Things to know about Restraints

- Restraints are only used at Children's Hospital & Medical Center in limited clinically appropriate situations when less restrictive methods of managing patient's movement don't work.
    - Examples of less restrictive methods include distraction, repositioning, swaddling, pain management, increased observation by staff/family
    - Identification of individualized patient stressors and implementing comforting interventions will assist in the prevention of a restraint event
    - Verbal de-escalation is a non-confrontational approach to the patient using redirection, problem-solving, and active listening and can be very effective in avoiding the need for restraint
    - Patients with acute change in condition or behavior should be assessed for underlying causes such as hypoxia, hypoglycemia, pain, or fever before considering restraints
    - Obtain pertinent information from patient/family that could cause adverse reaction to restraint if used—e.g. prior history of abuse, physical limitations such as spinal fusion
    - Physiological effects of restraint use may include dehydration, fractures, lower extremity edema, hypoxic encephalopathy, cardiac stress, breathing difficulties (often due to positioning), and death. Many of these effects are due to immobilization
    - Psychological effects of restraint use may include trauma, fear, agitation, combativeness
    - Calling "Disruptive Behavior" at 6911 summons Security to assist with a physically out of control patient

- Types of Restraints:
    - Nonviolent non self-destructive restraints are used to limit patient's movement in order to protect surgical/treatment sites when the patient cannot comprehend the consequences of their actions. Examples used at Children's include:
        - Soft wrist restraints to prevent extubation
        - Elbow splints to prevent removal of NG tube or disruption of surgical site for cleft lip repair
        - An enclosure bed used to decrease risk of harm related to confusion, agitation or inability to comprehend consequences of actions.
            - An 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
    - Violent or self-destructive restraints are used when patient becomes violent, aggressive, or combative, and is an immediate danger to self or others. Examples used at Children's include:
        - Soft wrist restraints to prevent the patient from trying to harm themselves
        - 4 point hard restraints when patient is kicking, biting, hitting at staff
    - The following are exclusions to restraints:
        - Adaptive/postural or protective devices such as customized wheelchair supports, high chair straps, protective helmets
        - Temporary procedural immobilization using child immobilization board or Velcro straps for radiology procedures
        - Forensic restraints such as handcuffs or leg irons which are managed by law enforcement only
    - Chemical restraints are medications given in addition to, or in replacement of, the patient's regular drug regimen to control extreme behavior during an emergency. 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 does not use medications for chemical restraint purposes.

- Ordering restraints:
  - Restraints must be ordered by a privileged physician or trained licensed independent practitioner after assessing the patient
  - Standing orders, orders for PRN (as needed) restraint, restraint orders that are signed and held, and order for restraints to be applied at a future date and/or time are not permitted
  - If a restraint is applied in an emergency situation, a verbal order may be taken by the nurse
  - If a violent self-destructive restraint is ordered, the practitioner must see the patient face to face within one hour of restraint initiation. 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 an in person re-evaluation before entering a new order for the continued use of restraint.
  - The documentation of the face to face assessment for violent self-destructive restraint will be entered into the appropriate dot phrase within a progress note in EPIC (.violentrestraint)
  - Violent self-destructive restraint orders must be renewed based on the patient's age
    - 4 hours for adults 19 years or older
    - 2 hours for children and adolescents 9-18 years of age
    - 1 hour for children under the age of 9
  - If a nonviolent self-destructive restraint is ordered, the practitioner must perform a complete assessment of the patient's situation regarding the need for restraint. If the patient remains in restraint for more than 24 hours after the original order, the provider will re-evaluate and document the need for restraint on a daily basis until the restraint is discontinued.
  - A nonviolent self-destructive restraint order is 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 nonviolent self-destructive restraint for more than 72 hours, a new order must be entered in the EMR.
  - Documentation of patient assessments must coincide with ordering and renewal

You must read the restraint policy and answer the following questions to demonstrate competency with restraints.

Restraint Self-Assessment:

1. Your patient requires elbow splints so they do not remove a pH probe. Which statement about the use of elbow splints is true?
   a. A physician order is required every 72 hours while the patient is in this nonviolent non-self-destructive restraint
   b. This would be considered a nonviolent restraint
   c. The restraint order must be discontinued when no longer indicated
   d. None of the above are correct
   e. All of the above are correct

2. Your patient, Charlie Brown, is a 14 year old patient admitted for medical management after a Tylenol overdose. The nurse calls to state that he has become verbally aggressive and is refusing his mucomyst treatments.

At this point appropriate interventions would NOT include:

   a. Hard restraint
   b. Re-direction

c. Clarification of behavioral expectations and limits
d. Utilize family and other support individuals to try to get compliance

3. By the time you arrive to assess the patient, Charlie threw his breakfast tray and is attempting to punch and kick the staff. A “Disruptive Behavior” has been called overhead and Security responded. Charlie has been placed in 4 point hard restraints.

Which of the following statements about violent restraints are true?

a. The patient’s physician or designated licensed provider must perform and document a face to face evaluation of the patient within one hour of restraint application
b. Charlie should be assessed for medical concerns that led to his acute behavior issue (such as hypoglycemia or hepatic encephalopathy)
c. Violent restraint orders must be renewed every hour to a max of 10 times by verbal order before a repeat evaluation must be done
d. Charlie should be assessed every 2 hours for his tolerance of the restraints
e. A & B only
f. All of the above

4. Documentation of the face to face assessment for a patient in a violent self-destructive restraint must include:
   a. Evaluation of the patient’s immediate situation
   b. Patient’s reaction to the use of restraint
   c. Patient’s medical and behavioral condition, including a complete review of systems, behavioral assessment, as well as review and assessment of the patient’s history, medication, most recent lab results, etc.
   d. The need to continue or terminate the restraint
   e. All of the above

5. It is best to ask the patient’s family to leave the room when restraints are used, as they may become upset to see their child restrained.
   a. True
   b. False

6. The following are examples of protective devices used for children EXCEPT:
   a. Protective helmets
   b. Bubble top cribs
   c. Straps on highchairs or wheelchairs
   d. Elbow splints

7. The best way to deal with a patient who is upset and yelling at staff is to:
   a. Let the charge nurse or administrative coordinator deal with him
   b. Use verbal de-escalation skills to talk to the patient in clear, simple and direct terms
   c. Yell back and tell him he is an overgrown brat
   d. Reassure the family that there are no underlying issues to address

8. Children’s Hospital does not use chemical restraint as defined by the state of Nebraska
   a. True
   b. False

9. Entering a restraint order for a future date and/or time is permitted
    a. True
    b. False