Restraint and Seclusion

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Menu

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Objectives

1. Defines restraint and seclusion
2. Identifies factors that contribute to patient's harmful behavior
3. Describes alternatives to restraint and seclusion
4. Identifies clinical justification for restraint/seclusion use and discontinuation
5. Selects least restrictive methods
6. Lists components of a restraint order
7. Describes requirements for notification
8. Identifies appropriate changes to the patient's plan of care
9. Defines content and frequency of assessment and monitoring
10. Defines elements and frequency of documentation
11. Identifies when restraint or seclusion is discontinued
12. States death reporting requirements

Introduction

All patients have the right to be free from:

- Restraint or seclusion
- Inappropriate use of restraint or seclusion

Each patient is treated with *respect* and *dignity*

Introduction

Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient or others, and must be discontinued at the earliest time

Categories of Use

Non-Violent or Non-Self-Destructive	Violent or Self-Destructive

Definition

Centers for Medicare and Medicaid Services (CMS) defines restraint as:

- Any 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
- Drug or medication used as a
  - Restriction to manage the patient's behavior or
  - Restrict the patient's freedom of movement and
  - Is not a standard treatment or dosage for the patient's condition

Definition

Restraint is NOT

- A device associated with medical, dental, diagnostic, or surgical procedures based on *standard practice for the procedure*
- Medications that are standard treatment for the patient's condition

Examples:

- Medical immobilization
  - IV armboards
  - Orthopedic devices
- Adaptive devices
  - Head brace
  - Back brace
- Protective helmets
- Prisoner handcuffs

Definition

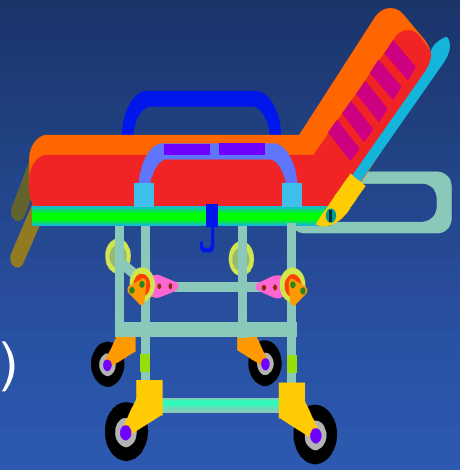
- Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.

- Seclusion may only be used for management of violent or self-destructive behavior

Definition

Side Rails

- Side rails are not considered to be a restraint if they protect the patient from falling out of bed. Examples:
  - Patient on stretcher (i.e. being transported)
  - Recovering from anesthesia or sedated
  - Experiencing involuntary movement (i.e. seizures)
  - Therapeutic beds (i.e. rotational beds)
- Four side rails raised to prevent a patient from exiting the bed is considered a restraint.



Patient Assessment

Assess patient to determine risk of harming self or others, and risk of emotional or physical injury if restraint or seclusion is used

Consider:

- Underlying causes of aggressive behavior
  - Medical and psychiatric condition
  - Emotional stress and psychosocial needs
- Patient history of physical or sexual abuse
- Your influence on aggressive behavior

Patient Assessment

Underlying Causes of Aggressive Behavior

Physical

- Inadequate pain relief
- Delirium - often due to infection, or electrolyte or metabolic imbalance
- Dementia
- Brain injury

Emotional

- Stress - related to hospitalization, illness of self or a loved one, grief or loss
- Family or spouse/partner dynamics that include threatening or abusive behavior

Patient Assessment

Underlying Causes of Aggressive Behavior

Psychiatric Symptoms

- Mania – can include impulsive behavior and unsafe choices
- Depression –often accompanied by irritability
- Psychosis
  - Paranoia – perceiving non-threatening people or objects as harmful
  - Delusions – distortions of reality which can result in anger if challenged
  - Hallucinations – sounds, sights, touch, or smell; can include sensations of being assaulted
- Personality Disorder – can include manipulative behavior, and sometimes willingness to harm self and others in order to achieve a goal

