Restraint (Non-violent and Violent)

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PURPOSE

It is the policy of Trinity Health that all patients have the right to safe and dignified care, delivered by competent care providers, which includes unrestricted freedom of movement.

Restraints are not used as a means of coercion, discipline, convenience, or retaliation. Restraints are the last resort of physical management after a thorough assessment of the patient. Restraint may only be imposed to ensure the immediate physical safety of a patient, a staff member, or others and must be discontinued at the earliest possible time. Restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. It is only under limited specified circumstances that restricted freedom of movement may be required to prevent harm or to manage dangerous behavior. When required, the least restrictive method of restraint that meets the patient's assessed need is applied.

Trinity Health Michigan hospitals comply with the Michigan Patient Bill of Rights, the Michigan Public Health Code, the Michigan Mental Health Code, the Standards of The Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS).

Under this policy **a restraint does not include the following devices:** prescribed orthopedic devices; surgical dressings or bandages; protective helmets; other methods that involve the physical holding of a patient/patient body part for the purpose of conducting routine physical examinations or tests; to protect the patient from falling out of bed; or to permit the patient to participate in activities without the risk of physical harm (does not include a physical escort).

Refer to the specific site-specific policy for management of patients in restraints for violent behavior or seclusion.

SCOPE

All patient care areas with staff who are competent in providing restraint as an intervention.

DEFINITIONS

1. **License Independent Practitioner (LIP)—**For ordering restraint, a LIP is any practitioner permitted by State law and hospital policy as having the authority to independently order restraints for patients. NPs and PAs may independently order restraints for patients.

    - A resident who is authorized by State law and the hospital's residency program to practice as a physician can carry out functions reserved for a physician or LIP by the regulation. A medical school student holds no license, and his/her work is reviewed and must be countersigned by the attending physician; therefore, he or she is not licensed or independent. A medical school student is not an LIP.

2. **Alternatives to restraint**—Alternative interventions should be considered before the application of restraints and include, but not be limited to, the following:

Restraint (Non-violent and Violent)

- Collaborate with patient and family in treatment plan
- Bed or chair alarm
- Disguise or cover exposed lines/tubes/drains, or other equipment
- Decrease stimulation
- Provide diversionary activities
- Environmental modification
- Family staying with patient
- Frequent toileting
- Refocus attention
- Repositioning using pad/pillows
- 1:1 patient care
- Individualized care planning which attempts to correlate behavior with an unmet need
- Increased frequency of nursing rounds
- Limit distractions
- Medicate
- Move closer to nurses' station
- Pain management -comfort measures
- Promote normal sleep pattern
- Promote physical activity
- Re-orientation to surroundings
- Verbal redirection
- Re-evaluate equipment

3. **Physical Restraint**—Physical restraint is involuntary use of any manual method that restricts or immobilizes the ability of a patient to move his/her extremities, body, or head freely. These methods can include physical force, mechanical devices, or a combination of both. Note: Trinity Health ministries may choose to not utilize each of the various types of restraint. Approved restraints include:
    - Soft restraint/Velcro (wrist/ankle)
    - Soft mitt
    - Lap/pelvic/waist belt, including self-release lap belts* for patients who are unable to self-release
    - Net bed
    - Geri Chair (chair with table)
    - Wheelchair belt loop
    - Vest/jacket
    - Roll belt
    - Locking limb restraints (generally only used for violent/self-harm restraints except for extenuating circumstances)

    *Self-Release Lap Belts - Patients must be taught how to self-release the belts using a return demonstration by the patient, and the education must be documented in the electronic health record (EHR). Self-release Lap Belts are not considered restraints and use is only permitted in patients that are cognitively intact, and physically able to self-release the lap belt. Consider the intention for use.

4. **Medication (Chemical) restraint**—A drug or medication is deemed to be a restraint only if it is not a standard treatment or dosage for the patient's condition, and the drug or medication is a restriction to manage the patient's behavior or restricts the patient's freedom of movement. Using a drug to restrain the patient for staff convenience is expressly prohibited. The standard use of psychotherapeutic medication to treat a patient condition to more effectively and appropriately function may in fact reduce the need for restrictive interventions.

5. **Restraint used for non-violent, non-self-destructive behavior**—Restraints used for acute medical/surgical care that directly support medical healing and/or reduce potential of inadvertent self-harm or injuries are considered non-behavioral health restraints.
    - These physical or chemical restraints are used to limit mobility or temporarily immobilize a patient related to a medical or surgical procedure. It is used for non-violent or non-aggressive patients.

Restraint (Non-violent and Violent)

- Physicians, Nurse Practitioners, and Physician Assistants are all permitted to order restraints for non-violent, non-self-destructive behavior.

