BUSINESS TITLE	Version #: Version
Title: Restraints: Orders, Use, Assessment, and Documentation	

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Approver(s): Kevin McEwan and Kathleen Barnhill	Effective Date:
Department(s): Intensive Care Unit (ICU) and Psychiatric Unit	Next Review Date:

Purpose/Summary:

Purpose: To promote and maintain patient safety by educating all medical personnel about the use of restraints in the psychiatric unit.

Summary: This policy outlines that prior to the use of restraints alternative methods must be implemented to control the behavior of the patient, including the use of therapeutic communication, bed alarms, maintaining a non-threatening and calm environment, and one-to-one observation. When the use of alternative measures has been implemented and the outcome is determined to be unsuccessful or if the patient poses a serious harm to self or others, then use of mechanical restraints can be considered. For the appropriate use of restraints, it is necessary to receive written consent from the patient, perform a complete patient assessment, obtain orders that specify the precise time frames in which the restraints will be applied and how patients will be assessed, and provide accurate documentation regarding the reason for the restraint use and its overall effect on the patient's physical and emotional wellbeing.

Definitions:

- Patient: An individual admitted to the hospital for treatment and care (Idaho Office of the Administrative Rules Coordinator, 2020).
- Restraint: A restraint is a mechanical device used to immobilize and/or reduce movement that would result in self-harm or injury of an individual, including a four-point medical grade restraint (Idaho Office of the Administrative Rules Coordinator, 2020).
- Seclusion: Seclusion is involuntary confinement of an individual to a patient room or designated area (Idaho Office of the Administrative Rules Coordinator, 2020).
- Informed Consent: Informed consent is the patient's right to be updated on their health status, treatment care options, and the request to refuse treatment options (Idaho Office of the Administrative Rules Coordinator, 2020).
- Medical Order: Medical order is written, verbal, or telephone orders from authorized persons to other authorized healthcare providers (Idaho Office of Administrative Rules Coordinator, 2020).
- Alternative method: Solutions which are implemented prior to the use of restraints or seclusion to control the behavior of the patient, including the use of therapeutic communication, bed alarms, a calm environment, and one-to-one observation (Kisacik et al., 2020).

- Neurovascular Complications: The result of cell or tissue death as a consequence of prolonged use of mechanical restraints as evidenced by oedema, redness, numbness, increase in temperature, color change, and nerve damage (Ertugrul & Ozden, 2020).
- Medical Professionals: All licensed or certified anesthesiologists, anesthetists, physicians, nurse practitioners, therapists, therapist assistants, technicians, pharmacists, physiatrists, physician's assistants, podiatrists, psychiatrists, radiologic directors and technologists, radiologist, radiotherapists, registered nurses, social workers, speech pathologists, audiologists, Chief Executive Officers, administrators, dieticians, dentists, independent practitioners, practical nurses, unlicensed assistive personnel, medical records practitioner who advocate for and in behalf of patients (Idaho Office of the Administrative Rules Coordinator, 2020).
- Complete Assessment: Measuring and tracking vital signs, including heart rate, blood pressure, temperature, respiratory rate, and oxygen saturation as well as providing the patient with fluids and nourishment, occasions for toileting and/or elimination, periodic release of restrained limbs to offer range of motion and exercise for those limbs, and any additional care as needed through observation of the patient's current status (Idaho Office of the Administrative Rules Coordinator, 2020).
- Psychiatric Unit: A specialized unit within a hospital that is designated for diagnoses and treatment of patients with mental illnesses (Idaho Office of the Administrative Rules Coordinator, 2020).
- Behavioral Activity Rating Scale (BARS): A scale that divides patients into seven levels of agitation ranging from difficult or unable to arouse to violent and determines which type of treatment to implement based on the severity of agitation (Lubbe, 2017).
- Richmond Agitation and Sedation Scale (RASS): A scale that assesses a patient's degree of agitation and sedation ranging from unarousable to combative, especially in intensive care units (Ladjevic et al., 2021).
- Code White: A hospital-based coded message used for the management of agitated patients and to reduce the risk of exposure to workplace violence (Aydin & Ileri, 2021).

Goals and Objectives:

1. Provide thorough education and training to all medical professionals regarding various types of restraints, proper techniques to use when applying each restraint, and appropriate situations that would call for the use of a restraint.
2. Maintain the safety of all patients with restraints by performing a complete assessment.
3. Provide education to all medical personnel about alternative methods for restraint use.

