| Institutional Handbook of Operating Procedures<br>Policy 09.13.06 | |
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| Section: Clinical | Responsible Vice President: Senior Vice President, Chief Medical & Clinical Innovation Officer |
| Subject: General Policies | Responsible Entity: Nursing Services |

## I. Title

*Initiating and Monitoring Restraints*

## II. Policy

The patient protections contained in this policy apply to all hospital patients when the use of restraint becomes necessary, regardless of patient location.

Restraints may only be used in accordance with written modifications to the patient's plan of care. The least restrictive form of restraint that protects the physical safety of the patient, staff, or others should always be used.

Restraints are:

1. Used only to protect the immediate physical safety of the patient, staff, or others;
2. Used only when less restrictive interventions are ineffective;
3. Not used as a means of coercion, discipline, convenience, or staff retaliation; and,
4. Discontinued at the earliest possible time, regardless of the scheduled expiration of the order. (A registered nurse (RN) who is competent in restraint usage may do this.)
5. UTMB does not use seclusion for management of violent or destructive behavior. **Seclusion does not include involuntary confinement for legally mandated but nonclinical purposes, such as the confinement of a person who is facing serious criminal charges or who is serving a criminal sentence.** (see IHOP Security Associated with Offender/Correctional Patients 08.02.07)

PURPOSE

To establish standardized decision-making criteria and practical procedures for the use and discontinuation of restraints to protect the patient's health and safety and the safety of others, as well as to preserve the patient's dignity, rights, and well-being.

SCOPE

Applies to staff members who provide patient care, who may assist with the application of restraints, and who monitor patients in restraints.

## III. Procedures

### A. Authorizing/Ordering Restraints

*Only a physician or other licensed provider (LP) does the following:*

1. Determines that all alternative interventions have been considered or have failed.
2. Assesses the risks and benefits of restraint use.
3. Orders the use of restraint when determined to be clinically necessary.
4. Includes the following details in all orders for restraint:

- Type of restraint
- Starting time
- Indications and reasons for use
- Criteria for release

Use of standing or as needed (PRN) restraint orders is prohibited. The use of PRN orders for drugs or medications is only prohibited when a drug or medication is being used as a restraint (*see definition for Chemical Restraint*).

## B. Emergency Situations Without an Available Authorized Physician or LP

*A qualified nurse does the following:*

1. Directs that the patient be restrained.
2. Notifies the physician or LP immediately and obtains an order. The failure to immediately obtain an order is viewed as the application of restraint without an order.
3. Keeps the patient under constant supervision until the physician or LP arrives.
4. Documents the following:
    - Name of the physician or LP who was notified
    - Time the physician or LP was notified
    - Alternative measures that were considered or attempted
    - Rationale for the restraint method used
    - Steps taken to ensure that the patient's needs, comfort, and safety were appropriately considered

*The physician or LP will do the following:*

1. Write an order for the restraint during the emergency application of the restraint.
2. Write an order for the restraint immediately after the restraint is applied if it is not possible to write the order during the emergency application of the restraint.

## C. Non-Violent Restraints (see Appendix A)

1. Orders

Non-Violent restraint orders remain in effect until the restraints are removed. At that time, the order is considered complete/ discontinued, and a new order must be obtained if it becomes necessary to re-apply the restraints.

2. Monitoring

Patients with Non-Violent Restraints must be monitored and assessed at least every two hours and interventions implemented as indicated.