6. **Restraint used for violent or self-destructive behavior**—Restraints used for emergent situations that protect the patient against injury to self or others are considered behavioral health restraints.
    - These are used to protect the patient against injury to self or others related to behavior that is violent, severely aggressive, extremely agitated, or posing a risk to self or others.
    - Physicians, Nurse Practitioners and Physician Assistants are all permitted to order restraints for violent, self-destructive behavior.

SPECIAL CONSIDERATIONS

1. Restraint Standards **do not apply when**:
    a. The use of handcuffs or other restrictive devices are applied by law enforcement officials for security purposes.
    b. Using therapeutic holding or comforting of children during procedures.
2. Side Rails **are not restraint devices** when used to meet the patient's assessed needs as listed below:
    a. Patients who are sedated (including preoperative and postoperative)
    b. Whenever the bed is in high position.
    c. Seizure precautions.
    d. Any semi-comatose or comatose patient.
    e. When using for patient transport.
    f. When the patient needs assistance in turning and for leverage.
    g. The patient requests all four side rails be placed in the up position. This must be documented in the EHR.
    h. If the patient's durable power of attorney (DPOA) for healthcare (as documented in the medical record with a valid Advance Care Plan), or family member requests that all four side rails be raised, to keep the patient from getting out of bed or falling, this request should prompt a patient and situational assessment whether such a restraint intervention is needed.
        - If a need for restraint is confirmed, the practitioner must determine the type of restraint intervention that will meet the patient's need with the least risk and most benefit to the patient. If restraint is used, then follow policy.
    i. For pediatric patients:
        - Full use of side rails at night and whenever patient condition warrants.
        - With use of a crib for infants 6 months and older, the canopy must be down and secured.
        - Infants up to 15 pounds may be placed in a pediatric bassinet.

Use of all 4-side rails or 2 full side rails limit movement and may be considered a restraint. It is the intent with which you restrict someone's freedom of movement that determines whether the device is a restraint. If the intent is to prevent the patient from getting out of bed rather than simply from falling out of bed, and the patient cannot lower the side rails, the use of the side rails constitutes restraint.

3. **Physical holds and forced medications**—While the regulations permit the physical holding of a patient for the purpose of conducting routine physical examinations or tests, patients do have the right to refuse treatment. This includes the right to refuse a medical examination or tests. Holding a patient in a manner that restricts the patient's movement against the patient's will is considered restraint.

Restraint (Non-violent and Violent)

Physically holding a patient during a forced psychotropic medication procedure is considered a restraint. The use of force to medicate a patient, as with other restraints, must have a physician's order prior to the application of restraint (use of force). If physical holding for forced medication is necessary with a violent patient, the 1-hour face-to- face evaluation requirement would also apply.

4. Considerations for standard treatment, that does not fall into the category of Medication (Chemical) restraint. For a drug to be considered a standard treatment or dosage (i.e., allowable):
    1. Medication is used within pharmaceutical parameters approved by the Food and Drug Administration and the manufacturer for indications for which the medication is manufactured and labeled to address, including listed dosage parameters.
    2. Use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association/organization.
    3. 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 or other Licensed Independent Practitioner's knowledge of the patient's expected and actual response.
    4. Expectation that the standard use of a medication to treat the patient's condition would enable the patient to more effectively or appropriately function than would be possible without the medication.

PROCEDURE

1. **Alternatives to restraint**—Alternatives to restraints will be attempted and the response of the patient documented in the electronic medical record. If alternatives are unsuccessful the least restrictive method of restraint is utilized.
2. **Initiation of restraints**—The RN will perform an assessment of the patient to determine if there is a need for the use of a restraint. Use of physical restraint may be initiated before obtaining a physician's/Licensed Independent Practitioner (LIP) order when the assessment by the RN determines there is a need for immediate intervention to prevent the patient from harming self or others. In these situations, the physician shall be contacted as soon as possible for an order. While in restraints, patient rights, dignity, and safety are maintained.

    In the case of an emergency, security personnel may be requested to assist the team with applying restraints.