The goals and objectives of this process interrelate to the hospitals goals and objectives as follows:
Quality: Thorough education and training ensures quality because it will help reduce variations on how each medical professional applies different types of restraints.
Providing the Exceptional Experience: A complete assessment provides an exceptional experience for each patient as it recognizes their individuality, and demonstrates respect for their beliefs and practices while also caring for their emotional, spiritual, and physical wellbeing.

Ensuring Our Future: Education about alternative methods will ensure our future because it recognizes the impact that restraint use has on each patient and aims to incorporate techniques that will reduce loss of control and dignity from the patient.

Equipment and Suitable Environment Needed:

- 4-Point medical grade restraints (Aydin & Ileri, 2021)
- Oxygen mask (Aydin & Ileri, 2021)
- Bed safety alarms (Aydin & Ileri, 2021)
- Blankets and/or sheets (Aydin & Ileri, 2021)
- Side rails (Aydin & Ileri, 2021)
- Restraint wheelchair (Visaggio et al., 2020)
- Seclusion room (Anderson et al., 2021)
- Seclusion bed (Chieze et al., 2021)

Procedure:

Overview	Details
Pre-Procedure	Step 1: Nursing staff should be trained and certified yearly or upon hire in the purpose, use, and monitoring of mechanical restraints. Step 2: Patient written consent for safety measures, including mechanical restraint, should be received to ensure patient wellbeing and safety. Step 3: All noninvasive de-escalating techniques and therapies have been implemented first and documented in the patient's medical chart. Step 4: Patient should be confirmed as a psychiatric patient and if chemical restraints are needed, see Madison Memorial Protocol. Step 5: Receive a written order for the use of the mechanical restraint from the patient's physician. No standing or PRN orders should be in place. Step 6: Assure no contraindications are present. Step 7: Collect vital signs, pertinent assessments, and ensure patient's comfortability prior to the administration of restraint. Step 8: Arrange for a RN or UAP to remain with the patient for the first 15 minutes after administration to check for respiratory distress or any immediate complications (Barton-Gooden, 2015).

Contraindication	Patients should be reassessed for eligibility of mechanical restraints if pregnant, burned or fractured extremities, extreme anxiety disorders, or poor skin integrity (Guvercin, 2018).
Precautions	Restraints should be in place for no longer than four hours at a time for adults eighteen and older. After four hours a renewed order will be needed and last no further than twenty-four hours (IDAPA 16, 2020). Teaching the use and benefits of mechanical restraints to patient family members will be performed before administration of mechanical restraints. Patients are at risk for cognitive decline, strangulation, poor circulation, respiratory distress, skin break down, reduced appetite, and behavioral or mental changes (Guvercin, 2018).
Procedure (+ Monitoring)	**Step 1:** Categorize the agitation as mild, moderate, or severe ● Mild ○ Agitated but cooperative ○ *eg)* Patient is redirectable or suggestible ● Moderate ○ Disruptive without danger to self or staff ● Severe ○ Excited delirium with or without danger to self or staff ○ life-threatening emergency ○ patient is acutely agitated—often w/ any combination of diaphoresis, tachypnea, hyperthermia, and incoherent ○ Impervious to pain or fatigue ○ "Superhuman strength" Optional: may use Behavior Activity Rating Scale (BARS) to categorize agitation (Lubbe, 2017). **Step 2:** De-escalation strategies other than physical restraint ● Verbal & Non-verbal de-escalation ○ Whenever possible, ensure a quiet, non-threatening environment that allows for a safe, one-on-one interaction with patients. ○ For the assigned staff: ■ Monitor own emotional response before & during interaction

- Maintain a safe distance for patients.
- Maintain non-threatening gestures to patients.

Step 3: Provide appropriate de-escalation care as categorized in Step 1

- Providing safe & effective physical restraint:
  - The goal of utilizing physical restraints is applying them as a temporizing measure and a last resort.