Assessment and interventions will include the following:

- Reassessment of need
- Observed behavior
- Breathing
- Circulation

- Skin
- Physical comfort
- Range of motion
- Hydration/Nutritional needs
- Elimination

Document the following in the patient's medical record:

- Restraint activity (applied, continued, discontinued)
- Patient's response to placement of restraints
- Updated plan of care or treatment plan
- Assessments and interventions (at minimum every 2 hours)
- Any injuries sustained and treatment provided for those injuries

**D. Violent or Self-Destructive Behavior Restraints** (see Appendix B)

1. Orders

For Violent or Self-Destructive Behavior Restraints, the time limit is based on the patient's age. **This includes Chemical Restraints.**

*The Physician or LP will do the following:*
Each order for restraint used for the management of violent or self-destructive behavior may only be ordered and renewed in accordance with the following limits for up to a total of 24 hours:

- Every 4 hours for patient ages 18 and older.
- Every 2 hours for patients ages 9 to 17.
- Every 1 hour for patients under 9 years of age.

When the original order is about to expire and it is determined there is ongoing need for restraint, an RN must contact the physician or LP, report the results of his or her most recent assessment, and request that the original order be renewed (not to exceed the time limits established above). The original order may be renewed for a maximum of 24 consecutive hours.

After 24 hours, a physician or LP responsible for the care of the patient must see the patient and conduct a face-to-face re-evaluation before writing a new order for use of Violent or Self-Destructive Behavior Restraint.

A physician or LP responsible for the care of the patient must evaluate the patient in-person within one hour of the initiation of Violent or Self-Destructive Behavior restraints.

The face-to-face evaluation must include the following:

1. An evaluation of the patient's immediate situation;
2. The patient's reaction to the restraints;
3. The patient's medical and behavioral condition; and,
4. The need to continue or terminate the restraints.

The purpose of the evaluation of the patient's medical condition during the face-to-face evaluation is to complete a comprehensive review of the patient's condition to determine if other factors are contributing to the patient's violent or self-destructive behavior.

2. Monitoring

*A qualified designated staff member will do the following:*

Patients with Violent, or Self-Destructive Behavior Restraints are to have one-to-one continuous observation for safety and comfort by a member of UTMB's workforce who is trained in one-to-one continuous observation. The qualified designated staff member will document the patient's observed behavior every 15 minutes while maintaining continuous, unobstructed view of the patient.

*A qualified nurse will do the following:*

Patients with Violent or Self-Destructive Behavior Restraints must be assessed by a qualified nurse at least every two hours and interventions implemented as indicated.

Assessment and interventions will include the following:

- Reassessment of need
- Observed behavior
- Breathing
- Circulation
- Skin
- Physical comfort
- Range of motion
- Hydration/Nutritional needs
- Elimination

Document the following in the patient's medical record:

- Restraint activity (applied, continued, discontinued)
- Patient's response to placement of restraints
- Updated plan of care or treatment plan
- Assessments and interventions (at minimum every 2 hours)
- Any injuries sustained and treatment provided for those injuries

**E. Additional Care**

1. Monitoring of patients in restraints will be performed by a staff member who has completed the required restraint training and competency assessment.
2. Care is provided based on the assessed needs of the patient.
3. Patients transported off a unit must be assessed for needs by a qualified nurse and accompanied by an individual qualified to provide monitoring and care identified in the assessment.

**F. Safety**

1. Restraints must be initiated in a way to avoid undue physical discomfort, harm, or pain. Only a minimal amount of physical force may be used to implement restraints.
2. If a patient is restrained in a supine position, the patient's head should be free to rotate from side-to-side and, if possible, the head of the bed should be elevated to prevent risk of aspiration.
3. If a patient is restrained in a prone position, the patient's airway must be unobstructed at all times and the expansion of the patient's lungs not restricted.

**G.** Unacceptable Physical Restraints

- Locking devices
- Vests
- Kerlix/gauze
- Tape
- Rope or cord
- Rubber bands
- Sheets

**H.** An event report must be completed if an injury occurs to a patient while in restraints.

**I.** Emergency Apprehension and Detention (EAD) The University of Texas Medical Branch Police Department (UTMB PD) must be notified for assistance if law enforcement action is required.