    Based on his/her continuing assessment of the patient, the RN will also be responsible for determining when it is clinically appropriate to discontinue and remove a patient from a physician/LIP ordered restraint.
    a. The individual RN caring for the patient is responsible for the correct, safe application of restraints and safety devices. The least restrictive type of restraint that meets the need of the patient will be tried first.
    b. For **non-violent, non-destructive behavior**, an evaluation between the physician/LIP and the patient will need to occur within **24 hours of initiation** of the restraints. Non-violent, non-destructive restraint orders will need to be renewed **every 24 hours** after an evaluation of the patient by a physician/LIP.
    c. For **violent or self-destructive behavior**, a face-to-face evaluation between the physician/LIP and the patient will need to occur within **one hour** of the initiation of the restraint.
        - The physician/LIP conducting a required evaluation must include an assessment of the following issues and document the evaluation findings in the patient's medical record:

Restraint (Non-violent and Violent)

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

- A physician/LIP restraint order to manage a patient's violent or self-destructive behavior must be renewed on the following scheduled:
  i. Adults 18 and older: every four (4) hours
  ii. Children aged 9-17: every two (2) hours
  iii. Children aged 8 and younger: every one (1) hour

Restraint (Non-violent and Violent)

Table 1 Initiation of Restraints

	Non-violent, non-destructive behavior	Violent or self-destructive behavior	Medication (chemical) restraint
Conditions for use	Applied for the primary reason to promote and support medical healing. (Grabs at tubes, dressings, etc.)	Emergent situations where there is imminent risk of a patient physically harming themselves or others. Other less restrictive means have not been effective.	
Initiation of restraint	Physician/LIP or Registered Nurse If the physician/LIP is not available, a registered nurse may initiate restraint in advance of a physician/LIP order. If the restraint was due to a significant change in the patient's condition, the physician shall be contacted as soon as possible for an order.	Physician/LIP or Registered Nurse A registered nurse may initiate restraint in advance of the physician/LIP order. RN will notify provider of restraint initiation as soon as possible, so that the face to face evaluation by the provider can be completed **within one hour.**	Registered Nurse will contact physician/LIP to discuss patient behavior and condition. Registered Nurse will administer prescribed medication, as ordered. **Note:** patients have a right to refuse medication, if patient requires physical hold, physician/LIP order is required.
If initiated by RN, notify physician/LIP to obtain order	As soon as possible	As soon as possible	Medication cannot be administered without physician/LIP order.
Evaluation	By physician/LIP within 24 hours of initiation of restraint, and then every 24 hours when a patient's restraint order is renewed.	Face to face by physician/LIP within one hour of restraint initiation and 24 hours for continued restraint use if restraint renewal orders are necessary.	Face to face by physician/LIP within one hour of restraint initiation/medication administration
Restraint Order Renewal	Every 24 hours and/or whenever a more restrictive restraint is needed, including more limbs. The order must match the restraint in use.	a. Every four (4) hours for adults 18 and older b. Every two (2) hours for ages 9-17 c. Every one (1) hour age 8 and younger d. The order must match the restraint in use	Medication (chemical) restraints are ordered as one time only.
Restraint discontinuation	As soon as no longer needed, a physician/LIP order is not required Document removal and behaviors POC is updated	As soon as no longer needed, a physician/LIP order is not required Document removal and behaviors POC is updated	Restraint is automatically discontinued once dose has achieved desired effect.

Restraint (Non-violent and Violent)

3. **Care of the patient in physical restraints**
   a. The RN shall complete the initial assessment upon initiation of restraints. Along with the RN the following individuals may participate in the care of the restrained patient.
      - License Practical Nurse (LPN)
      - Assistive staff such as: Patient Care Attendant (PCT/PCA) and Emergency Department Technician
   b. For non-violent, non-destructive behavior, patients must be observed minimally every two hours. All elements of the Restraint nonviolent flowsheet must be completed when restraints are applied and for all subsequent reassessment for the duration of the restraint use.
   c. For violent or self-destructive behavior, patients need to be monitored continuously. This is required regardless of the number of limbs restrained (2, 3 or 4), the type of limb restraint (soft or locked*) or the patient's location (inpatient versus ED). All elements on the Restraints (violent) Flow Sheet must be completed when the restraints are initiation and for all subsequent reassessments until discontinuation.
      - *Locked restraints are applied in the following manner:
        i. Secure straps to the metal portion of bed frame (Do Not secure straps to side rails) and lock.
        ii. Apply cuffs snugly to the appropriate limbs, per order
        iii. Allow 2-3 inches of slack to allow for movement
        iv. Place key near the patient and within easy reach of the staff (tape to Care Board in room, or place in Nurse Server)

Restraint (Non-violent and Violent)

Table 2 Care of the Patient in Restraints

Restraint (NV) Non-violent, non-self-destructive behavior	Restraint (V) Violent or self-destructive behavior

