Restraint Comparison Table

<table>
<tr><td>Topic</td><td>Non-behavioral Restraints</td><td>Violent or Self-Destructive Restraints (Behavioral)</td></tr>
<tr><td>Clinical Justification Criteria</td><td>• Pulling at lines
• Pulling at tubes
• Removal of equipment
• Removal of dressing
• Inability to respond to direct requests or follow instructions</td><td>• Imminent risk of harm to self
• Imminent risk of harm to others
• Imminent risk of harm to self or other

Used to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.</td></tr>
<tr><td>Alternatives Attempted</td><td colspan="2">Alternatives to restraint will be considered and/or attempted
(and documented in the medical record) prior to the application of restraints.</td></tr>
<tr><td rowspan="2">Provider Evaluation/ Order</td><td>A written order based on an examination of the patient by the provider is entered into the medical record prior to initiation of restraint.*</td><td>The physician/provider must evaluate the patient prior to, during, or immediately after <u>initiation</u> of restraint.

The physician/provider must:
• Document an evaluation of the patient’s immediate situation;
• Document an evaluation of the patient’s reaction to the intervention;
• Document an evaluation of the patient’s medical and behavioral condition;
• Determine whether restraint should be continued; and
• Supply an order for the restraint.</td></tr>
<tr><td colspan="2">* <u>NOTE:</u> A qualified RN may apply restraints in response to an unanticipated event prior to a physician order. The provider who is primarily responsible for that patient’s care must then be notified immediately and a provider order obtained.</td></tr>
<tr><td>Provider Order Restrictions</td><td colspan="2">PRN Orders are NOT allowed.</td></tr>
<tr><td>Provider Order Notification</td><td colspan="2">The use of restraints is based on a current assessment.
The qualified RN will:
• Notify the physician/provider and obtain an order prior to application
• (unless emergent, in which case an order should be obtained during or immediately after initiating restraints)
• Notify and consult with the <u>faculty</u> provider as soon as possible after restraints are initiated.
• Document faculty notification in the medical record.</td></tr>
</table>

Restraint Comparison Table

<table>
<tr><th></th><th>Non-behavioral Restraints</th><th>Violent or Self-Destructive Restraints (Behavioral)</th></tr>
<tr><td rowspan="2">Time Duration/ Limits of Order</td><td>• The order for non-behavioral restraints will last as long as the restraints are in place. A new order is required before restraints can be re-applied after being removed.</td><td>Orders are time limited based on age:
• Up to 4 hours for patients ages 18 and older
• Up to 2 hours for children ages 9 to 17
• Up to 1 hour for children 8 and under</td></tr>
<tr><td colspan="2">Once restraints are removed, the restraint order must be completed in Epic.
Before restraints are reapplied, a new order is required.</td></tr>
<tr><td>Re-evaluation and continued use</td><td>Continued use of restraint requires a qualified RN to examine the patient and determine if the restraint continues to be clinically justified at least once each shift.</td><td>The patient is evaluated by a qualified RN <u>or</u> provider at least every:
• 4 hours for adults 18 and older
• 2 hours for children and ages 9 to 17
• 1 hour for children under 9

The RN must notify the provider if continued use of restraints is required and a new order is entered by the provider.
HOWEVER
The physician/provider MUST conduct a face-to-face evaluation no less than every 24 hours prior to renewing behavioral restraints. At that time, the provider shall reevaluate the efficacy of the patient’s treatment plan and work with the patient to identify ways to help him/her regain control.</td></tr>
<tr><td rowspan="2">Monitoring / Care of patient</td><td>The patient will be observed at least every two hours (or more frequently based on assessed needs).</td><td><u>Direct</u> continuous observation is required. (i.e., a sitter at bedside). In-person assessments must be documented every 10 to 15 minutes, with no time lapse of greater than 15 minutes.</td></tr>
<tr><td colspan="2">• Monitoring of patients in restraints will be performed by a staff member who has completed the required restraint training and competency assessment.
• Care is provided based on the assessed needs of the patient. Care will include:
- Offering liquids and nutrition
- 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
• Patients transported off the unit must be assessed for needs by a qualified RN and be accompanied by an individual qualified to provide monitoring and care identified in the assessment.
• Patients restrained with a lap or waist belt must have continuous observation.</td></tr>
</table>

Restraint Comparison Table

	Non-behavioral Restraints	Violent or Self-Destructive Restraints (Behavioral)
Nursing Documentation	Non Behavioral Restraint Flowsheet *(in EHR if available)* • Verification of restraint order; • Modification of the plan of care; • Individual patient assessments and reassessments; • Clinical Justification; • Intervention used (restraint type); • Education; • Monitoring results; • Staff concerns regarding safety; risks to the patient, staff or others that necessitated the use of restraint (if applicable); and • Any injuries to the patient	Violent or Self-Destructive Restraint Flowsheet *(in EHR if available)* • Verification of restraint order; • Modification of the plan of care; • Faculty Notification; • Individual patient assessments and reassessments; • Clinical Justification; • Intervention used (restraint type); • Education; • Monitoring results; • Staff concerns regarding safety risks to the patient, staff or others that necessitated the use of restraint (if applicable); • Any injuries to the patient (if applicable); and • Application participants
Nursing Interventions	• Obtain appropriate physician/provider order. • Explain to the patient and/or the patient's family (including significant other) the reason for the use of the restraint device. • Notification of family, if not present, is recommended (if appropriate). • Apply restraints in manner that avoids undue physical discomfort, harm, or pain. 1. If a patient is restrained in a supine position, the patient's head should be free to rotate from side-to-side and, when possible, the head of the bed should be elevated to prevent risk of aspiration. 2. 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. • Ensure call light is readily accessible to any patient without continuous observation. • Provide emotional/psychological support. • Explain and assist the patient in meeting safety and/or behavior criteria for the discontinuation of restraints. • Maintain proper body alignment. • Individualize the patient's plan of care to include continuous regard for the patient's rights of privacy, dignity and attention to safety and physical and psychological needs.	
Removal	• A restraint shall be discontinued or the level of restraint reduced by a qualified RN as warranted by patient condition and by nursing reassessment findings at the earliest possible time, regardless of the expiration time of the written order. • A temporary release that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, and range of motion) is not considered a discontinuation of the intervention. • Upon removal of restraints, nursing must document discontinuation of the restraint and *complete* the restraint order in Epic.	

Restraint Comparison Table

	Non-behavioral Restraints	Violent or Self-Destructive Restraints (Behavioral)
Repeat episode	• If a patient's restraints are removed and the patient again exhibits behavior that can only be handled through the use of restraint, a new provider order is required.	
Rehabilitation Professionals Responsibilities	• When working with a patient whose restraints have previously been applied, staff should assess whether the restraints will impede effective delivery of treatment and should remove the restraint when and if indicated, while providing for the patient's safety at all times throughout the course of the treatment. • Upon conclusion of a treatment, staff will reapply the restraint to provide for patient safety. • Staff should work collaboratively with other members of the multidisciplinary team to identify other alternatives to restraints and to insure that the patient's dignity is considered at all times.	Not applicable.
Deaths associated with Restraint	Notify the Clinical Operations Administrator if death occurs: • while a patient is in restraints; • within 24-hours after the patient has been removed from restraints; OR • within one week after the use of restraints, where it is reasonable to assume the use of restraints contributed directly or indirectly to the patient's death. The preceding information will be recorded in a log and reported to the Centers for Medicare and Medicaid Services (CMS) when required. Reporting is coordinated through the Clinical Operations Administrator (COA) and Nursing Quality.	