1. UTMB PD should be contacted as soon as a patient is determined to be experiencing a mental health crisis.
2. A faculty physician must complete a clinical affirmation that describes why the patient is a threat to themselves or others.
3. The description must contain detailed information about what the patient did to be considered as concerning.
4. Once a qualified mental health facility has been located and the patient has been accepted, a UTMB police officer will complete an EAD and take appropriate action for the transportation of the patient to the facility.
5. The patient will need to be transported by Emergency Medical Services in the event the patient has a continuous medical need.

**J. Reporting**

1. The following information will be recorded in a log and reported to the Centers for Medicare and Medicaid Services (CMS) when required:
   a) Each death that occurs while the patient is in restraints;
   b) Each death that occurs within 24 hours after the patient has been removed from restraints; and
   c) Each death known to the hospital that occurs within one week after restraints are used when it is reasonable to assume that the use of the restraints contributed directly or indirectly to the patient's death.

2. Any patient deaths described above involving restraints other than soft two-point wrist restraints is reported no later than the close of business on the day following knowledge of the patient's death. This is coordinated through the Clinical Operations Administrator (COA) and Hospital Quality and Healthcare Safety Department. When a report is required to CMS, the date and time report is documented in the medical record.

3. An event report must be completed if an injury occurs to a patient while in Restraint(s). Refer to Unusual Event Reporting IHOP 09.13.13

4. If an injury occurs to a faculty member, trainee/student, or other member of UTMB's workforce, while managing a patient in Restraint(s), the applicable member of UTMB's workforce must complete an employee event report and a patient safety event report.

5. Any and all deaths associated with Restraint use are to be reported promptly to Risk Management and Patient Safety as well as the **Administrator on call**. A patient safety event report must be completed.

## K. Training Requirements

1. Physicians and LPs ordering restraints are required to have knowledge of UTMB restraint policy.

2. A registered nurse initiating restraints must complete the UTMB restraint training offered during orientation and maintain annual competency in restraints practice thereafter.

3. Clinical support staff involved in the application of restraints and the care/monitoring of patients in restraints must complete the UTMB restraint training offered during orientation and maintain annual competency in restraints practice annually thereafter.

## L. Exclusions

The following are excluded from the definition of restraints:

1. Devices used for security, detention, or public safety reasons on patients in forensic custody and those devices are not involved in the provision of health care. (See IHOP Policy 08.02.07 Security Associated with Offender/Correctional Patients;
2. A voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without mechanical support.
3. A positioning or securing device used to maintain the position, limit mobility or temporarily immobilize during medical, dental, diagnostic, or surgical procedures.
4. Methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of the bed. However, side rails are frequently not used as a method to prevent the patient from falling out of bed, but instead, used to restrict the patient's freedom to exit the bed. **The use of side rails to prevent the patient from exiting the bed would be considered a restraint**. When the clinician raises all four side rails in order to restrain a patient, then the requirements of this policy apply. Raising fewer than four side rails when the bed has segmented side rails would not necessarily immobilize or reduce the ability of a patient to move freely as defined in the regulation.
5. The brief physical holding of a patient without undue force, used as part of a behavioral plan for the purpose of providing emotional comfort and/or calming to the patient or physical safety to the client, other clients, staff member(s) or others; and
6. The use of cribs in age or developmentally appropriate individuals, infant snuggling or bundling for developmental purposes and use of side rails in response to medical interventions or physical condition to provide patient safety while not intending to restrict patient from getting out of bed.
7. In populations that use No-No devices, if the device limits freedom of movement or access to the patient's body (i.e., the No-No is tied down or if both arms have No-No's) it is considered a restraint and the restraint standards apply. However, if, while the No-No is in place, the patient still has freedom of movement, and the device is not tied down then it is not considered a restraint. It is considered a positioning device.

8. The use of non-bulky mitts when the mitt is secured only to the wrist and is not additionally secured to an immobile object, such as the bed or chair. However, if the mitts are applied so tightly that the patient's hand or fingers are immobilized, this would be considered restraint. Likewise, if the mitts are so bulky that the patient's ability to use their hands is significantly reduced, this would be considered restraint whether the mitt is tethered to an immobile object or not.