Documentation requirements upon **Initiation** of restraint—completed by RN
• Patient Behaviors leading up to restraint application (Psychosocial section of IP Assessment Flowsheet)
• Restraint Education (Work List task)
• Apply Care Plan template appropriate to the intervention
• Initiate Restraints (Work List task)
  ○ Restraint Order
  ○ Assessment
  ○ Justification
  ○ Restraint Monitoring
  ○ Restraint Type
	Documentation requirements upon **Initiation** of restraint—completed by RN
	• Patient Behaviors leading up to restraint application (Psychosocial section of IP Assessment Flowsheet)
	• Restraint Education (Work List task)
	• Apply Care Plan template appropriate to the intervention
	• Initiate Restraints (Work List task)
	  ○ Restraint Order
	  ○ Assessment
	  ○ Justification
	  ○ Restraint Monitoring
	  ○ Restraint Monitoring Care
	  ○ Restraint Type

Restraint (NV) Non-violent, non-self-destructive behavior	**Restraint (V) Violent or self-destructive behavior**

	Documentation requirements **every 15 minutes—** completed by either RN, PCT, or other nursing care assistant role that is BLS prepared
	• Restraint Monitoring
	  ○ Psychosocial Status
	  ○ Physical Comfort
	  ○ Circulation
	  ○ Continuous Observation

Documentation requirements **every 2 hours—** completed by either RN, PCT, or other nursing care assistant role that is BLS prepared
• Clinical Justification
• Restraint Monitoring
  ○ Visual Check
  ○ Circulation
  ○ Range of Motion
  ○ Fluids
  ○ Food/Meal
  ○ Elimination
• Restraint Type
	Documentation requirements **every 2 hours**—completed by RN, PCT, or other nursing care assistant role that is BLS prepared
	• Clinical Justification
	• Restraint Monitoring
	  ○ Psychosocial Status
	  ○ Physical Comfort
	  ○ Circulation
	  ○ Continuous Observation
	• Restraint Monitoring Care
	  ○ Range of Motion
	  ○ Fluids
	  ○ Food/Meal
	  ○ Elimination
	• Restraint Type

Door to the patient room will be kept open unless healthcare providers are in the room providing care.	

Restraint (Non-violent and Violent)

d. Monitoring and reassessment may permit the early termination of restraint. Staff may release restraint before the time limit based on reassessment. Restraints are discontinued when the patient can cooperate, is no longer a harm risk to self or others, is no longer interfering with the treatment sites, can ambulate safely without assistance or request assistance. Document discontinuation of restraints and rationale.
   - **Note:** if the restraint is reduced/partially removed, for example from 4 point to 2 point, this requires a new restraint order.

e. A new order is required for restraints if the restraint is removed before the expiration of the original order, but later needs to be reapplied (Exception: completion of ADLs, toileting, ROM, ambulation, and medical treatment), or if the patient's behavior requires a more restrictive type of restraint.

f. Restraint orders must not be written as a PRN order.

g. For patients who are in restraints for Violent or self-destructive behavior the patient will be made aware of behavioral criteria they must meet to have restraints discontinued. Staff will work with them throughout the restraint period to achieve criteria.

h. All patients in restraints will be provided verbal or written education materials.

i. A list of patients in restraints is documented in a central location on each nursing unit. This alerts staff in case of an emergency. In the event of evacuation, the staff member monitoring observation and physiological needs of the patient is responsible for removing the restraints and moving the patient to a safe location.

j. The inpatient RN is responsible for developing the care plan to incorporate the use of restraints and revise the care plan when the restraints are discontinued.

k. Clinical leadership (Nurse Manager or designee and/or Nursing Director, and Physician Leadership) are immediately notified any of the following:
   - The patient remains in restraint or seclusion for violent or self-destructive behavior for more than 12 hours
   - The patient experiences two or more separate episodes of restraint or seclusion or any duration within 12 hours
   - If either of these conditions continue, the clinical leader is notified every 24 hours

4. **Care of the patient in Medication (chemical) restraint**
   a. The RN shall complete and document the initial assessment upon initiation of restraints. Along with the RN the following individuals may participate in the care of the restrained patient.
      - License Practical Nurse (LPN)
      - Assistive staff such as: Patient Care Attendant (PCT/PCA) and Emergency Department Technician

   b. Monitoring and documentation
      - Describe the specific behaviors necessitating chemical restraint.
      - Monitoring of vital signs,
      - Level of Consciousness (LOC), and behavior each time a chemical restraint is administered, and then as clinically indicated or per ordered parameters.

5. Seclusion can only be done in designated patient care areas (e.g., Behavioral Health), refer to Behavioral Health Restraint and Seclusion policy.

6. **Performance improvement**—Restraint data is collected and incorporated into performance improvement activities. Data collection will be done to determine why restraint/seclusion is used and how use can be

Restraint (Non-violent and Violent)

decreased. Any deaths associated with restraint use will be reported by the Clinical Quality, Safety, and Risk Services to the Center for Medicare and Medicaid Services.

