APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.:	PAGE:
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TITLE: RESTRAINT USE FOR BEHAVIORAL HEALTH PURPOSES				
LAST REVIEWED/REVISED: 06/2018				
ENDORSED: NM 06/2018, PSC 08/2018, EOC 08/2018, MEC 09/2018, EMC 11/2018				

PURPOSE:

- To establish guidelines for the use of restraints for the safety of patients and others.
- To provide for the safety of patients when it is determined that there is a potential for self-harm or injury to others.
- To comply with Centers for Medicare and Medicaid Services (CMS) regulatory statutes §482.13, and The Joint Commission (TJC) standards.

POLICY:

I. All patients have the right to be free from restraints that are not medically necessary or are used for their risk for behavioral episodes. The patient's plan of care shall include High Risk for Injury and indicate preventative measures to be implemented to prevent use of restraints. Patients shall also be assessed for any preexisting medical conditions, physical disabilities or history of sexual or psychological abuse that would place the patient at greater risk during restraints.

II. The use of restraints for behavioral health purposes shall only occur during emergency situations, or when the patient's behavior poses any imminent signs of harm to self or others. This excludes handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons.

III. Alternative approaches to de-escalating the patient's behavioral episode shall be performed prior to applying restraints for behavioral health purposes. Only hard restraints shall be used for these patients. The use of hard restraints shall be the last resort when all alternative approaches have been unsuccessful.

IV. A registered nurse can initiate each episode of restraint use for behavioral health purposes and notify the attending physician immediately to obtain an order for restraint use for behavioral health purposes. This registered nurse shall be competent in minimizing the use of restraints for behavioral health purposes and maximizing patient safety when used, as well as, competent in the safe application of such restraints.

V. The restraint order for behavioral health purposes is time limited, cannot be an as needed (PRN) order, and may be renewed according to the time limits for a maximum of 24 consecutive hours. The attending physician must perform a face to face evaluation within 1 hour from initiation of restraint use for behavioral health purposes. After 24 hours, before writing a new order for the use of restraints for behavioral health reasons, the attending physician must see and assess the patient.

VI. The use of restraints for behavioral health purposes requires constant observation/monitoring of the patient, thus activating the patient sitter program. The nursing supervisor along with the charge nurse of the nursing unit shall adjust the staffing pattern accordingly to ensure quality care and safety is provided to the patient at all times.

VII. The attending physician oversees the use of restraints for behavioral health purposes, and shall work with the patient and clinical staff to identify ways to help the patient regain control. The use of restraints for behavioral health purposes shall be discontinued at the time the patient has regained control of his/her behavior. Restraints must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

VIII. The patient's rights, dignity and well-being shall be protected and preserved during the use of restraints.

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.

Behavioral Purposes Restraint Use: the use of restraints for patients with an unanticipated outburst of violent, severely aggressive or destructive behavior that poses an imminent danger to the patients and/or others.

PROCEDURE:

I. ASSESSMENT

A. On admission, the patient will be assessed for previous violent behavior, or previous history of harming self or others. Should there be any positive findings; the nurse will assess the patient's personal methods of minimizing such behaviors. The nurse shall also assess for any history of abuse or other co morbidities. Patients with identified histories of behavioral episodes shall be assessed for any current behavioral health advance directives, and whether the patient consents to inform family members about his/her care.

B. When it is determined that the patient's behavior may result in self-harm or harm to others, the registered nurse shall call for assistance (call a Code 60, if necessary) and attempt to de-escalate the situation, using alternative approaches to restraint use. Alternative approaches to behavioral health restraint use includes:

1. establishment of a non-threatening communication;
2. involvement of family members in treatment and monitoring;
3. decreasing stimuli;
4. creation of a safer environment;
5. establishment of a patient sitter by a trained staff;
6. relocation closer to nursing station.

C. If alternative approaches are unsuccessful, restraints shall be applied in accordance to safe and appropriate restraining techniques.