Patient Assessment

Effects of Sexual or Physical Abuse

- Increased feelings of vulnerability related to hospitalization
- Avoidance of being touched
- Heightened negative reactions to being touched, whether intentional or accidental
- Psychological harm of applying restraints may outweigh the benefits

Patient Assessment
Staff Influence on Patient Behavior

Verbal

- Statements that are:
  - Dismissive
  - Judgmental
  - Derogatory or Dehumanizing
  - Promises you don't intend to keep
- Tone of Voice - harsh, irritated
- Volume – too loud
- Rate of speech – too fast

Patient Assessment

Staff Influence on Patient Behavior

Non-Verbal

- Invading Personal Space
  - Usually 1.5 – 3 feet
  - Depends on preferences, culture, gender, mood
- Body Posture and Motion
  - Facial expressions – eye rolling
  - Gestures – finger pointing
  - Posture – arms crossed
  - Movements – fast, jerky

Patient Assessment

Patient Experience

From Patient Being Restrained

Themes:

- Restriction
  - Loss of freedom and control
  - Ability to move
- Discomfort
  - Decision to use
  - Physical pain r/t device
  - Not being able to eliminate

From Significant Other/ Relative

Themes:

- Anger
  - Use of restraint
  - How restraint applied
- Discomfort
  - Guilt
  - Degrading
  - Loss of progress

Alternatives

- Type of intervention used takes into consideration information learned from the patient assessment

Nonphysical techniques are always the preferred intervention!

Alternatives

- Verbal redirection – reminding patient of unsafe behavior as they are doing it
- Verbal de-escalation – verbally reducing the patient's level of agitation
- Distraction – engagement in an activity such as playing a card game, conversation, folding wash cloths, watching a movie, etc.
- Increased level of observation – more frequent checks, video surveillance, constant observation
- Role of family – ways to be involved in above (with patient permission and family agreement)

Alternatives

Preventing Patient Injury

Treatment Interference

- Attempting to pull out lines, tubes or equipment (e.g. nasogastric tube, endotracheal tube, IV, foley catheter)
- Implement preventive strategies
  - Cover or hide lines with sleeve
  - Secure tubes to patient's comfort

Alternatives

Preventing Patient Injury

Fall or Wandering Risk

- Implement hospital fall prevention program
  - Rounding/observation schedule
  - Mobility aids/assistance
  - Modify high risk environment & medications
  - Elimination schedule
  - Close proximity observation

Alternatives

Managing patient behavior

Behaviors that require intervention can escalate through a predictable pattern:

1. Anxiety
2. Defensive
3. Aggressive

First and best intervention is always verbal

Alternatives

Anxiety: a noticeable increase or change in behavior

- Signaled by irritability, pacing, finger drumming, wringing the hands, staring…

Intervention:

- Be supportive – empathetic, nonjudgmental
- Attempt to alleviate anxiety by addressing the need that the patient is trying to communicate to you

Alternatives

Defensive: the beginning stage of irrational behavior

- Patient is belligerent and challenges authority
  - "Who are you to tell me…"
  - "I'm not going to do that…"

Intervention:

- Take control of the situation
- Set limits that are clear, reasonable, and enforceable
- Give the patient choices, and time to make their choice

Alternatives

Aggressive: irrational behavior, loss of control

- Person becomes violent to self or others

Intervention: Self Protection

- Stand at least one leg-length away from the patient – outside striking distance
- Turn body at an angle – protects vulnerable frontal areas, less confrontational
- Put hands up to deflect strikes, establishes a limit for proximity
- Call for help, Code Green or Code Yellow

Last Resort

Restraint and seclusion is considered a last resort and only appropriate when the following criteria are met:

- There is imminent risk of harm to patient or others
- Alternatives are not a viable option or all appropriate alternatives have been tried and are ineffective
- Use is based on the patient's assessed needs - patient demonstrates clinical justification

Clinical Justification

Non-Violent or Non-Self-Destructive:

- Attempting to remove lines/ equipment
- Fall Risk
- Wandering Risk

Prevent patient injury

Violent or Self-Destructive:

- Attempting to harm -
  - Self
  - Staff
  - Others

Manage patient behavior

Methods

Least Restrictive:

The type or technique used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm

Match the type or technique with the patient's actual behavior and clinical justification

Methods

Methods are implemented in a safe and appropriate manner and in accordance with manufacturer's instructions.

