RESTRAINTS

Provider Education

S. Mulcahey MS RN_BC Clinical Educator OTD 7/23/2020

Topics Included

- DNV Guidelines
- Definition of restraints
- Restraint Prevention and Alternatives
- Restraint Categories
- Restraint Types
- Restraint Application and Use
- Restraint Orders, Monitoring and Documenting

DNV Guidelines:

SR.1 All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, that is not medically necessary, or that is imposed by staff as a means of coercion, discipline, convenience, or retaliation. Each patient should be treated with respect and dignity.

SR.3 *At a minimum, physicians, NP, PA, Residents authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of the hospital policy regarding the use of restraint or seclusion.*

Review and be familiar with the following policies:

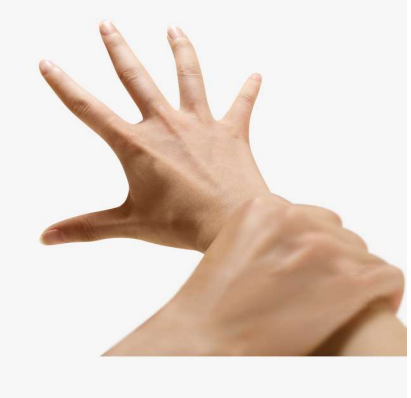
PSY R-06 Restraint and Seclusion Standards for Inpatient Psychiatric Units

CM R-13 Restraints Standards for Non-Psychiatric Patient Care Units

Restraint defined-CMS

Any manual method, physical or mechanical device, material, or equipment that:

- Immobilizes or reduces the ability of a patient to move his/her arms, legs, body or head freely.
- A drug or medication when used as a restriction to manage the patient's behavior or restrict the freedom of movement and is not a standard treatment or dosage for the pt's condition.



DNV Guidelines on Drugs Used as a Restraint

If the use of the medication for the patient meets the definition of a drug used as a restraint, the assessment, monitoring and documentation requirements apply. The use of PRN orders is prohibited for drugs or medications that are being used as restraints.

The standard is not intended to interfere with the clinical treatment of patients who need medication in appropriate doses that are standard medical or psychiatric treatment for the patient's condition. Medications such as the following are not considered restraints when based on the assessed needs of the particular patient with careful monitoring to minimize adverse effects:

- *Therapeutic doses of psychotropic medication for patients who are suffering from serious mental illness to improve their level of functioning so that they can more actively participate in their treatment.*

- *Therapeutic doses of anti-anxiety medications to calm the patient who is anxious.*

- *Appropriate doses of sleeping medication prescribed to treat insomnia.*

- *Appropriate doses of analgesic medication ordered for pain management.*

DNV GL Interpretive Guidelines and Surveyor Guidance Revision 18-2 (January 2019) http://www.upstate.edu/ihospital/intra/pdf/interpetiveguidelines18_2.pdf

DNV Additional Guidelines on Meds

A notation that certain medications are a standard treatment for a patient's medical or psychiatric conditions and are NOT subject to the requirements of the restraint standard is acceptable in the following circumstances:

- *The medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications it is manufactured and labeled to address, including listed dosage parameters.*

The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization.

- *The use of the medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's*

DNV Example:

"A patient has Sundowner's Syndrome, a syndrome in which a patient's dementia becomes more apparent at the end of the day than the beginning of the day. The patient may become agitated, angry, or anxious at sundown. This may lead to wandering, pacing the floors, or other nervous behaviors. The unit's staff find the patient's behavior bothersome and ask the physician to order a high dose of a sedative to keep him in bed. The patient has no medical symptoms or condition that indicates that he needs a sedative. In this case, for this patient, ***the sedative is being used as a restraint for staff convenience****. Such use is not permitted by the regulation. The regulation does not allow a drug to be used to restrain the patient for staff convenience, to coerce or discipline the patient, or as a method of retaliation."*

DNV Guidelines on Seclusion

SR.1c Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. A situation where a patient is restricted to a room or area alone and staff are physically intervening to prevent the patient from leaving the room or area is also considered seclusion.

