity
 - 4. Performance of range of motion in extremity(s) restrained
 - 5. Completion of nutrition and hydration needs
 - 6. Vital Signs (as appropriate)

7. Completion of hygiene and elimination needs
8. Readiness for discontinuation of restraints
- ii. Even if the patient is being supervised out of restraints, the RN must continue the applicable two hour assessments including:
 1. Psychological status
 2. Completion of nutrition and hydration needs
 3. Vital signs (as appropriate)
 4. Completion of hygiene and elimination needs
 5. Readiness for discontinuation of restraints
- iii. If the patient is going home in restraints, the RN must continue the two hour monitoring up until the patient is discharged.
- iv. Enclosure Bed Monitoring:
 1. Enclosure Beds do not restrict the movement of the patient's extremities, therefore focused limb assessments do not need to be completed.
 2. Enclosure Beds do have the potential of patient extremities becoming entrapped between the mesh and the bed frame. An Enclosure Bed check must be completed every two (2) hours. This check should include the visualization of all extremities, their free movement, color and appearance, and the absence of any apparent abnormal findings
- b. **VIOLENT OR SELF DESTRUCTIVE:**
 - i. Patients in restraint for violent or self-destructive behavior will be observed continuously by a staff member. Parents/guardians are not allowed to independently provide supervision of care. Patients will be assessed by the RN at least every 15 minutes for:
 1. Physical Comfort and psychological status
 2. Signs of compromised circulation and range of motion in extremity(s) restrained
 3. Skin Integrity
 4. Need for continuous observation
 5. Readiness for discontinuation of restraints
 - ii. Patients will be assessed by the RN at least every 2 hours for:
 1. Performance of range of motion in extremity(s) restrained
 2. Completion of nutrition and hydration needs
 3. Completion of hygiene and elimination needs
 4. Vital Signs (as appropriate)

6. Restraint Discontinuation/Removal

- a. Based on the Licensed Provider's order, restraints will be removed at the earliest possible time when the restraint is no longer clinically justified or when the patient demonstrates that he/she is no longer a danger to self or others.
- b. Restraints may be removed only by those staffs trained and competent in the type of restraint (soft limb or hard limb) being used.
- c. Restraint removal will be documented as described below.
- d. In the Med-Surg or CARES areas only, patients may be sent home with soft elbow splints (Welcome Sleeves) when medically necessary to protect a surgical treatment site such as following cleft palate repair. Prior to the patient's dismissal, patients/families will receive education relating to care of the patient in elbow splints at home.

DOCUMENTATION:

1. The patient's plan of care will be modified when the need for restraint is identified, by the creation/implementation of a patient goal and interventions to maintain safety and discontinue the restraint at the earliest possible time. The patient/family will be educated on changes in the patient's plan of care associated with the use of restraint. The patient's plan of care will be updated again when restraint is no longer indicated.

2. Discuss the need for restraint with patient and/or family to include purpose and required monitoring. Ensure patient/family teaching is documented, also indicating if family was not available.
3. If the parent/caregiver will be providing supervision to the patient during temporary restraint release for cares, provide them with a Restraint Teaching Sheet and document in the Education Activity
4. Initial Restraint Application both nonviolent and violent
 - a. Add appropriate flow sheet based on type of restraint (Violent vs. Non-violent)
 - b. Document that purpose and monitoring of restraints was explained to both the patient and family or note if patient is unable to comprehend or family unavailable.
 - c. The patient's response to the restraint intervention which is the patient's reaction/behavior to initial restraint application
 - d. Add restraint to patient's care plan
5. NONVIOLENT
 - a. Document the following at the start of the first restraint order (not every order)
 - i. Whether there is an order upon application of restraint(s).
 - ii. Less restrictive alternatives attempted
 - iii. Patient's response to restraint interventions
 - iv. Desired behaviors to discontinue the restraint
 - v. Clinical justification for the restraint
 - vi. Psychological status
 - vii. Restraint type, which extremities are restrained using the code I = Initiated
 - viii. Document restraint on the patient's care plan
 - ix. Document restraint education
 - b. Document the following daily
 - i. Less restrictive alternatives attempted
 - ii. Desired behaviors to discontinue the restraint
 - c. Assessment of the following must be performed at least every 2 hours and documented:
 - i. Clinical justification for restraint use
 - i. Psychological Status
 - ii. Assessment of the restrained extremity/extremities
 1. Skin
 2. Color
 3. Sensation
 4. Edema
 5. Range of motion
 - iii. Fluids
 - iv. Food/meal
 - v. Elimination
 - vi. Restraint type, which extremities are restrained, and release of limb restraints using the codes R = release/reapplied; S = released for supervised cares
 - vii. If the patient has an order to go home with restraints, the restraint documentation must be completed up until the time the patient is discharged.
 - d. When the restraint is discontinued document:
 - i. Restraint type, which extremities are restraint using the code D = DC'd no longer justified
 - ii. Update the patient's care plan
 - iii. Update education
6. ENCLOSURE BED:
 - a. Document the following when an enclosure bed is initiated:
 - i. Restraint type (enclosure bed) using the code I = Initiated
 - ii. Document restraint on the patient's care plan
 - iii. Document restraint education
 - b. Document the following every 2 hours while the enclosure bed is in use:

- i. Assessment of the extremities
 1. Skin
 2. Color
 3. Sensation
 4. Edema
 5. Range of Motion
 - ii. Fluids
 - iii. Food/meal
 - iv. Elimination
 - v. Restraint type (Enclosure bed), release of limb restraints using the codes R = release/reapplied;
 - c. When the enclosure bed is discontinued document:
 - i. Restraint type (enclosure bed) using the code D = DC'd no longer justified
 - ii. Update the patient's care plan
 - iii. Update education
7. VIOLENT OR SELF-DESTRUCTIVE
 - a. Document the following at the start of the first restraint order (not every order)
 - i. MD notified and order obtained. Insert a column in the EMR to denote the true time MD/LIP was notified and order obtained
 - ii. Less restrictive alternatives attempted
 - iii. Risk factors such as pre-existing medical conditions; physical disabilities; or history of sexual or physical abuse
 - iv. Patient's response to the initial restraint intervention
 - v. Desired behaviors to discontinue the restraint
 - vi. Precipitating factors – attach a note describing what led up to the restraint event
 - vii. Clinical justification for the restraint
 - viii. Psychological status
 - ix. Restraint type, which extremities are restrained, "Start"
 - x. Document restraint on the patient's care plan
 - xi. Document restraint education
 - b. Document the following at the start of each time limited order:
 - i. Order obtained
 - ii. Less restrictive alternatives attempted
 - iii. Desired behaviors to discontinue the restraint
 - iv. Clinical justification for the restraint
 - v. Psychological status
 - vi. Restraint type, which extremities are restrained, "Continued"
 - c. Assessment of the following must be performed every 15 minutes and documented:
 - i. Clinical Justification for restraint use
 - ii. Psychological Status
 - iii. Physical Comfort
 - iv. Assessment of the restrained extremity/extremities
 1. Color
 2. Skin
 3. Sensation
 4. Edema
 - v. Need for continuous observation
 - vi. Restraint type, which extremities are restrained, "Continued"
 - d. Assessment of the following must be performed every 2 hours and documented:
 - i. Range of motion
 - ii. Fluids
 - iii. Food/meal

- iv. Elimination
- e. Document as a comment or note any deviation from baseline assessment
- f. When the restraint is discontinued document:
 - i. Restraint type, which extremities are restrained, "DC'd no longer justified"
 - ii. Update the patient's care plan
 - iii. Update education

DOCUMENTATION REVIEW:

To support restraint documentation review to ensure all elements are present for compliance, a checklist for nonviolent and violent self-destructive restraints is attached to this policy in appendix A and appendix B.

PERFORMANCE IMPROVEMENT & REPORTING

Aggregate data from restraint episodes will be reported monthly to patient care Directors. This data will include, but not be limited to, review of appropriateness of restraint utilization, adequacy of patient assessment and reassessment, and number of days in soft restraint per unit. Data will be analyzed to identify opportunities for incrementally improving restraint use. Action will be taken as appropriate to:

- Ensure compliance with policies and procedures;
- Identify, develop and promote preventive strategies and the use of safe and effective alternatives; and
- Redesign patient care processes associated with restraint use, when possible.

An unexpected death that occurs while a patient is restrained; within 24 hours of discontinuance of such restraint, or when it is reasonable to assume that a patient's death is a result of restraint use, will be considered a potential sentinel event. Notifications and analysis will be completed according to Administrative Policy ADM041: Sentinel/Significant Adverse Event.

When the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the following procedure will be completed:

1. Maintain a log in the Performance Improvement Department that includes the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es) * for:
 - a. Any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient.
 - b. Any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient.
2. Document in the patient record the date and time that the death was recorded in the log.
3. Make the information in the log available to CMS, either electronically or in writing, immediately upon request.

REFERENCES:

The Joint Commission Comprehensive Accreditation Manual for Hospitals, 2016 Provision of Care Chapter

The Joint Commission Standards BoosterPak for Use of Restraint and Seclusion for Organizations Using Joint Commission Accreditation for Deemed Status 2013

Center for Medicare/Medicaid Services, State Operations Manual Appendix A- Survey Protocol, Regulations and Interpretive Guidelines for Hospitals; Rev. 78, 12-22-11

Nebraska Health and Human Services Regulation and Licensure. http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-175/Chapter-09.pdf; accessed December 21/2016

