


**GUAM MEMORIAL HOSPITAL AUTHORITY
 NURSING SERVICES MANUAL**

APPROVED BY:  Zennia Pecina, RN, MSN Associate Administrator of Nursing Services	RESPONSIBILITY: Nursing Services	EFFECTIVE DATE: November 25, 2008	POLICY NO.: 6301-II C-16	PAGE: 1 of 9
TITLE: RESTRAINTS FOR NON-BEHAVIORAL REASONS				
LAST REVIEWED/REVISED: 11/2015				
ENDORSED: NM 08/2015, PSC 09/2015, MEC 10/2015; EMC 11/2015				

PURPOSE:

To outline the hospital-wide management of patients requiring restraining devices for non-behavioral reasons.

POLICY:

1. All patients have the right to be free from restraints that are not medically necessary or are used for any other purposes other than for the benefit and safety of the patient. Restraints shall be used only where alternative methods are not sufficient to protect patients or others from injury and are not a substitute for less restrictive forms of protective needs of the patient prior to the application of restraints or medical protective device.
2. On emergent cases, such as the patient is harming himself/herself or others, the use of alternative approaches for non-behavioral reasons is not necessary. Under these conditions, the use of restraints is clinically justified for behavioral reasons. (Please refer to Policy 6301-II-C-30: Restraint Use for Behavioral Management Reasons).
3. The use of restraints can be initiated by a qualified registered nurse after alternative approaches have been unsuccessful. These unsuccessful attempts shall be documented. The registered nurse must notify the physician and obtain a telephone order for restraint use within 12 hours of initiation.
4. When the use of restraints for non-behavioral reasons results from an unanticipated change in the patient's condition, the registered nurse shall notify the attending physician immediately.
5. Should a telephone order be obtained for the initial restraint use, this order must be authenticated (dated, timed, and co-signed) by the ordering physician within a 24-hour time frame, wherein an in-person evaluation shall be conducted.
6. The continuance of restraints beyond 24 hours from initial restraint application is clinically justified by the physician (after an inpatient evaluation) and accompanied by a renew restraint order. Any subsequent restraint order must be obtained by the next calendar day after it has been clinically justified for continued use via an in-person evaluation.

DEFINITIONS:

- A restraint is 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.
- Restraint for Non-Behavioral Reason: This applies to the patient who is not acting out or behaving destructively or dangerously, however there are appropriate clinical justifications for the patient to be on restraints to improve the patient's well-being by directly supporting medical healing.

- A. If preventative strategies or alternative approaches to restraints have been unsuccessful, then the registered nurse may obtain a restraint order from the physician.
- B. The restraint order must include the following criteria (see Attachment A):
 1. Specify the reason (medical necessity which should indicate that restraint is to improve the patient's well-being) for the restraint
 2. The type of restraint
 3. The extremity or body part(s) to be restrained
 4. The duration (the date, time of day, and maximum length of time) for restraint application, not to exceed 24 hours
 5. Any specific measures for ensuring the individual's safety, health, or well-being, and criteria for release from restraint.
 6. Never be written as a standing order, or on an as needed basis (that is, PRN)
 - a. If a patient was recently released from restraints and exhibits behavior that can only be handled by the reapplication of restraint, a new order would be required. Staff cannot discontinue an order then re-start it under the same order because that would constitute a PRN order. Each episode of restraint use must be initiated in accordance with the order of a physician. However, a temporary release that occurs for the purpose of caring for a patient's needs (that is, toileting, feeding, and range of motion) is not considered a discontinuation of the intervention.
 7. Be followed by consultation with the patient's attending physician as soon as possible if the attending physician did not order the restraint
- C. If the physician is not available to issue a restraint order, a qualified registered nurse initiates the restraint based on an appropriate assessment of the patient. The reason for restraints must be documented and communicated to the attending physician within 12 hours of the initiation of the restraint, and a written or telephone order is obtained and entered into the patient's medical record.
 - If the restraint is initiated based on a significant change in the patient's condition, the physician must be notified immediately.

III. RESTRAINT PARAMETERS

- A. Orders for soft restraints are not to exceed 24 hours
- B. In case of emergency, when the patient exhibits behavioral problems, the patient may be placed in restraints with the discretion of the registered nurse and an order obtained from the treating physician within one (1) hour of the restraint (Please refer to Policy 6301-11-C-30: Restraint Use for Behavioral Management Reasons).
- C. All patients placed in restraints should not be placed in prone position (in accordance to 10 GCA Health and Safety Chapter 82 § 82610) and should have the head of the bed elevated 30 degrees, unless contraindicated to the patient's condition.
- D. All restraints are to be kept in full view and not covered with a sheet or blanket.
- E. A registered nurse will direct the application of restraints if "done by a non-licensed nursing staff.
- F. Only the minimum amount of temporary restraint necessary to immobilize the patient/extremity is to be used.
- G. Soft restraints must be easily removed by any staff member in the event of fire or other emergencies. All restraints tied to a non-movable part of a bed or stretcher must use an easy-release tie method.

H. The patient and/or family member must be educated on the use of restraints, its reason and the criteria for releasing/discontinuing the restraints.

1. Pediatric Considerations:

1. The reason for applying a restraint must always be explained to both the parent and the child. A doll or stuffed animal may be used for demonstration.
2. During the application of the restraint, stimulation and diversion should be provided to relieve the sense of helplessness and loneliness.
3. Removal of restraints is reasonable when the child is attended by attentive family members or by staff who are observing and supervising the patient closely. Under this condition, a new physician order for restraint does not need to be obtained until the restraint order expires.