Seclusion may only be used for the management of violent or self- destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

According to Upstate Policy CM R-13 and PSY R-06 Staff at University Hospital do not utilize seclusion outside of the Emergency Departments and the Inpatient Psychiatric Units

National Goals are to Work Towards Restraint Free Institutions

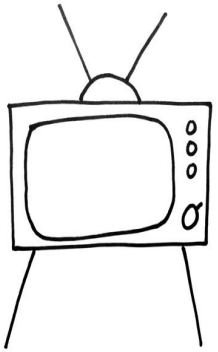
Restraint Preventive Measures

- Good communication with previous care providers (including family) about the patient's usual routine, behavior and care
- Organizational culture and structure to support restraint-free care
- Decrease invasive treatments, keeping patient informed of their care
- Develop relationships with families and arrange for family member to stay with the patient
- Consistency in care
- Proper surveillance
- Reduce confusion/noise and maintain appropriateness of the environment
- Flexible team approach based on dialogue among staff
- Utilize de-escalation techniques
- Positive and caring attitude of staff and providers

Try Alternatives to Restraints:

Any intervention or device that eliminates the need to use a restraint:

- Calming techniques
- Therapeutic relationship
- Diversional activities (TV, Video, Puzzles, Volunteers)
- Re-Orient
- Family
- Move patient closer to patient care station
- Place in hallway & frequent checks
- Safety & Fall Prevention Interventions
- Safety Companion or Sitter



Consider the following situations: Could you prevent restraints in some situations?

- The patient is pulling at tubes, lines, or dressings.
- The confused patient is interfering with the provision of care.
- The patient's actions are endangering him or herself.
- Patient is thrashing around in bed or attempting to get out of bed in a way or under conditions where it might cause harm.
- The patient's diagnosis or condition is such that he or she may unpredictably and suddenly awaken and harm him/herself.
- The intubated patient being weaned from anesthesia or at risk for self-extubation.

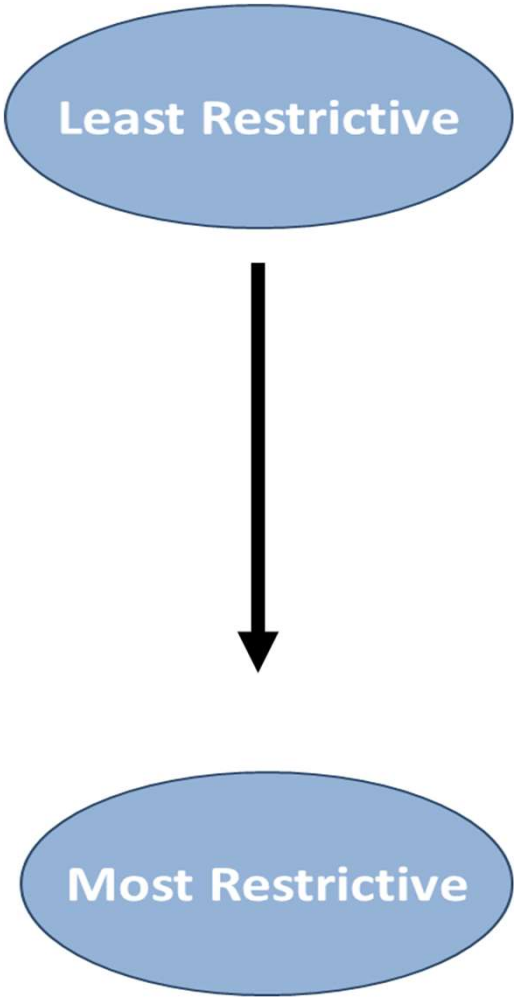
Alternatives to Restraints: Any intervention or device that eliminates the need to use a restraint. Some examples are lap belts that can be released by the patient, moving the patient closer to the nursing station, or utilizing a safety companion or family member to stay with the patient.

Categories:

- Acute Care/Non-violent/Non-Self-Destructive Patient: Patients who Interfere w/care that compromises their medical condition and safety but does not pose threat to others.
- Behavioral Health Care/Violent or Self-destructive Patient: Patients whose behavior poses an immediate threat to self or others.
- Inpatient Psychiatric Unit (IPU): Patients who are in IPU & those waiting transfer from ED.

Least to Most Restrictive Device

- Side rails
- Enclosed net bed
- Soft Padded Belt (not released by patient)
- Elbow Immobilizer
- Soft wrist or ankle restraints
- 4-point restraints soft limb restraints
- Twice-As-Tough-Cuffs Quick Release
- Twice-As-Tough-Cuffs for Stretcher



Who can order restraints?

- Non-Psych units- MD/NP/PA/Resident may order restraints
- Psych units- The licensed treating physician or resident may order restraints
  - Covid Update for PSYCH Units:

    During the declared CoVID-19 state of emergency, the requirements in NYCRR 526.4 (Restraint and Seclusion) requiring a physician for the order and the in-person, face to face examination of the patient for restraint or seclusion may temporarily be fulfilled by an order and an in-person, face to face examination by a licensed nurse practitioner or physician assistant.

How are restraints managed and patients monitored?

- RN monitoring differs depending on the age of the patient, type of restraint used and if the unit is a Psych or non-Psych unit.