1. If a patient is in a physical hold for behavioral health purposes, another staff who is trained and competent in the use of restraints and who is not involved in the physical hold is assigned to observe the patient.

a. Observation of the patient shall be performed by the licensed personnel competent in patient assessment. Adjustments in the physical hold, while ensuring the safety of the patient and all staff, shall be performed as soon as possible to allow the licensed staff to perform the observation.
b. Staff performing the physical hold does not need to be licensed personnel but should be competent and has current training on the application and use of restraints.

D. The registered nurse shall immediately contact the physician to inform him/her that the patient has been restrained for behavioral health purposes. A detailed justification by a qualified registered nurse shall be communicated to the attending physician. The registered nurse shall obtain a telephone/verbal order for restraint use for behavioral health purposes. The patient must be seen by the attending physician face to face within one hour after the initiation of the intervention to evaluate:

- the patient's immediate situation;
- the patient's reaction to the intervention;
- the patient's medical and behavioral condition;
- the need to continue or terminate the restraint.

II. RESTRAINT ORDERS:

A competent registered nurse may initiate the use of restraints for behavioral health purposes, and must contact the physician immediately upon the application of the restraint to obtain a restraint order.

A. The physician orders shall include the following *(see Attachment I):*
1. The reason for restraints: for behavioral health purposes
2. Type of restraint
3. Affected extremity
4. Duration of restraint (time limit):
a. up to 4 hours for adults (18 years and above);
b. up to 2 hours for children and adolescents aged 9-17 years;
c. up to 1 hour for children under age 9.

5. Criteria for release:
a. patient is cooperative/coherent;
b. patient is calm;
c. patient is oriented;
d. cessation of threats.

B. PRN orders are <u>NOT ALLOWED</u>.

III. PHYSICIAN EVALUATION OF THE RESTRAINT USE

A. Upon the initial application of restraints, a face to face evaluation by the attending physician shall occur within one hour of application of restraints.

B. The physician order for restraints are time limited, as above. **If the restraint use continues and needs to extend beyond 24 hours, before writing a new order for the use of restraints for behavioral health reasons, the attending physician must see and assess the patient.**

C. The physician shall reevaluate the effectiveness of the treatment plan and work with the patient and clinical staff to identify ways to help them regain control.

IV. APPLYING RESTRAINT

A. Verify physician orders.

B. Explain to the patient/family the plan and rationale for using restraints and the condition/behavior required for release from restraints.

C. Application of restraints will be based on manufacturer's guidelines and/or Lippincott's Nurse Practice Manual.

D. Apply appropriate size restraint snugly to the body part but not tight enough to interfere with circulation or breathing.

E. Using a slipknot, fasten restraints to the mattress frame, not the side-rails.

F. Place call light within reach, and ensure that the bed is placed at the lowest position.

G. Elevate the Head of Bed at 30 degrees to prevent any aspiration.

V. PLAN/INTERVENTION/MONITORING

A. When it is determined that restraint use is for behavioral health purposes, the patient's plan of care shall be modified to include continuous monitoring by an appropriately trained licensed nursing personnel.

B. Continuous in-person observation/monitoring shall be done by a trained staff member. Staff member shall alert the licensed nurse of any behavioral observations.

C. Assessment shall occur every hour minutes by a licensed nurse. The following criteria shall be assessed:

1. Vital signs (per physician's orders)*
2. Mental status/behavior
3. Circulation
4. Skin color
5. Sensation
6. Respiratory status
7. Skin integrity
8. Hydration/Nutritional needs*

9. Elimination needs*
10. Range of motion (ROM) exercises*
11. Injuries related to restraints
12. Readiness of restraint release

**Note: Indicated criteria listed above must be done at minimum every two hours.*

D. Repositioning of restraints shall occur every two (2) hours.

E. Patient and Family Education on restraint use shall be done accordingly, and documented in the patient's medical health record. Inform the patient's family when restraints for behavioral reasons have been applied. Educate patient/family on reason for restraint, and the plan of care, and criteria for restraint release.

F. Ensure that the patient's rights and dignity, and the environmental safety measures are maintained. Environmental safety includes placing the bed at the lowest position and ensuring that the call button is within reach.

