Banner Health

POLICY and PROCEDURE

TITLE: Restraint Use in Violent Situations			
Number: 12415		**Version: 12415.4**	
Type: Patient Care		**Author: System Restraint Policy Team (Mary Keenan)**	
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Facility: System			
Population (Define): Adults			
Replaces: System #5863, #7302; BTMC, #5774, #2102, #5968; McKee, #1797; #1798; #4867; BBWMC/BDWMC, #10877; NCMC, #2842; #2841; BHH, #2311; BDMC #5513, #5713; BGSMC #5875; WMC #11244; BDWMC #10879; BBWMC #10878			
Approved by: CNOs, BH System Practice Oversight Team			

TITLE: *Restraint Use in Violent Situations*

I. Purpose/Expected Outcome:

A. Use of restraint or seclusion may be required in emergency situations to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. This policy ensures that the use of restraint or seclusion will promote patient safety, rights, dignity and well-being and be in accordance with applicable Federal and State regulations.

B. This policy does not apply to:
   1. Use of drugs, such as sedatives, within standard dosing parameters for the patient's condition
   2. Restraint use in Non-violent Situations
   3. Patients with Forensic Correctional Restrictions
   4. Behavioral Health licensed units or departments

II. Definitions:

A. **Restraint:** 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.

B. **Alternative Interventions**: Preventive strategies and innovative actions that are intended to meet the patient's unmet needs and eliminate the cause of behaviors that put the patient at risk for restraint use.

C. **Restraint Use in Violent Situations:** Restraint or Seclusion used to manage violent or self-destructive behavior that poses an imminent danger to the physical safety of the patient, staff or others, regardless of the patient's location.

D. **Restraint Use in Non-violent Situations:** Restraints applied in situations where less restrictive interventions have failed to produce the desired behavioral change to protect the patient from interference with medical treatment or risk of physical harm.

E. **Seclusion:** Involuntary confinement of a person in a room or an area where the person is physically prevented from leaving. May only be used for management of violent or self-destructive behavior.

F. **Use of Drug as Restraints:** Medication used as a restriction to manage the patient's behavior or restrict movement and is not a standard treatment or dosage for the patient's condition.

G. **Code Gray (In Alaska – Code Violet):** The hospital code to assist with communication

of a violent situation involving threatening or violent behavior and summoning the security officers on duty.

H. **De-escalation techniques:** Interventions designed to reduce maladaptive and threatening behavior.

I. **Violent Behavior:** Behavior that may cause harm to self, staff members or others. Such as kicking, flailing, or punching

J. **Self-destructive Behavior:** Behavior that may cause self inflicted injury either intentionally or unintentionally. This does not include extubation or pulling out of lines or catheters.

III. Policy:

A. Staff shall promote the safety, rights, dignity and well being of the patients through alternative interventions whenever possible.

B. Use of a "PRN" order for restraint or seclusion is not acceptable

C. Violent restraint or seclusion of any kind will be an intervention of last resort to secure the physical safety of the patient, a staff member, or others. Restraints will be used in the least restrictive manner possible and will be discontinued as soon as possible.

D. A comprehensive training program will educate the staff in behavioral assessment and innovative alternatives to meet the patient's needs. This program will allow staff to practice and demonstrate competence in:
   1. Behavioral assessment
   2. Preventative strategies
   3. Alternative interventions, including de-escalation and deflection techniques
   4. Proper application of restraints
   5. The monitoring and care of patients in restraints, including supporting documentation

E. Only those members of the staff who have completed the training program may initiate use and care for patients in restraint or seclusion.

F. Additional training will be provided to a select group of registered nurses that equip them with the skill and competencies to perform the 1 hour face-to-face evaluation of patients, in accordance with applicable state and federal regulations.

G. All physicians and Licensed Independent Practitioners responsible for ordering restraints will be educated on hospital restraint policies during orientation to the facility and following adoption of any changes to the policy that impact Medical Staff.

H. Patients and their families/significant others will be educated about the reason for restraint or seclusion use as appropriate. Educational materials will be provided to identify alternatives and help reduce the use of restraint or seclusion.

I. Banner Health will comply with all mandatory reporting requirements pertaining to restraint-related adverse events.

J. Each facility will have a mechanism in place to identify and monitor restraint use.

IV. Procedure/Interventions:

A. Assessment and alternative interventions

   1. Identify behaviors that pose an imminent danger to the physical safety of the patient, staff or others. **(TRAINED STAFF)**
      a. If patient behavior is a significant change, notify physician immediately. There may be a physiological change that requires immediate intervention.
   2. Initiate a Code Gray (In Alaska – Code Violet), as appropriate, to communicate the need for Security Department assistance and other resources.
   3. Implement alternative interventions to de-escalate the situation, meet the patient's needs

and/or eliminate the cause of behaviors. (See Attachment A.)