See appropriate policies below for standards:

PSY R-06 Restraint and Seclusion Standards for Inpatient Psychiatric Units

CM R-13 Restraints Standards for Non-Psychiatric Patient Care Units

ACUTE CARE

NON VIOLENT

Restraint Orders: (Acute Care/Non-Violent)

- Proper restraint for situation
- In an EMERGENCY, RN may apply restraints –and will immediately notify provider for order
- Orders should not interfere with medical treatment or clinical condition.
- Orders must never be “standing orders” or “as needed basis”.
- Any change in the order requires a new order (additional or different type).
- Requires evaluation by the MD/NP/PA/Resident responsible for the patients care, within 24 hrs of initiation of restraint and before a new order.

Restraint Orders: (Acute Care/Non-Violent)

- If the original order for restraint was entered as a telephone order, the appropriate provider per policy, must conduct an in-person evaluation of the patient prior to countersigning order.

- A new restraint order MUST be completed at a minimum of q24h not to exceed one calendar day.

- All Restraint orders and evaluations will be documented in the EMR and include: Justification, factors, type & alternatives attempted prior.

- If the attending physician did not order the restraint, he/she must be consulted within 24 hours of the restraint application by the ordering physician, NP, PA or resident.

Please review the policy in the link below:

CM R-13 Restraints Standards for Non-Psychiatric Patient Care Units

BEHAVIORAL HEALTH

VIOLENT/SELF DESTRUCTIVE

Violent Restraints

- 4 point (wrists and ankle)
- Chemical
- Seclusion
- Physical Hold

Considerations:

- •Alternatives to restraints
- •Least restrictive device
- •Monitoring/injury prevention
- •Access to call light
- •Addressing underlying cause
- •Nutrition, hydration, toileting

Twice-As-Tough Cuff (Violent/Self Destructive)

- Used in **extreme circumstances** only for the highly aggressive, combative, or self destructive patient on non-psychiatric units.
- Less restrictive devices must be attempted prior to using this restraint (document).

Twice-As-Tough Cuff (Violent/Self Destructive)

- The procedure will be initiated by the RN
- The physician will be called immediately.
- Patient must be seen face-to-face by the provider responsible for the patients care within 1 hr after initiation of intervention. (Psych unit within 30 min and includes psych evaluation)
- When the restraint is not ordered by the patient's attending physician, the order must be followed by a consultation with the patient's treating physician as soon as possible.

ACUTE CARE

Psych Unit

PSY R-06 Restraint and Seclusion Standards for Inpatient Psychiatric Units

Please Review the policy in the Link Below:

PSY R-06 Restraint and Seclusion Standards for Inpatient Psychiatric Units

Key Points

- Prevention and use of alternatives to restraints is vital
- A drug or medication when used as a restriction to manage the patient's behavior or restrict the freedom of movement and is not a standard treatment for their medical or psychiatric condition is a restraint, and is documented and managed according to the restraint policy
- Verify that the rationale for restraint is described and the least restrictive technique was selected. Verify that staff attempted other less restrictive measures before applying restraint or seclusion.
- An order for restraint or seclusion is never to be written as a standing order or on an as needed basis (PRN).
- When the restraint or seclusion is not ordered by the patients attending physician, the order must be followed by consultation with the patient's treating physician as soon as possible.
- When the attending physician is unavailable, responsibility for the patient must be delegated to another physician, who would then be considered the attending physician
- The attending physician must be contacted prior to the expiration of orders for restraint or seclusion
- A temporary release that occurs for the purpose of caring for a patient's needs, for example, toileting, feeding, and range of motion, is not considered a discontinuation of the intervention.

Additional Points

- Each episode of restraint must be initiated in accordance with the order of the appropriate provider who is responsible for the care of the patient, and must include:
  - Clinical justification
  - Clinical factors
  - Type of restraint
  - Alternatives used
- Written modification to the patient's plan of care or treatment plan based on an assessment and evaluation of the patient.
- A patient will be released from seclusion or restraint as soon as he or she no longer presents an imminent risk of danger to self or others.
- Only the Physician or RN may determine that the restraint may be discontinued.
- If the restraint or seclusion is discontinued prior to the expiration of the order, a new order must be obtained prior to re-initiation of the restraint or seclusion.
- Evaluation must be documented in EMR by the provider and include: The patients immediate situation, reaction to the intervention, medical and behavioral condition and need to continue or terminate the intervention.

Thank you!!

References

DNV GL Interpretive Guidelines and Surveyor Guidance Revision 18-2 (January 2019) http://www.upstate.edu/ihospital/intra/pdf/interpetiveguidelines18_2.pdf

Hcpro. (2016). Cms restraint training requirements handbook. Place of publication not identified: Hcpro. Retrieved January 29, 2019.

Upstate Policies:

PSY R-06 Restraint and Seclusion Standards for Inpatient Psychiatric Units

CM R-13 Restraints Standards for Non-Psychiatric Patient Care Units