G. The plan of care for the patient shall be modified to include restraint use and assessment.

H. Should the patient remain at risk for harming self or others, additional staff will be called for assistance upon need to release restraints and respond to emergency situations. All other emergency plans will be activated as necessary (Code 72 or 60), if necessary.

VI. POST RESTRAINT USE DEBRIEFING

A. A post restraint use debriefing shall be conducted within 24 hours after discontinuation for each restraint episode. The debriefing shall be led by the Unit Supervisor and involves the clinical staff, patient, and family member. The debriefing includes:

1. identification of what led to the use of restraint and what could have been done differently;
2. ascertainment that the patient's physical well-being, psychological comfort, and the right to privacy were maintained;
3. an opportunity for the patient to express any physical or psychological trauma that may have resulted from the use of restraints;
4. any modification of the patient's plan of care, treatment, and services.

B. The debriefing form (Attachment II) shall be forwarded to the Risk Manager and information in the form shall be used in quality and performance improvement activities. The debriefing form shall not be included in the patient's medical record.

VII. DOCUMENTATION

Documentation of restraint use in the medical record includes the following:

- any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior;

- a description of the patient's behavior and the intervention used;
- any alternatives or other less restrictive intervention attempted;
- the patient's condition or symptom(s) that warranted the use of the restraint;
- the patient's response to the intervention(s) used, including the rationale for continued use of the intervention;
- individual patient assessment and reassessment;
- the intervals of monitoring;
- revisions to the plan of care;
- the patient's behavior and the staff concerns regarding safety risk to the patient, staff, and others that necessitate the use of restraints;
- notification of the use of restraint to the attending physician;
- any consultations.

Any injuries related to restraints use must be documented and reported on Safety Learning System (SLS), or Patient Safety Form if the SLS is down, and forwarded to the Risk Manager immediately. *(Please refer to Policy A-PS800-Patient Safety Program.* The Risk Manager shall maintain a log of reported incidents related to the use of restraints. CMS also requires hospital report the following information to CMS and TJC no later than the close of business the next business day following knowledge of the patient's death:

- each death that occurs while a patient is in restraints;
- each death that occurs within 24 hours after the patient has been removed from restraints;
- each death known to the hospital that occurs within one week after restraints, where it is reasonable to assume that the use of restraints contributed directly or indirectly to the patient's death, regardless of the type (s) of restraint used on the patient during this time.

The debriefing session shall be documented in the Restraint Use for Behavioral health purposes Debriefing Form *(See Attachment II)* and forwarded to the Risk Manager.

VIII. STAFF EDUCATION

A. All nursing staff and security personnel must have ongoing education and training in the proper and safe use of restraints.

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

D. Training is to include the following areas:

1. restraint policy;
2. techniques to identify staff and patient behaviors, event, and environmental factors that may trigger circumstances that require the use of restraints;
3. an awareness among staff about what restraints may feel like to the patients;
4. the use of nonphysical intervention skills. Staff will possess a certification in Crisis Prevention Intervention, instructed by a certified CPI instructor

5. choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition;
6. the safe application and use of all types of restraints used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress;
7. clinical identification of specific behavioral changes that indicate that restraint is no longer needed;
8. monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, and vital signs;
9. the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification;
10. recognition of how age, developmental consideration, gender issues, ethnicity, and history of sexual and physical abuse may affect the way in which a patient reacts to physical contact;
11. for behavioral health purposes, the use of behavioral criteria for discontinuing restraints and how to help the patient in meeting the criteria.

IX. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

A. As part of the hospital's QAPI program, departments/units (that have a role in the implementation or care of patients with restraints for behavioral health purposes), in collaboration with the Risk Management Program Officer, will monitor indicators/measures that assist hospital leadership with the following:

1. Assessing and monitoring the hospital's use of restraints for behavioral health purposes

2. Implementing actions to ensure that restraints for behavioral health purposes are used only to ensure the physical safety of the patient, staff and others; and

3. Ensuring that the hospital complies with CMS standards, as well as any requirement(s) that may exist by Guam law and hospital policy, when the use of restraints for behavioral health purposes are necessary.