4. Identify risk factors, including history of behavioral conditions, substance abuse, prior physical injury to self or others, physical or sexual abuse or stimulus that might be causing such behavior.
5. Consult with patient's physician if de-escalation techniques and/or other alternative interventions are not effective. Contributing factors, such as anxiety or withdrawal from substance abuse, may require medication orders.
6. Document the assessment, alternative interventions that have been implemented and the results.

B. Initiation of restraint or seclusion

1. Apply restraints under the supervision of a physician or RN. **(TRAINED STAFF)**
2. Obtain a written or documented verbal order prior to initiation of restraint or seclusion. If the need for restraint or seclusion occurs so quickly that an order cannot be obtained prior to the application of the restraint or seclusion, the order must be obtained either during the emergency application of the restraint or seclusion or immediately after (within a few minutes) the application of the restrain or seclusion.
   a. Each order for restraint or seclusion in violent situations must state the maximum duration of the restrain or seclusion according to the following limits.
   b. Age related time limitations for orders:
      i. Every four hours for patients age 18 and older
      ii. Every two hours for patients ages 9 through 17
      iii. Every one hour for patients less than age 9.
   c. Orders may be renewed if necessary up to a total of 24 hours in increments stated above.
3. Perform a face-to-face evaluation of the patient as soon as possible, but no later than 1 hour after the initiation of violent restraint or seclusion. **(PHYSICIAN, LIP, OR TRAINED RN)**
   a. If the use of restraint or seclusion is discontinued in less than one hour, a face-to-face evaluation must still take place.
   b. Include in the evaluation:
      i. The patient's immediate situation
      ii. The patient's reaction to the intervention
      iii. The patient's medical and behavioral condition
      iv. The need to continue or terminate the restraint or seclusion.
         (i) If the face to face evaluation is performed by a Registered Nurse trained according to the policy and procedure, the attending physician or other physician responsible for care of the patient must be consulted as soon as possible after completion of the 1 hour face-to-face evaluation.
4. See and assess the patient after 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, **(PHYSICIAN, LIP)**
5. Monitor the patient for appropriateness and necessity of restraints or seclusion, restraint safely applied, risks associated with the intervention, level of distress or agitation, cognitive status and vital signs if able to obtain **(TRAINED STAFF)**
   a. Restraint **or** Seclusion: Minimum of every 15 minutes, more frequent or continuous depending on assessment of patient.
   b. Restraint **and** Seclusion: Continual face to face monitoring.
   c. Continuous monitoring, and documentation of the following, includes but is not limited to:
      i. Patient's condition,

ii. Cognitive status
iii. Risks associated with the chosen intervention,
iv. Type of intervention used
v. Other relevant factors
vi. Circulation and range of motion in restrained extremities,
vii. Nutrition,
viii. Hydration,
ix. Hygiene,
x. Elimination,
xi. Comfort,
xii. Psychological status
xiii. Readiness for discontinuation of restraints.

6. Notify Family regarding initiation of restraint or seclusion if release obtained from patient. Minor patient's parents must be notified within 1 hour after initiation of restraint or seclusion. Provide educational from Krames.

C. Discontinuing restraint or seclusion
1. Discontinue restraint or seclusion at the earliest possible time, regardless of the length of time specified in the order.
2. Discontinue restraints based on criteria identified in provider orders. Restraint or seclusion may be discontinued under the supervision of an RN when one or more of the criteria are met.
   a. A minimum of two staff members will release locked restraints.
   b. Once restraint or seclusion is discontinued, further use constitutes a new episode and the procedure must start at the beginning including requiring a new order.

D. Quality improvement activities related to the use of restraint or seclusion:
1. Document all episodes of restraint on a restraint log/audit tool.
2. Review of restraint use will be conducted monthly by designated personnel and restraint trends will be reported via facility quality reporting structure.
3. Report all potential restraint-related adverse events and/or deaths will be using the incident reporting system.
4. Make a report to CMS per CMS guidelines for all deaths related to restraints **(PERSON/DEPARTMENT RESPONSIBLE)**.

