Purpose:

To provide guidelines regarding appropriate restraint use for the medical well-being of nonviolent medical-surgical patients and unanticipated severely aggressive or destructive behavior that places the patient(s) or others in imminent danger.

Policy:

A. Restraint Philosophy

1. Louisiana State University Health Sciences Center – Shreveport strives to be a restraint-free environment. All patients have a right to considerate, respectful care at all times, with recognition of their personal safety, dignity, rights and well being.

2. Restraint use within the hospital is limited to those situations with adequate, appropriate clinical justification. Orders for restraint intervention are appropriate only after non-physical alternative measures have failed unless safety issues demand an immediate physical response. Behavioral health care reasons for the use of restraint are primarily to protect the patient against injury to self or others because of an emotional or behavioral disorder. Alternative measures may include, but are limited to: behavioral intervention, distraction, verbal de-escalation, communication using non-threatening body language/tone of voice, more frequent observation, environmental change (quiet surroundings), room change, comfort measures, obtaining family/sitter support, orientation to his/her surroundings, treatment change, night light, verbal calming techniques, obtaining a psychiatric consult, etc. Each episode of use is recorded along with the following:

   a. Events of the situation and start time;

   b. Alternative measures tried, and

   c. Patient’s response to the alternative measures

3. Emergency, pediatric and/or cognitively or physically impaired patients are closely assessed to determine if their presenting behavior is usually manifested in this manner, and/or if their behavior may harm themselves or others. If the patient’s presenting behavior is usual for the patient and they are not threatening themselves or others, then restraints shall not be utilized. If restraints are used in these situations, the physician and/or RN may determine that more frequent reassessment is indicated. (Referring to use of
4. The use of restraint is not based on an individual's restraint history or solely on a history of dangerous behavior. Restraints should only be used for as long as necessary to help a patient regain control of his behavior.

5. Staffing levels and assignments shall be set to minimize circumstances that give rise to restraint use and to maximize safety when restraint is used.

B. Policy Application

1. Restraint use to promote medical-surgical healing applies to patients of any age receiving pediatric, obstetrical and rehabilitative care. This includes those who are:

   a. hospitalized in an acute care hospital in order to receive medical or surgical services,

   b. in the emergency department for the purpose of assessment, stabilization or treatment for other than behavioral health reasons,

   c. in medical observation beds,

   d. undergoing rehabilitation as an outpatient or inpatient,

   e. undergoing same-day surgical or other ambulatory healthcare procedures, and/or

   f. receiving subacute services.

2. Restraint use associated with unanticipated, severely aggressive or destructive behavior applies to:

   a. patients with a behavioral health disorder in the emergency department for the purpose of assessment, stabilization, or treatment, even if awaiting transfer to a psychiatric hospital/unit,

   b. patients with a behavioral health disorder awaiting transfer from a non-psychiatric bed to a psychiatric bed/unit after receiving medical or surgical care,

   c. patients with a behavioral health disorder who are hospitalized in other than a psychiatric unit in order to receive medical-surgical services, and/or

   d. medical-surgical patients with severely aggressive or destructive behavior.
C. The following devices/situations are specifically excluded from requirements as set forth by this policy:

1. Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic or surgical procedures and the related post-procedure care processes. Such standard practices may or may not be described in procedure or practice descriptions. Examples may include, but are not limited to surgical positioning, radiotherapy, protection of surgical and treatment sites in pediatric patients, etc.

2. Devices utilized for forensic and correction restrictions for security purposes (i.e. prisoner shackles such as leg-irons, handcuffs, etc). Restraint use, related to the clinical care of a person under forensic or corrective restrictions does apply (i.e. prisoner patient requiring restraints related to clinical care (pulling lines, etc.) or who exhibits unanticipated severely aggressive or destructive behavior that places the patient(s) or others in imminent danger.

3. A voluntary mechanical support based on assessed patient need used to achieve proper body position, balance or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support.

4. Protective equipment such as helmets.

5. Restraint/seclusion for behavioral health purposes in patients hospitalized on the psychiatric unit.

6. Cribs with side rails raised in pediatric patients who are unaware of restrictions on their movement; and/or

7. Raised side rails in comatose, unresponsive patients.

D. Definitions

1. **Physical Restraint** is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient’s body that he or she cannot easily remove that restricts freedom of movement or normal access to one’s body. This is a functional definition and is not based on the device used. This definition does not apply to interactions with patients that are brief and focus on redirection or assistance in activities of daily living; such as hygiene.