B. The following data set is collected on a monthly basis, using a patient identifier (e.g. patient number, medical record number, etc.) on all episodes of restraint use for behavioral health purposes:

1. shift;
2. Setting/Unit/Location;
3. staff who initiated the process/restraint;
4. staffing pattern at the time restraint use for behavioral purposes was initiated;
4. the length of each episode;
5. date and time each episode was initiated;
6. day of the week each episode was initiated;
7. the type of restraint used;
8. whether injuries were sustained by the patient or staff;
9. age of the patient;
10. gender of the patient;
11. medications administered (i.e. psychoactive medications)

C. In analyzing data (on a monthly basis) related to restraint use for behavioral purposes, particular attention is extended to:

1. the number of restraint episodes per individual;
2. the number of times when psychoactive medications were used as an alternative to, or to enable discontinuation of restraint;
3. internal data comparison on restraints use to identify levels of performance, patterns, trends, and variation.

D. The aforementioned data and analysis shall be reported monthly to the Patient Safety Committee, and quarterly to the Performance Improvement Committee, Medical Executive Committee, and Board of Trustees Quality and Safety Subcommittee. The Risk Management Program Officer, in collaboration with applicable departments/units, will ensure the following are reported for QAPI:

1. identification of opportunities to improve, with subsequent action taken;
2. evaluation of the actions taken, in order to confirm that improvements were achieved;
3. taking further action when planned improvements are not achieved or sustained.

REFERENCE(S):

- Centers for Medicare and Medicaid Services (2015). Conditions of participation: Patient's rights. 42 C.F.R. § 482.13 (e-g)

- The Joint Commission (2018). Provision of care, treatment and services standards.

RELATED POLICY:

- 6301-II-C-16, Restraint Use for Non-Behavioral Health Purposes, Nursing Services Manual
- 6301-Il C-4, Code Blue Team: Duties and Responsibilities, of the Administrative Manual.
- 401, CODE-60 Security Threat, of the Safety and Security Manual
- A-PS500, Rapid Response Team, of the Administrative Manual
- A-PS800, Patient Safety Program, of the Administrative Manual
- A-PC600, Patient Sitter Program, of the Administrative Manual

RESCISSION:

6301-II C-30, Restraint Use for Behavioral Health Purposes, of the Nursing Services Manual made effective June 28, 2013.

ATTACHMENTS

I. Physician's Order Form: Behavioral Management Restraint Orders Page 1 & 2
II. Restraint Use for Behavioral health purposes Debriefing Form
III. Restraint Use Flowchart

ATTACHMENT I

ITEMS WITH BOXES/PARENTHESES MUST BE ☑ TO BE ORDERED, Orders that have been changed (additions, deletions, or strike outs) must be initiated by the Ordering MD for the order to be void.

DATE	TIME	PHYSICIAN'S ORDER (Excluding IV Fluids and MEDICATIONS
		BEHAVIORAL HEALTH PURPOSES RESTRAINT ORDER
		Restrain the following extremities
		☐ Lt Wrist ☐ Lt Ankle
		☐ Rt Wrist ☐ Rt Ankle
		☐ Chest
		☐ Other:
		Type of Restraint
		☐ Soft ☐ Belt
		☐ Hard ☐ Vest
		☐ Mitten Mummy
		☐ Chemical (Indicate on right side)
		☐ Other:
		Duration (Maximum time limit):
		Restraint Order must be renewed at
		Expiration
		☐ 4 hrs: Adult ≥ 18 years old
		☐ 2 hrs: Pediatrics 9-17 years old
		☐ 1 hr: Pediatrics < 9 years old
		Vital Signs (While on Restraints)
		Every:
		☐ 15 minutes
		☐ 30 minutes
		☐ 1 hour
		☐ 2 hours
		☐ 4 hours
		Reason for Restraints
		Potential to injury to:
		☐ Self
		☐ Others (Specify)
		As Demonstrated by:

IVF and MEDICATION ORDER ONLY

IVF and MEDICATION ORDER ONLY

IVF and MEDICATION ORDER ONLY

ALLERGIES

DATE	TIME	INTRAVENOUS FLUID and MEDICATION ORDERS
		Enter order for chemical restraint below.
		Remember to date, time and sign the order

Continued on next page >>>>>>

Physician's Initials: _____

- ✓ Summary/Blanket Orders are not acceptable
- ✓ Medication orders must be complete
- ✓ PRN medication orders must include an indication
- ✓ Write legibly
- ✓ Rewrite orders upon transfer and/or post-operatively
- ✓ Date, Time, and sign verbal & telephone orders within 48 hrs.