V. Procedural Documentation:

A. Document the following in the medical record:
1. Physician's order for each episode of restraint or seclusion.
2. Initial assessment, including description of behavior that necessitated initiation of restraint or seclusion, alternative interventions used prior to initiation of restraint or seclusion and the effectiveness.
3. There must be written modification to the patient's plan of care addressing the use of restraints or seclusion.
   a. Findings of the 1 hour face-to-face evaluation of the patient, including:
   b. The patient's current situation;
   c. The patient's reaction to the intervention;
   d. The patient's medical and behavioral condition; and,
   e. The need to continue or terminate the restraint or seclusion.
4. Results of patient monitoring.

5. Reassessment of readiness for discontinuation of restraint or seclusion.
6. Significant changes in patient condition
7. **In the event of death:** Document in the patient's medical record the date and time of CMS mandatory reporting and to whom the report was made.
8. 15 minute checks are documented on the Observation Form.

VI. Additional Information:

A. An educational program provides the staff with strategies and alternatives to meet the patient's needs. This program allows the staff to practice and demonstrate competence in, but not limited to:
   1. Behavioral assessment
   2. Preventive strategies
   3. Alternative interventions
   4. Proper application of restraints
   5. Monitoring and care of patients in restraints, including supporting documentation
   6. First aid for non-licensed personnel

VII. References:

Federal Register/ Vol. 71, No. 236/ December 8, 2006/Rules and Regulations. Department of Health and Human Services, 42 CFR Part 482 Medicare & Medicaid Programs; Hospital Conditions of Participation: Patients' Rights; Final Rule.

Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH). (2009, June). Standards PC.03.03.01 to PC.03.03.21 and PC.03.05.01 to PC.03.05.19.

Park, M. and Tang, JH. Evidence-Based Guideline: Changing the Practice of Physical Restraint Use in Acute Care. (2007). *J of Gerontol Nursing*; 33(2): 9-16.

VIII. Other Related Policies/Procedures:

A. Restraint use in Non-violent Situations (Non-Violent Behavior)
B. Restraint Use in Behavioral Health

IX. Cross Index As:

A. Restraints

X. Attachments:

A. Appendix A: Alternatives to Restraints

ALTERNATIVES TO RESTRAINTS

Physical Modification Approaches to Reduce Restraint Use

1. Modify environment (e.g. increase/decrease lighting, establish wandering paths, disguise exits, room or bed change).
2. Adapt wheelchairs (e.g. wedge pillow, lap buddy).
3. Provide body props/postural enhancer (e.g. wedge pillow, lap buddy).
4. Install alarm/safety devices (e.g. bed or chair alarm).
5. Reduce unnecessary visual or auditory stimuli (e.g. eliminate buzzers, bells, intercoms, television, shut doors).
6. Personalize rooms.
7. Use secured unit (med/psych only).

Activity-Related Approaches to Reduce Restraint Use (Consider PT/OT consult)

1. Structure daily activities (e.g. utilize orientation boards in rooms).
2. Permit or encourage wandering/pacing.
3. Provide physical exercise (e.g. ambulating).
4. Provide appropriate assistive devices (e.g. cane, walker, wheelchair, slide board).
5. Provide appropriate stimulation/socialization (e.g. radio, TV, video).

Physiological and Nursing Care Approaches to Reduce Restraint Use

1. Evaluate underlying physical or psychological problems.
2. Evaluate sleep patterns.
3. Relieve pain.
4. Use appropriate footwear (e.g. slipper socks, supportive shoes).
5. Use eyeglasses, hearing aids, or dentures.
6. Adequate hydration (consider consult with Clinical Dietitian).
7. Relocate near nursing station.
8. Institute toileting schedule.
9. Implement repositioning techniques.
10. Schedule daily nap.
11. Reevaluate drug use/medications.
12. Take out of room as appropriate.
13. Provide frequent reminders and/or assistance to avoid a specific behavior.
14. Provide repeated reassurances.
15. Provide snacks.
16. Provide diversion/recreation (e.g. busy box).
17. All personal items within reach (e.g. water, hearing aide, glasses, dentures, Kleenex, call light, urinal).
18. Provide bath/shower/massage (e.g. back rub, foot rub).

Psychological Approaches to Reduce Restraint Use (Consider SS/CM consult)

1. Actively listen/explore feelings and perceptions of patient.
2. Encourage independence in other aspects of care.
3. Provide reality orientation (e.g. orientation boards, clocks).
4. Accept patient's perceptions of their reality.
5. Provide additional supervision and observation (e.g. family and friends to sit with patient).