Original Implementation Date: 4/81

Responsible Approval Group: Clinical Practice Council

RESTRAINTS, USE OF

Codes: R = Reviewed, F = Form Change, P = Practice Change, W = Wording Change or Spelling, E = Equipment Change, C = Combining Two or More Procedures or Procedure/Policy, D = Deleted (place in historical file)																			
RW	6/95	W	12/97	RW	7/00	P	4/01	PW	3/02	WP	2/04	RWP	8/04	R	2/05	RW	11/06	W	2/07
RWC	4/09	W	6/09	WP	10/09	WP	11/09	WP	2/10	W	5/11	W	10/11	C	5/13*	RWP	6/15	RWP	3/16
WP	9/16	RWP	01/17																

* Combined with PTCR88h – Behavioral Restraints

Non-Violent Restraint Checklist	
Patient Name: Last, First	Patient MRN #
Patient Age:	Patient Room #:
Type of restraint used is documented and documented as "I" Initiated	Yes No
Restraint ordered by LIP and the type ordered matches the type you are documenting	Yes No
Less restrictive alternatives to restraint documented when initiated	Yes No
Patient's response to restraint interventions was documented when restraint initiated	Yes No
Desired behaviors to discontinue the restraint was documented when initiated	Yes No
Clinical Justification was documented when restraint initiated	Yes No
Psychological status documented when restraint initiated	Yes No
All assessment items documented (pink section) every 2 hours (NA if patient out of restraint within 2 hours)	Yes No NA
Restraint type "R" for release/reapplication; "S" for release for supervised care was documented every 2 hours (NA if patient out of restraint within 2 hours)	Yes No NA
Less restrictive alternatives are charted daily while restraint is applied (NA if patient out of restraint prior to next day)	Yes No NA
Desired behaviors to discontinue the restraint are charted daily while restraint is applied (NA if patient out of restraint prior to next day)	Yes No NA
MD/LIP renewal order present (every 72 hours for duration of restraint use) (NA if patient out of restraint prior to 72 hours)	Yes No NA
Time discontinued "D" documented at end of restraint episode, or "H" if patient goes home on restraints.	Yes No
Restraint education complete	Yes No
Restraint Care Plan documentation present (NA only if patient in ED)	Yes No NA

Violent Self Destructive Restraint Checklist	
Patient Name: Last, First	Patient MRN #:
Patient Age:	Patient Room #:
Type of restraint used is documented and documented as "Start"	Yes No
MD/LIP ordered restraint according to age parameter and the order matched the type of restraint you are documenting <ul style="list-style-type: none"> • 4 hours for adults 18 years of older • 2 hours for children and adolescents 9-17 years of age • 1 hour for children under 9 years of age 	Yes No
Less restrictive alternatives were documented when restraints initiated	Yes No
Risk factors were documented when restraints initiated	Yes No
Patient's response to restraint interventions was documented when restraints initiated	Yes No
Desired behaviors to discontinue the restraint was documented when restraints initiated	Yes No
Precipitating Factors that led up to the restraint was documented (a nursing note was added to explain restraint event)	Yes No
Clinical justification was documented when restraints initiated	Yes No
Psychological status was documented when restraints initiated	Yes No
Restraint education complete	Yes No
Restraint care plan documentation present (If patient admitted on a unit) - Added when restraints initiated and resolved when restraint discontinued	Yes No NA
MD/LIP completed face to face assessment within 1 hour of initiating violent restraint order	Yes No
MD uses smart phrase for the face to face assessment when documenting in progress note. The smart phrase will include necessary elements (the smart phrase is: violentrestraint): <ul style="list-style-type: none"> • Patient's immediate situation • Patient's reaction to restraint intervention • Patient's medical and behavioral conditions • The need to continue or terminate the restraint 	Yes No
Restraint monitoring requirements (physical comfort, color, skin, sensation, edema, continuous observation) were documented every 15 minutes (NA if patient out of restraint within 15 minutes)	Yes No NA
Restraint type was documented as "Continued" every 15 minutes (NA if patient out of restraint within 15 minutes)	Yes No NA
Restraint monitoring requirements (ROM, fluids, food/meal, elimination) were documented every 2 hours (NA if patient out of restraint within 2 hours)	Yes No NA
MD/LIP renewed the order every time the order expired according to age parameters (NA if no renewal order needed based on age parameters) <ul style="list-style-type: none"> • 4 hours for adults 18 years of older • 2 hours for children and adolescents 9-17 years of age • 1 hour for children under 9 years of age 	Yes No NA
Order obtained cell documented with every renewal order (NA if no renewal order needed)	Yes No NA
Less Restrictive Alternatives to restraints were documented with each renewal order	Yes No NA
Desired behaviors to discontinue the restraints were documented with each renewal order	Yes No NA
Clinical justification was documented with each renewal order	Yes No NA
Psychological status was documented with each renewal order	Yes No NA
MD/LIP completed a face to face assessment every 24 hours while patient in restraint	Yes No NA
All elements of face to face assessment are included in LIP's documentation every 24 hours while patient in restraint using the smart phrase for documentation in progress note (the smart phrase is: violentrestraint)	Yes No NA
Restraint was discontinued as soon as patient met criteria and documented as "D"	Yes No