- Elbow immobilizer
- Side rails
- Mittens with/without ties
- Enclosed bed
- Belts (lap belt, roll belt)
- Soft wrist/ankle
- Leather wrist/ankle
- Vest
- Medication
- Seclusion
- Physical hold

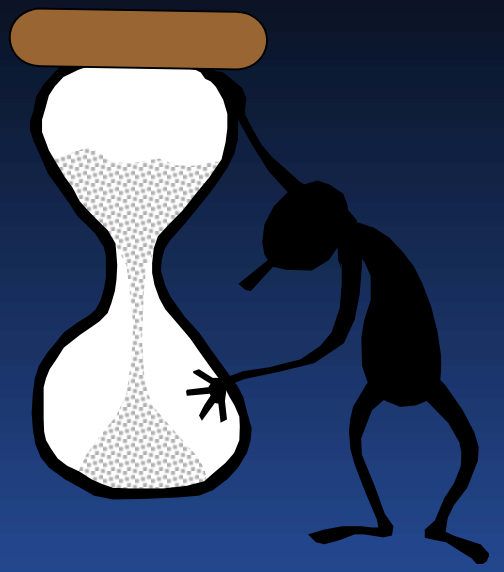
Orders

Restraint or seclusion use must be
the physician who is responsible fo
the patient

There are 3 components to the order:

- ☑ Clinical justification
- ☑ Method
- ☑ Time limit

Orders



Orders are time limited!

Non-Violent or Non-Self-Destructive:	Violent or Self-Destructive:
▪ Up to 24 hours	– 4 hours for age 18 or older – 2 hours for age 9 -17 – 1 hour for under age 9

Orders

- PRN and standing orders are prohibited
- If intervention is discontinued prior to expiration of time-limited order, a new order must be obtained if intervention is reapplied
- If the need continues beyond the time-limited order a new order is required

Notification

Notify the patient's attending physician as soon as possible if he/she did not order the restraint or seclusion intervention.

Notification of the attending physician:

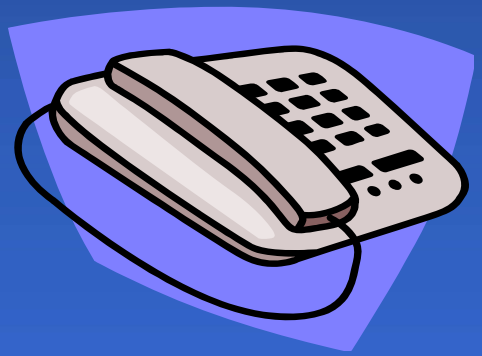
- Promotes continuity of care
- Assures patient safety
- Elicits information that might be relevant in choosing the most appropriate intervention

Notification

Non-Violent or Non-Self-Destructive

If RN initiates use of restraint when the physician is not available:

- Notify physician immediately
- Obtain written or verbal order as soon as possible



Notification

Violent or Self-Destructive

In situations where restraint or seclusion occurs so quickly that the order cannot be obtained before intervention:

- Notify physician and obtain order immediately after applying the intervention
- Notify patient's family (if patient consented to have family informed about his/her care)

Notification

Violent or Self-Destructive

Notify your manager immediately and every 24 hours thereafter for:

- Patients who remain in restraint or seclusion greater than 12 hours
- Patients who experience 2 or more episodes of restraint or seclusion of any duration within 12 hours