## IV. Definitions

Restraints: Any manual method, 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; or a drug or medication when it is 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 (also known as **Chemical Restraint**)

Restraint Types:

**Non-violent Restraints**: Used when patient interference with medical devices threatens the patient's plan of care, and the use directly supports the medical healing of the patient.

**Violent or Self-Destructive Behavior Restraints**: Used for violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.

**Chemical Restraint (Violent or Self-Destructive Behavioral Restraint Type)**: When a drug or medication is used as a restriction to manage the patient's behavior, restrict the patient's freedom of movement, reduce the patient's ability to effectively or appropriately interact with the world around them, and is not a standard treatment or dosage for the patient's condition.

Criteria used to determine whether the use of a drug or medication, or combination of drugs or medications is a standard treatment or dosage for the patient's condition includes:

- The drug or medication is used within the pharmaceutical parameters approved by the Food and Drug Administration and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters;
- The use of the drug or medication follows national practice standards established or recognized by the medical community, or professional medical associations or organizations;
- The use of the drug or medication to treat a specific patient's clinical condition is based on the patient's symptoms, overall clinical situation, and on the physician's or other licensed practitioner's knowledge of that patient's expected and actual response to the medication.
- The intent of the treatment is to allow the patient to better interact with the environment.

Licensed Practitioner (LP): Any individual permitted by law and UTMB to provide care and services within the scope of the individual's license.

Qualified Designated Staff Members: Staff members who have completed the required restraint training module and competency assessment. Completion of the module is required annually.

Qualified Nurse: A registered nurse who has completed the required restraint training module and competency assessment. Completion of the module is required annually.

## V. Related UTMB Policies and Procedures

IHOP - 08.02.07 - Security Associated with Offender/Correctional Patients
IHOP - 09.13.13 - Unusual Event Reporting

## VI. References

CMS State Operations Manual. Appendix A- Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. §482.13(e) Standard: Restraint or seclusion.

*Moore, M.J., & Im, D. The acutely agitated or violent adult: Pharmacologic management. In: Ganetsky, M., ed. UpToDate. Wolters Kluwer. Updated June 2024.*

Restraints for Nonviolent or Non-Self-Destructive Behavior. Elsevier Skills Extended Text. Published April 2024.

Restraints for Violent or Self-Destructive Behavior. Elsevier Skills Extended Text. Published April 2024.