IV. PROCEDURE TO APPLYING RESTRAINTS

- A. Verify that the order for restraint includes rationale for restraint; the date, time of day, and maximum length of time for the restraint; type of restraint; extremity or body part(s) to be affected; and the criteria for release from restraint. Determine if alternative, less restrictive methods have been attempted, however, were ineffective.
- B. Explain to the patient and/or family the plan and rationale for using restraints and the condition/behavior required for release from restraints.
- C. Apply appropriate size restraint snugly to the body part but not tight enough to interfere with circulation or breathing.
- D. Application of restraints will be based on manufacturer's guidelines and /or Lippincott's Manual of Nursing Practices.
- E. Using a slipknot, fasten restraint to the bed frame, not to the side rails.
- F. Place the call light within reach.

V. ASSESSMENT OF THE PATIENT DURING RESTRAINT CHECK:

The condition of the restrained patient must be continually assessed, monitored, and reevaluated at least every two (2) hours or sooner according to patient need (see also VII. Documentation). Monitoring is accomplished by observation, interaction with the patient, or related to direct examination of the patient by a trained registered nurse. The following shall be assessed:

- A. Patient's rights and dignity are maintained
- B. Environmental safety
- C. General comfort level of patient;
- D. The skin for breakdown;
- E. The general condition/behavior of the patient (restless, resting, agitated, talking in normal tone of voice, yelling, etc.);
- F. Circulation;
- G. Respiration;
- H. Psychological status; and
- I. The readiness for discontinuation of restraint (release criteria).

VI. RELEASE INTERVENTION

To ensure that the patient's dignity and physical well-being is maintained release interventions are to be done at least every two hours or sooner according to patient need.

- A. Give active or passive range of motion exercise to each restrained extremity prior to replacing restraint while awake.
- B. Allow the patient to perform hydration and nutritional needs, comfort, elimination and personal hygiene.
- C. Change the patient's position every two (2) hours.

VII. DOCUMENTATION

- A. Documentation of restraint use and assessment is to be done in the iMED.
 - 1. Justification of restraint use for each restraint use episode shall be documented in the Restraint Use Justification Assessment. If needed, further documentation on patient's behavior indicating the need of restraints shall be documented in the Patient's Notes.
 - 2. The Restraint Use Justification Assessment shall be completed daily at 0600.
 - 3. Ongoing Restraint assessments shall be documented in the Behavioral/Activity Assessment. If further documentation is needed regarding the use of restraints, it shall be documented in the patient notes.
 - 4. Behavioral/Activity Assessments should be documented on every even hour.
- B. Further documentation will be done in the patient's notes in regards to any injury associated with restraints and its treatment
 - 1. The Nurse supervisor and Risk manager will be notified immediately for any injury and/or death associated with restraints. An occurrence report must be completed.

VIII. STAFF TRAINING

Staff applying restraints will have training in, and demonstrate competency with, the physical application and use of restraint, as well as the requirements and regulations regarding restraints.

- A. Training is to include the following area:
 - 1. Techniques to identify staff and patient behaviors, event, and environmental factors that may trigger circumstances that require the use of a restraint.
 - 2. The use of nonphysical intervention skills.
 - 3. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
 - 4. The safe application and use of all types of restraint used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).
 - 5. Clinical identification of specific behavioral changes that indicate that restraint is not longer needed.
 - 6. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and conducting the 1-hour in-person evaluation.
 - 7. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
 - 8. Recognition of how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a patient reacts to physical contact.
 - 9. For behavior management, the use of behavior criteria *for* discontinuing restraint and how to help the patient in meeting the criteria.

IX. PERFORMANCE IMPROVEMENT

- A. Restraint use and the compliance to policy shall be monitored and reported monthly (and quarterly to the Performance Improvement Committee). Opportunities to improve compliance to the policy shall be indicated in the report.

ATTACHMENTS:

I. Physician Orders: Restraint Use for Non-behavioral (Medical-Surgical) Reasons

II. Restraint Use Flowchart

RELATED POLICIES:

Policy # 6301- II C-30, Restraints for Behavioral Management Reasons, Nursing Services Manual, effective 5/2012

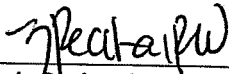


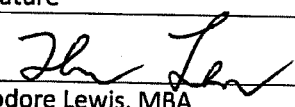
RESCISSION:

Policy # 6301-C16, Restraints of the Nursing Administration Manual made effective December 1985.

GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledged that they have reviewed and approved the following:

<input type="checkbox"/>	Bylaws	Submitted by Department/Committee: Nursing Management
<input type="checkbox"/>	Rules and Regulations	Policy No.: 6301-II-C-16
<input checked="" type="checkbox"/>	Policies & Procedures -Revised	Title: <u>RESTRAINTS FOR NON-BEHAVIORAL REASONS</u>

Reviewed/Endorsed	Date	Signature
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Title		Patient Safety Committee, Chairperson
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	10/28/15	
Title		Hoa Nguyen, MD Medical Executive Committee, President
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	11-12-15	
Title		Theodore Lewis, MBA Executive Management Council
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Title		
Reviewed/Endorsed	Date	Signature
Title		
Reviewed/Endorsed	Date	Signature
Title		

*Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Compliance Officer