Manager assesses whether additional resources are needed to facilitate discontinuation or minimize recurrent use

Plan of Care

The use of restraint or seclusion is reflected in the patient's plan of care

- Consult with the physician to:
  - Treat underlying factors
  - Develop a plan for care
- Inform patient of reason why restraint or seclusion was initiated and criteria for discontinuation
- Educate patient and family (if appropriate) about use of restraint or seclusion
- Update in accordance with guidelines of care

Assessment & Monitoring

Assessment and monitoring are crucial for the prevention of patient injury or death

Assessment

- Assesses patient's condition (physical, emotional, behavioral)
- Ensures intervention is used only while unsafe situation continues
- Evaluates if intervention can be discontinued
- Ascertains if less restrictive methods possible

Monitoring

- Checks if restraint applied correctly
- Determines patient's well-being and safety
- Preserves patient's rights and dignity
- Provides opportunity to meet patient needs (comfort, positioning, nourishment, elimination, personal care)

Assessment & Monitoring

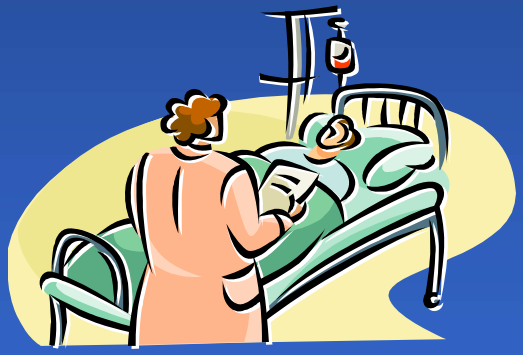
Methods for meeting the needs of patients in restraint or seclusion include observation, interaction or direct examination to:

- Assess the patient:

  Physical - vital signs, circulation, pain, skin integrity

  Emotional/behavioral – mental status, cognition, criteria/readiness for discontinuation of intervention

  Response to intervention – including trauma, distress, or injury related to intervention
- Perform range of motion and positioning
- Offer food and water
- Assist with toileting and personal care
- Provide privacy and comfort
- Assess if patient meets criteria for discontinuation



Assessment & Monitoring

Frequency of assessment and monitoring is individualized based on the patient's condition and risks associated with the intervention (especially vulnerable populations).

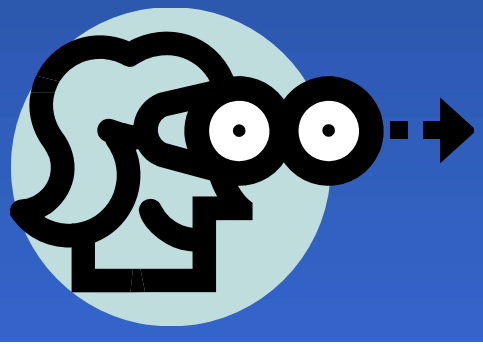
Minimum expectations are as follows:

Non-violent or Non-self-destructive:

- Perform every 2 hours

Violent or Self-destructive:

- Assess every 15 minutes
- Monitor continuously



Simultaneous use of restraint & seclusion:

- Continuous observation by trained staff in close proximity

Assessment & Monitoring

When restraint or seclusion is used for the management of **violent or self-destructive** behavior, a face-to-face evaluation must be performed within 1 hour of intervention.

Face-to-face evaluation is performed by:

- Physician
  -Reevaluates once every 8° (age 18+) or 4°(age ≤17) with continued use
- Registered Nurse or Physician Assistant who has received ***specific training to conduct face-to-face evaluation***

Assessment & Monitoring

Restraint characteristics that increase risk of injury:

- Supine position → *Aspiration*
- Prone position → *Suffocation*
- Patients with deformity → *Injury due to improper application*
- Split side rails (slippage) → *Entrapment*
- High vest/waist device → *Strangulation*
- Patients who smoke → *Fire*

Call for assistance!
-Rapid Response Team
-Code Blue
***

Assessment & Monitoring

Patient characteristics that increase risk of injury:

- Obesity → Own body weight prevents breathing
- Delirium, Dementia, Mental Illness → Unable to comprehend restraint, struggles until physical collapse
- Compromised Respiratory or Cardiac Function → Results in cardiac or respiratory failure earlier than other patients

Cessation of struggle against restraints and shallow or labored breathing can signal cardiopulmonary arrest…

Discontinuation

Criteria for removal of restraints MUST be made clear to the patient as part of the process of applying restraints.