## VII. Dates Approved or Amended

| *Originated: 02/13/1992* | |
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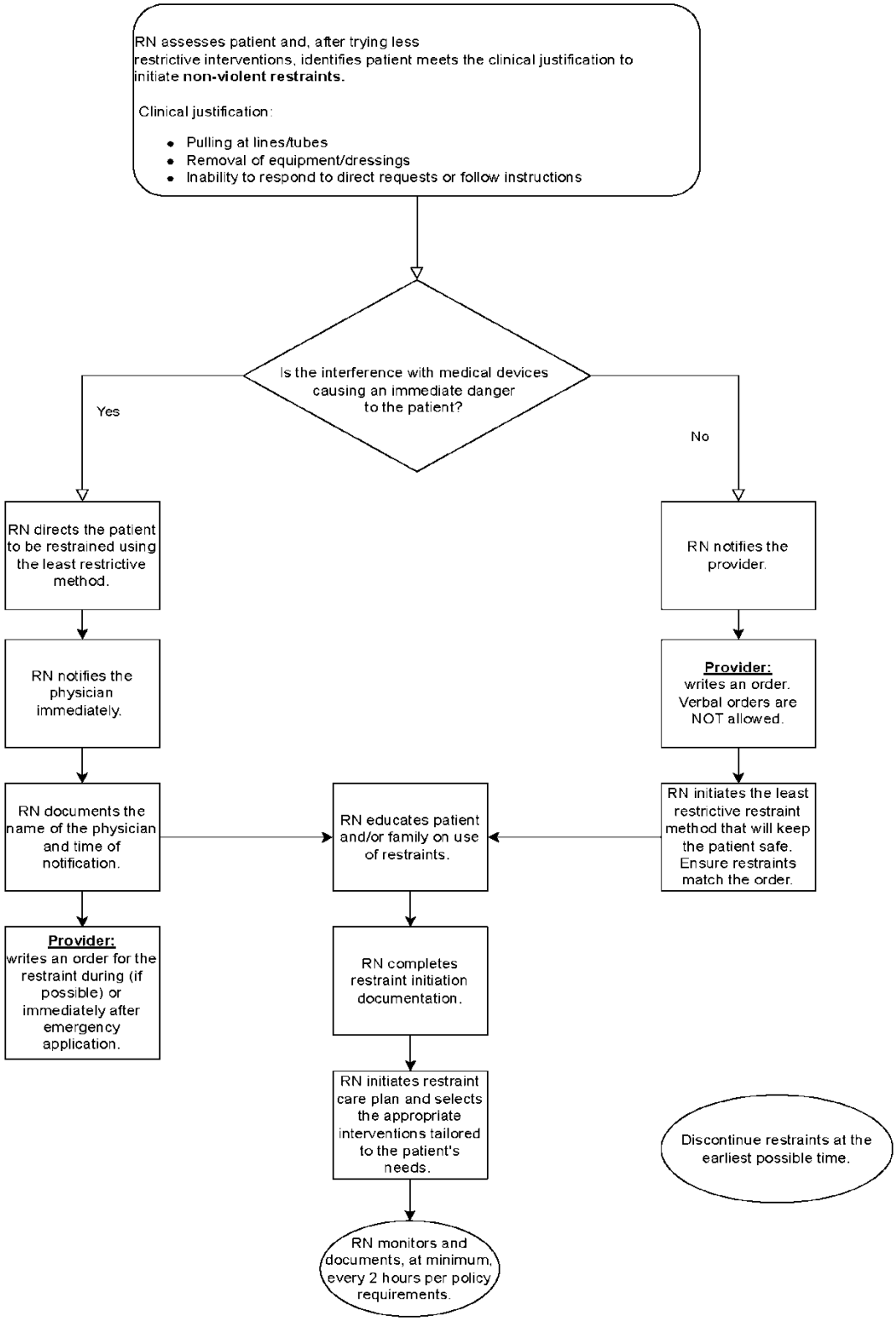
| *Reviewed with Changes* | *Reviewed without Changes* |
| 04/05/2012 | 02/25/2015 |
| 09/19/2014 | 11/08/2017 |
| 12/12/24 | 11/01/2021 |

## VIII. UTMB Responsible Entity

Department of Quality and Healthcare Safety

409-747-2151


RN assesses patient and, after trying less restrictive interventions, identifies patient meets the clinical justification to initiate **non-violent restraints.**
Clinical justification:
Pulling at lines/tubes
Removal of equipment/dressings
Inability to respond to direct requests or follow instructions
Is the interference with medical devices causing an immediate danger to the patient?
Yes
No
RN directs the patient to be restrained using the least restrictive method.
RN notifies the physician immediately.
RN documents the name of the physician and time of notification.
Provider: writes an order for the restraint during (if possible) or immediately after emergency application.
RN notifies the provider.
Provider: writes an order. Verbal orders are NOT allowed.
RN initiates the least restrictive restraint method that will keep the patient safe. Ensure restraints match the order.
RN educates patient and/or family on use of restraints.
RN completes restraint initiation documentation.
RN initiates restraint care plan and selects the appropriate interventions tailored to the patient's needs.
RN monitors and documents, at minimum, every 2 hours per policy requirements.
Discontinue restraints at the earliest possible time.