

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER –
SHREVEPORT

RESTRAINT OF THE NONVIOLENT PATIENT

Purpose:

To provide guidelines regarding appropriate use of restraints on nonviolent patients.

Policy:

A. Physician Orders

1. A physician's order shall be obtained prior to application of restraints **except** in emergency situations as defined by Policy 5.15. No restraints shall be ordered unless the physician, after personally observing and examining the patient, is clinically satisfied that the use of restraints is justified to prevent the patient from removing tubes, lines/dressing or to protect the patient (i.e. support medical healing).
2. The order for restraint/seclusion shall be documented on the Physician's Orders (**SN1138**) by use of a restraint label (**SN 1221, SN 1283**), stamp, or by handwriting. Restraints shall not be ordered PRN or as standing orders. The physician who orders the restraints and/or the registered nurse that obtains a verbal/telephone order in an emergency shall document the following in the space provided:
 - a. Date and time of order
 - b. Type of restraint
 - c. Clinical reason for restraint
 - d. Restraint time frame refer to section "3" for time frame guidelines
 - e. Behavioral guidelines for early release of restraints if different from that listed in policy

- f. Monitoring requirements, if more restrictive than hospital policy, and
 - g. Signature of ordering physician
 - h. In the case of a verbal, the name of the individual who gave the order and who accepted it. The verbal order shall be read back to the physician.
3. Maximum Time frames for Physician orders
- a. The INITIAL restraint order is limited to 24 hours
 - b. RENEWAL restraint orders are valid for no longer than one calendar day (example: A renewal restraint order written today for one calendar day will expire at midnight tomorrow).
 - c. The physician must conduct a face-to-face reassessment to determine the continued need for restraint before writing a new restraint order.
 - d. The maximum time frame to obtain verbal order from physician – 12 hours after restraint initiation.
 - e. In an emergency, the physician must personally examine the patient, evaluate the need for restraint, and sign the restraint order within 24 hours of restraint initiation.
4. Assessment/Reassessment
- a. The RN shall modify the Plan of Care to reflect monitoring/care required for patients in restraints.
 - b. The patient's diagnosis, treatment, and health status dictates whether continual assessment, monitoring, and reevaluation is required while restrained or if the patient can be monitored and reassessed at regular intervals not to exceed every two hours for nonviolent medical-surgical patients. This determination is made based on the clinical judgment of the RN/physician.
 - c. Monitoring is accomplished by an RN/LPN via observation, interaction with the patient, or by direct

patient examination. Monitoring shall include evaluation of the continued need for restraints and a skin and circulatory assessment of the affected extremity. Assessments and interventions shall also be performed and documented at this time as appropriate to the type of restraint employed and may include:

- 1) Alternatives/less restrictive restraint interventions attempted and outcome/readiness for restraint discontinuation;
- 2) Whether the restraint has been appropriately applied, removed or reapplied, and signs of injury;
- 3) Assistance with ADL's (bathroom, food/fluids as permitted by the patient's medical regime);
- 4) Repositioning for comfort as possible;
- 5) Physical well-being, hygiene, dignity/rights maintained.
- 6) Level of distress/agitation;
- 7) Vital signs taken based on the patient's diagnosis, treatment, and health status, and/or
- 8) Changes in the patient's behavior or clinical condition needed to initiate the removal of restraints.

- d. The LPN notifies the RN/physician if the patient is ready for restraint discontinuation. The RN/physician makes the decision to discontinue restraints based on criteria listed in section "C" below.

B. Protocols for restrained patients leaving the unit/floor

1. If a patient in restraints needs to leave the floor/unit for a test/procedure, they leave the unit as close to the time of the test/procedure as possible and are accompanied by appropriately trained staff.

2. A minimum of a nursing assistant must remain with a restrained, nonviolent medical-surgical patient at all times while they are off the unit.

C. Restraint Termination

1. Restriction of patient movement or activity by restraints shall be terminated at the earliest possible time. This shall be based on observation and assessment that determines that the patient no longer needs the restraint to protect self or others, tubes/lines, or dressings have been discontinued, or behavioral guidelines ordered by the physician have been met and documented. The physician or RN or other licensed personnel makes the decision to terminate restraint use.
2. When restraint/seclusion is terminated prior to the expiration of the order, a new order must be obtained prior to reapplying the restraints.



Administrator

8/20/09
Date

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