- Criteria are reasonable and related to the behavior that required the application of restraints
- Verbal confirmation from the patient of understanding is essential
- If the patient is unable to process the information, re-orient them to the reason for restraint as necessary until they are able to understand or the restraint is removed

Discontinuation

Restraint or seclusion is discontinued at the earliest possible time, regardless of the length of time written on the order

Discontinue restraint or seclusion when:

- Assessment shows signs of physiological deterioration
- The psychological risks of restraint outweigh the benefits
- Identification of an alternative
- Criteria for discontinuation is met
- Clinical justification no longer present
- Patient becomes sedated or falls asleep

Discontinuation

- Discontinuing restraints, then reapplying them to the same patient requires a new order
- A “trial period” out of restraints is not allowed – restraints are either on or off!
- Temporary release for the purpose of providing care i.e. ROM, eating, toileting is NOT considered discontinuing order

Discontinuation

Violent or Self-Destructive

Patients are debriefed after each episode of restraint or seclusion:

- Includes staff members who participated in the intervention, the patient, and family (if appropriate)
- Occurs within 24 hours of episode
- Includes:

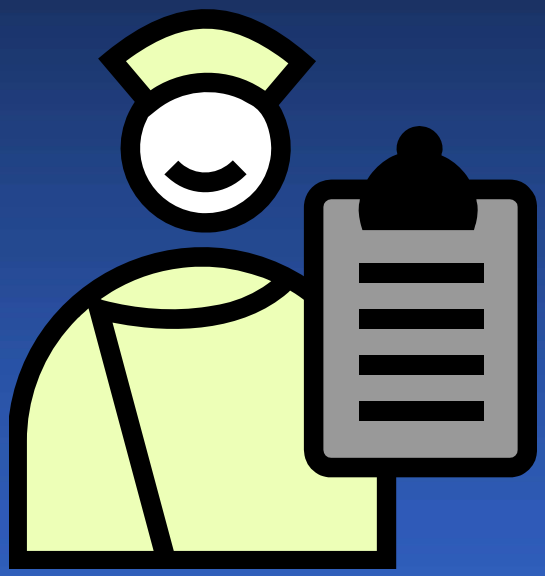
  - What led to use of intervention, what could have been done differently
  - Patient's well-being
  - Counseling of patient for any trauma from restraint
  - Modification of plan of care if indicated

Documentation

When each episode of restraint or seclusion is used, documentation in the patient's medical record includes:

- Alternatives/less restrictive interventions attempted Patient's behavior, condition, symptom(s) or circumstances that led to use of restraint or seclusion
- Intervention used, orders for use
- Patient's response to intervention(s) used
- Results of assessment and monitoring
- Physician and family notifications, patient debriefings
- Significant and/or unanticipated changes in patient's condition
- Rationale for continued use
- Criteria for discontinuing intervention

Documentation



Non-Violent or Non-Self-Destructive

- Document every 2 hours

Violent or Self-Destructive

- Document every 15 minutes

Death Reporting

Any death that is associated with the use of restraint or seclusion is reported to appropriate regulatory bodies

- Notify the Manager/Administrative Liaison (AL) of any death where it is reasonable to assume that the use of restraint or seclusion contributed to a patient's death

Summary

- Click here for link to http://sharpnet/nursing/upload/Restraint-and-Seclusion-Factoid.doc

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