7. **Death in restraints**: **Centers for Medicare and Medicaid Services (CMS) reporting process**— The Quality Department will screen all deaths for the following criteria: Death of a patient associated with the use of restraints is a reportable event All deaths related to the following conditions should be reported immediately to Risk Management and the House Supervisor.
   a. Each death that occurs while a patient is in restraints or seclusion.
   b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
   c. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of the restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in the context indicates, but is not limited to, deaths related to restrictions of movement for prolonged period, or death related to chest compression, restriction of breathing or asphyxiation.

   After screening is completed—Each death referenced, except those deaths that occur while a patient is only in soft, 2-point wrist restraints must be reported to CMS Regional Office by telephone no later than the close of business the next business day following knowledge of the patient's death.

   For all reported deaths that occur while a patient is in soft, 2-point wrist restraints only, the following information will be captured on an internal log to be kept and maintained by the Quality Department.
   - Patient's name
   - Patient's date of birth
   - Patient's date of death
   - Date death reported
   - Name of attending physician or other licensed independent practitioner who is responsible for the care of the patient
   - Patient's medical record number
   - Primary diagnoses(es)
   - Deaths that meet the requirements for inclusion on the internal log must be recorded on that log within 7 days of the patient death
   - This log must be made available to CMS immediately upon request
   - Quality staff must document in the patient's medical record if the death was reported to CMS or recorded in the internal log

8. **Staff competence/training requirements**
   a. Education and competency assessment for the care providers regarding restraints will occur:
      - At orientation
      - Before participation in the use of restraints
      - On a periodic basis thereafter
   b. Education will include:
      - Hospital policy
      - Recognition of staff and patient behaviors, events and environmental factors that may trigger circumstances requiring the use of restraints
      - Use of non-physical intervention skills
      - Alternatives to using restraints,

Restraint (Non-violent and Violent)

- Method for choosing the least restrictive intervention based on an assessment of the patients medical or behavioral status or condition
- Safe and proper application and use including training on how to recognize and respond to signs of physical and psychological distress
- Assessment and reassessment that indicates that the restraint is no longer necessary
- Documentation of continued need for restraints
- Patient monitoring and care needs including observation, skin integrity, circulation and respiratory status, vital signs, and protection of patient's dignity, rights, and wellbeing.
- Ability to initiate emergency measures including cardiopulmonary resuscitation

c. Competency will occur for appropriate assistive patient care staff which includes CPR training. Educational activities will be planned based on changes in policy and quality improvement data.
   - Education and training are documented in HealthStream

REFERENCES

State Operations Manual, Appendix A - Survey Protocol, Regulations, and Interpretive Guidelines for Hospitals, (Rev. 176, 12-29-17)

The Joint Commission – Comprehensive Accreditation Manual

REVIEWER(S) AND DATE(S)

Lisa Friedman, Nursing Director—Employee Education	06/2024
TH MI Nursing Policy Council	06/2024

Restraint (Non-violent and Violent)

For the Patient's Safety
Restraints – Information Sheet

What is a restraint?
A restraint is any object or device that is used to limit movement or decreases the patient's ability to reach a part of their body. Restraints are only used to protect the patient from injuring themselves or others. There are several types of physical restraints. These include, but are not limited to soft wrist restraints, a soft lap belt, and soft hand mittens.

Why is my loved one in a restraint?
Restraints are applied only when needed to protect a patient or others from injury. All measures have been taken by staff to try and prevent the patient from being placed in restraints. However, if a patient is posing a safety risk to themselves or staff members physical restraints may be used.

When are restraints used?
- When patients are unable to follow instructions to maintain personal safety or safety of others.
- When patients are attempting to pull/remove or discontinue tubes, lines, drains or equipment.

What to expect while a patient is restrained:
- Restraints will be removed as soon as safely possible.
- A physician order is required when a patient is restrained. The physician must come and physically see the patient and the order is renewed as necessary.
- Restraints can sometimes be removed while family is present. It is very important to discuss this with the nurse before the restraint can be removed.
- A caregiver will check the patient every hour. Every two hours, the patient in restraints will be offered something to drink and asked if he/she needs to use the restroom.

How family can help?
- Spend time with your family member.
- Talk calmly and provide reassurance.
- Help caregivers understand the patient's needs and gestures.
- Help communicate information to the patient.
- Bring personal reminders/items from home.

These measures can sometimes help reorient the patient so that they are calm and able to come out of the restraints. If you have other suggestions that may help, please let the patient's nurse know.