Step 4: Administer restraint as categorized in Step 1

<u>Moderate to Severe Agitation:</u>

- If necessary, call a Code White for the moderate - severely agitated patient (Aydin & Ileri, 2021).
  - ensure that calling a code white does not escalate the situation further. The initiation of a white code should be initiated in a calm manner so as to not provoke an already agitated patient.
- Criteria for a Code White may include:
  - acute, excited delirium
  - an immediate physical threat to self or staff
  - requiring multiple staff to restrain
- Administration of Restraint for the severely agitated patient
  - Place patient in the supine position whenever possible and elevate head of the bed to approximately 30 degrees
  - Use 4-point medical grade restraints
  - Ensure that the restraints are tied to the bed frame (not the side rails)
- Administration of a Restraint Chair as an alternative to 4-point medical restraint
  - Place patient into upright seated position
  - Secure proper placement of patient's legs, torso, elbows and wrists into the harnesses and straps
  - Staff may now ambulate the patient using the wheels of the chair as needed (Visaggio, 2020).
- Use of a Seclusion Room as a form of restraint and/or de-escalation of a moderately-severely agitated patient

	○ May be used when clinical judgement concludes that less restrictive interventions are insufficient or inappropriate to use ○ Patient must have a 1:1 ratio of staff when limited to the seclusion room (Chieze, 2021). <u>Mild Agitation:</u> ● Minimal restraints to consider: ○ Bed alarms ○ 3 side rails ○ Ensuring the presence of assigned staff at all times as a form of restraint. ○ Blankets and/or sheets to cover essential medical interventions so as to detour the Pt from interfering with them. Examples include: Foley catheters, IV's and NG tubes. ○ Sedative medications to alleviate the possibility of escalation to aggressive or violent behavior. ○ Oxygen masks may be used as a method to both oxygenate the patient and prevent biting ● Use of a Seclusion Room as a form of restraint and/or de-escalation of a Mildly agitated patient ○ May be used when clinical judgement concludes that less restrictive interventions are insufficient or inappropriate to use ○ Patient must have a 1:1 ratio of staff when limited to the seclusion room (Chieze, 2021). **Step 5:** Maintain and Monitor Physically Restrained patient ● Ensure safety for both patient and staff ○ Assign a qualified staff member to monitor the patient. Never leave the restrained patient alone. ● All interventions or assessments of restraints should be documented. ○ Assessments should be performed every 15 minutes to ensure safety and accountability (Balaji, 2019). ○ The patient's level of agitation can be monitored and documented using the

	Richmond Agitation and Sedation Scale (RASS) (Ladjevic et al., 2021).
Discontinuing	Step 1: The discontinuation of mechanical restraints must be done after four hours without a renewed written order, not to exceed twenty-four hours total (IDAPA 16, 2020). Step 2: Before removal, assess patients using the Richmond Agitation Sedation Scale (RASS) and need for a renewed order if not a 0 or 1+ rating (Balaji, 2019). Step 3: Assess for pain, toileting needs, pallor, pulse, and paresthesia after removal every 15 minutes, 30 minutes, and then hour. Step 4: Physician and nurse determine termination in mutual agreement. Step 5: Document removal and patient response. Report the findings and abnormalities to the primary health care provider (Fernandez-Costa, 2020).

Internal References:

See physical restraint policy in other units.

External References:

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Lubbe, D., Nitsche, A. (2017). Reducing assimilation and contrast effects on selection interview ratings using behaviorally anchored rating scales. *International Journal of Selection and Assessment, 27*(1), 43-53. https://doi.org/10.1111/ijsa.12230

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Requirements:

"All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff" (IDAPA 16, 2020). "Restraint and/or seclusion must be discontinued at the earliest possible time when the patient no longer presents an immediate risk of harm to self or others" (IDAPA 16, 2020).

Quality Assurance and Sustainability:

Quality assurance will be determined through training new employees on policy and procedures. This training will include evidence-based practice for the use of mechanical restraints and safety checks for patients that are ordered restraints. Healthcare staff will be trained on using therapeutic communication and alternative methods to de-escalate situations before using restraints.

Annual training will ensure health care staff competency in the use of restraints. The training will include how to apply restraints, perform safety checks for patients that are on restraints, and thorough charting on the application and patient response.

A quality assurance manager will supervise and review patient's charting where restraints were used during hospital admission, to identify and analyze complications resulting from the use of restraints. Quarterly, the manager will implement the necessary adaptations that would ensure patient safety and quality of care. Their job also entails organizing and executing annual training on appropriate mechanical restraint use and alternative methods needed for all medical professionals at Madison Memorial Hospital.

Disclaimer:

This is a resource to assist psychiatric unit medical professionals at Madison Memorial Hospital to carry out mechanical restraints; however, this does not ensure all patient safety. This policy does not apply in all circumstances. In some situations, policy may need adaptation.