2. **Chemical Restraint** is defined as a psychoactive medication that alters the patient’s sensorium for the purpose of restricting freedom of movement.
The use of any psychoactive medication that is not a usual or customary part of a medical diagnostic or treatment procedure, and that is used to restrict a patient’s freedom of movement, should be reported as a variance.

E. Guidelines for Restraints in Emergency Situation

1. An emergency is defined as an instance in which there is an imminent risk of a patient harming himself/herself or others, including staff; when nonphysical interventions are not viable, safety issues require an immediate physical response, and a physician is not readily available to conduct an assessment and write restraint orders.

2. If the MD is not available to order restraints in an emergency, a RN or other qualified licensed personnel (as cited in section G) based upon an appropriate assessment of the patient may initiate restraint use. The RN or licensed staff shall write documentation of the assessment findings and justification in the medical record. A verbal physician’s order shall be within a few minutes.

3. If initiation of restraint is based on a significant change in patient condition, the RN shall immediately notify the MD.

F. Least Restrictive Restraint Devices

1. The least restrictive restraint device shall be utilized. Manufacturer’s instructions for restraint application shall be followed. Generally, restraint devices are listed in order from least restrictive to most restrictive. However, restraint interventions should be tailored to the individual patient based on an assessment. Restrainment devices may include, but are not limited to, the following:

   a. Pediatric L-Bow, etc
   b. mittens without straps
   c. mittens with straps
   d. soft wrist restraints
   e. Posey vests
   f. Non-locking restraints
   g. locking restraints
2. Generally, a one-point restraint is less restrictive than two points; two-points are less restrictive than three; three-points are less restrictive than four; and four-points are less restrictive than five. One-point restraint generally refers to one extremity restrained; two-points refers to two extremities, etc. Five-points generally means a vest and four extremities are restrained.

G. Staff Education

1. Training for ALL STAFF who have DIRECT patient contact (RN, LPN, NA, Psyche Aide, PT/OT, Cardiopulmonary, UPD, Radiology Tech, etc.)

All staff that has direct patient contact shall receive ongoing education and training in the proper and safe use of restraints before they participate in restraint use. Those who apply mechanical restraints must have competency assessed and documented in their file. This education also covers alternative methods for managing behavior, symptoms and situations that have traditionally been treated through the use of restraints.

2. Additional training requirements for staff that manage restraint use in the patient with unanticipated severely aggressive or destructive behavior:

   a. Staff who are authorized to perform the 15-minute assessments (RN, LPN) also receive ongoing training and demonstrate competence in:

      1). assisting individuals in meeting behavior criteria for the discontinuation of restraint or seclusion;

      2). recognizing readiness for the discontinuation of restraint or seclusion; and

      3). recognizing when to contact a physician/START/code team/EMS to evaluate and/or treat the patient’s physical status.

   b. In addition to the above criteria, RN and other licensed staff who, in the absence of an MD, are authorized to initiate restraint or seclusion, and/or perform evaluations /reevaluations of individuals who are in restraint or seclusion in order to assess their readiness for discontinuation or to establish the need to secure a new order, receive training and demonstrate competencies for the specific task.

3. Training in first aid, CPR and EMS:

   a. An appropriate number of staff are available at all times who are competent to initiate first aid and CPR.

   b. The START and code teams and University Police are accessible at all times.
H. Patient/Family Education

As appropriate, staff shall make every effort to discuss the issue of restraint with the patient and/or family/significant at or around the time of restraint initiation.

I. Reporting Adverse Events

1. Staff shall complete a variance report for any injury or death that occurs while a patient is restrained, or where it is reasonable to assume that a patient’s injury/death is a result of restraint. Staff shall immediately notify the Administrator/Administrator On Call of any death that occurs while a patient is restrained or where it is reasonable to assume that a patient’s death is a result of a restraint. Refer to Hospital Policy #2.2 Variance Reporting/Sentinel Events for additional information.

2. The hospital shall report to the Centers for Medicare and Medicaid Services (CMS) Regional Office any death that occurs while a patient is restrained for the management of unanticipated severely aggressive behavior. This report shall be made by the next business day following the patient’s death. Staff shall document in the patient’s medical record the date and time the death was reported to CMS.

3. Patients who receive psychoactive medications that are not a usual or customary part of a medical diagnostic or treatment procedure, and that is used to restrict a patient’s freedom of movement are reported through a variance report.

[Signature]

Administrator

1/20/11

Date

Approved by Clinical Board 6/20/00, 1/12/01, 8/19/03, 7/18/06, 8/21/07, 1/18/11
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