

Institutional Handbook of Operating Procedures
Policy 09.13.06

Section: Clinical	Responsible Vice President: Executive Vice President and CEO, Health System
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.

Authorizing/Ordering Restraint

Only an authorized physician, or another licensed independent practitioner 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
- Anticipated ending time (as soon as possible, based on an individualized patient assessment and reevaluation)
- Indications and reasons for use
- Behavioral criteria for release

Emergency Situations Without an Available, Authorized Physician, or Licensed Independent Practitioner

A registered nurse (RN) who is competent in restraint usage does the following:

1. Directs that the patient be restrained.
2. Notifies the authorized physician, or licensed independent practitioner immediately and obtains an order.
3. Keeps the patient under constant supervision until the physician, or licensed independent practitioner arrives.
4. Documents the following:
 - Name of the authorized physician, or licensed independent practitioner who was notified
 - Time the physician, or licensed independent practitioner 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 notified physician or licensed independent practitioner 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.
3. Use of standing or PRN orders is prohibited

III. Renewal of orders by restraint type:

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

When the order expires, the patient is re-evaluated in person and if needed, a new order for Violent or Self-Destructive Behavior Restraints is to be re-issued or renewed only 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.

After 24 hours, in the management of patients on Violent or Self-Destructive Behavior Restraint, a Physician or designee responsible for the care of the patient must see and assess the patient before a new order for use of Restraint is placed.

- B. **Non-Behavioral 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.

IV. Registered Nurse Assessment and Documentation by Restraint Type:**A. Non-Violent Restraints:**

1. Patients with Non-Violent Restraint(s) must be monitored and assessed at least every two hours and interventions implemented as indicated. Monitoring/assessment and interventions will include the following:
 - Reassessment of need
 - Observed behavior(s) in response to the restraint
 - Airway
 - Circulation
 - Skin
 - Physical comfort
 - Range of motion
 - Hydration/Nutritional needs
 - Elimination
2. Document the following in the patient's medical record:
 - Assessments and interventions
 - Placement and discontinuation of Non-Violent Restraint(s)
 - Updated plan of care or treatment plan
 - Any injuries sustained and treatment provided for those injuries

B. Violent or Self-Destructive Behavior Restraint(s)

1. Patients with Violent, or Self-Destructive Behavior Restraint(s) are to have One-to-One Constant Observation for safety and comfort by a member of UTMB's workforce who is trained in One-to-One Constant Observation.
2. Assessment and interventions must be performed every 15 minutes and interventions implemented as indicated. Monitoring/assessment and interventions will include the following:
 - Reassessment of ongoing need for Restraint
 - Continuous observation
 - Observed behavior(s) in response to the restraint
 - Airway
 - Circulation
 - Skin
 - Physical comfort
 - Range of motion
 - Hydration/Nutritional needs
 - Elimination
3. Document the following in the patient's medical record:
 - Assessments and interventions
 - Placement and discontinuation of the Violent or Self-Destructive Behavior Restraint
 - Updated plan of care or treatment plan
 - Any injuries sustained and treatment provided for those injuries

- V. Physician/LIP Assessment and Documentation Requirements for Violent or Self-Destructive (Behavioral) restraints:** A physician or other LIP responsible for the care of the patient must evaluate the patient in-person within one hour of the initiation of behavioral restraints.

The in-person 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.

Violent or Self-Destructive (Behavioral) restraint orders may be renewed according to the time limits for a maximum of 24 consecutive hours.

Every 24 hours, a physician or other authorized LIP primarily responsible for the patient's ongoing care sees and evaluates the patient before writing a new order for behavioral restraint.

VI. Additional Monitoring and Care

- A. Monitoring of patients in restraints will be performed by a staff member who has completed the required restraint training and competency assessment.
- B. 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.
- C. Patients restrained with a lap or waist belt must have continuous observation.
- D. Care is provided based on the assessed needs of the patient.
- E. Care will include:
 - Offering liquids and nutrition
 - Comfort measures
 - Toileting
 - Temporary release that occurs for the purpose of caring for a patient's needs (for example, toileting, feeding, and range of motion)
 - Other interventions as indicated by assessment findings.

VII. Safety

- A. 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.
 - 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.
 - 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.
- B. An event report must be completed if an injury occurs to a patient while in Restraint(s).
- C. 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.
 - UTMB PD should be contacted (409-772-2691) as soon as a patient is determined to be experiencing a mental health crisis.
 - A Faculty Physician must complete a clinical affirmation that describes why the patient is a threat to themselves or others.
 - The description must contain detailed information about what the patient did to be considered as concerning.

- 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.
- The patient will need to be transported by Emergency Medical Services in the event the patient has a continuous medical need.

VIII. Unacceptable Physical Restraints

Unacceptable physical restraints include:

1. Locking devices
2. Vests
3. Kerlix/gauze
4. Rope or cord
5. Rubber bands
6. Sheets

IX. Reporting

- A. The following information will be recorded in a log and reported to the Centers for Medicare and Medicaid Services (CMS) when required:
 - Each death that occurs while the patient is in restraints;
 - Each death that occurs within 24 hours after the patient has been removed from restraints; and
 - 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.
- B. 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.
- C. An event report must be completed if an injury occurs to a patient while in Restraint(s). Refer to Unusual Event Reporting IHOP 9.13.13
- D. 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.
- E. 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.

X. Training Requirements

- A. LIPs ordering restraints are required to have knowledge of UTMB restraint policy.
- B. A registered nurse initiating restraints must complete the UTMB restraint training offered during orientation and maintain annual competency in restraints practice thereafter.
- C. 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.

XI. 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-behavioral 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 (Behavioral) 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 or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Licensed Independent Practitioner (LIP): Any individual permitted by law and UTMB to provide care and services without direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

Qualified Nurse: A registered nurse who has completed the required restraint training and competency assessment.

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. 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
5. 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.
6. 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.
7. The use of 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 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.

XII. Related UTMB Policies and Procedures

[IHOP - 08.02.07 - Security Associated with Offender/Correctional Patients](#)

XIII. Supporting Documents

[Restraint Comparison Table](#)

[Restraint Algorithms](#)

XIV. References

Joint Commission Standard PC.03.05.09, EP 1. The [hospital]’s policies and procedures regarding restraint or seclusion include the following:

CMS and TJC Restraint Information Crosswalk (2021)

XV. Dates Approved or Amended

<i>Originated: 02/13/1992</i>	
<i>Reviewed with Changes</i>	<i>Reviewed without Changes</i>
04/05/2012	02/25/2015
09/19/2014	11/08/2017
	11/01/2021

XVI. UTMB Responsible Entity

Department of Quality

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