DO NOT USE ABBREVIATIONS

U	MS
IU	MSO4
QD	MgSO4
QOD	Trailing Zero
Lack of Leading Zero	

BEHAVIORAL HEALTH PURPOSES RESTRAINT ORDER

Guam Memorial Hospital Authority

Reviewed/Revised: 08/15

Form # Stock#

PATIENT ID LABEL

ITEMS WITH BOXES/PARENTHESES MUST BE ☑ TO BE ORDERED, Orders that have been changed (additions, deletions, or strike outs) must be initiated by the Ordering MD for the order to be void.

DATE	TIME	PHYSICIAN'S ORDER (Excluding IV Fluids and MEDICATIONS
		Alternative Interventions attempted
		☐ Establishment of non-threatening
		communication
		☐ Involvement of family members
		in treatment and monitoring
		☐ Decreasing stimuli
		☐ Creation of safer environment
		☐ Establishment of a one-to-one
		patient sitter
		☐ Relocation closer to nurses station
		☐ Others:
		Behavior criteria for discontinuance
		of Restraints
		☐ Patient is cooperative/coherent
		☐ Patient is calm
		☐ Patient is oriented
		☐ Cessation of threats
		☐ Others:
		☐ Initiate Behavioral/Activity
		Assessment for Restraints
		☐ Monitor patient every 15 minutes
		☐ Education Patient and family on
		Restraint policy
I have conducted a in-person evaluation of the patient and determined there is a need for continued restraints.		
Physician Signature		Date/Time

IVF and MEDICATION ORDER ONLY

IVF and MEDICATION ORDER ONLY

IVF and MEDICATION ORDER ONLY

DATE	TIME	INTRAVENOUS FLUID and MEDICATION ORDERS

BEHAVIORAL HEALTH PURPOSES RESTRAINT ORDER PAGE 2 of 2

Guam Memorial Hospital Authority

Reviewed/Revised: 08/15

Form # Stock#

PATIENT ID LABEL

ATTACHMENT II

RESTRAINT USE FOR BEHAVIORAL HEALTH PURPOSES - DEBRIEFING FORM

NOTE: DO NOT PLACE IN PATIENT'S MEDICAL RECORD

Date (include day of week): _____ Time: _____ Location: _____

Persons participating (and Title):

_____ _____

_____ _____

Total Census: _____ Patient Acuity: ____ I ____ II ____ III ____ IV;
Total RN on shift: _____ Total LPN on shift: _____ Total CNA/Tech on shift: _____
Type of Restraint Used: _____ Hard Restraints _____ Soft Restraints | Other: _____
First incident of restraint use this admission? _____ Yes _____ No

1. What happened? What signs were observed when the patient's behavior was escalating?

2. Describe any de-escalating options employed and the patient's response.

3. What events resulted in the patient to be restrained?

4. Did the patient experience any injury/trauma related to restraint use?
   a. Injury: _____ None

      i. Patient: _____
      ii. Staff Member: _____
      iii. Other: _____

5. Did the patient feel his/her needs, including privacy were met? _____ Yes _____ No

6. Review of patient's input: _____
   _____
   _____

7. Recommendations and implementation of change in treatment plan. (What do you think should be done differently the next time, or to prevent a future occurrence?)
   _____
   _____
   _____

_____ _____
Staff Member Completing Form (Print & Signature) Date/Time

RESTRAINT USE FOR BEHAVIORAL HEALTH PURPOSES DEBRIEFING FORM

Guam Memorial Hospital Authority PATIENT ID
Reviewed/Revised:
Stock # Form#

ATTACHMENT III

Restraint Use for Behavioral Purposes