Patient Restraint Policy

Purpose

- To prevent interference /obstruction with medical treatments (such as self-extubation and intubation).
- To protect medical devices (such as intravenous lines, indwelling urinary catheters, and feeding tubes).
- To prevent falls and injury of any kind.
- To control disruptive behavior (such as agitation, wandering, and combativeness).
- To preclude the possibility of harming self, staff and other patients

Responsibility

Nursing staff, Physicians, Support Staff, Occupational therapist

Definitions:

Restraint is any involuntary method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to the body.

Chemical restraint:
The use of a sedating psychotropic drug to manage or control behavior. Psychoactive medication used in this manner is an inappropriate use of medication.

Physical restraint:
The direct application of physical force to a patient, without the patient's permission, to restrict his or her freedom of movement (JCAHO, 2000). The physical force may be human, mechanical devices, or a combination thereof.

**Policy:**

- Patient dignity should be maintained during restraint.

**Physician Orders**

- Restraints shall be applied with only a physician's order that defines the reason for restraint, less restrictive alternatives, attempted/considered, type of restraint to be used, and duration for which the restraint may be applied.
- This time limit shall not exceed one calendar day, after which new orders are required if restraints must be continued.
- In emergency situations, (i.e., self-extubation), if the physician is not available to issue the restraint order, restraint is initiated by a registered nurse based on an appropriate assessment of the patient.
- In that case, the physician is notified within 12 hours of the initiation of restraint and a verbal or written order is obtained from that physician and entered into the patient's medical record.
- If a renewal order is required after the initiation of restraint, the first renewal order must be obtained within one calendar day of initiation.
- Verbal restraint orders must be co-signed by the physician within 24 hours of the initiation of restraint.

**Device Application:**

Restraint shall be applied only by staff who have appropriate training and knowledge of using restraints.
Ongoing Care and Monitoring:

Patients shall be monitored at least every two (2) hours to determine the following and make adjustments as necessary:

- Position, circulation, and skin integrity of restrained area
- Maintenance of privacy and comfortable body and room temperature.
- Appropriate application of the device(s).
- Toileting and fluid needs.
- Nutrition
- Range of motion
- Restraint reduction or removal

Documentation in the medical record shall reflect the required monitoring.

- Patients shall be positioned for safety and comfort.
- Patients shall have active or passive range of motion to the affected joint(s) as medically necessary.
- The patient and/or family, whenever possible, shall be educated regarding:
  a. Reason for restraint
  b. How the patient/family can avoid restraint
  c. Criteria necessary for release from restraint.

Reassessment of Use:

The Consultant, in collaboration with the health care team, shall evaluate the patient at the end of the prescribed duration of restraint to determine the need for continued use of the device(s). If restraint remains necessary, the order must be renewed. In the absence of order renewal, restraints shall be removed by the responsible Nursing staff.
Reapplication of Restraint

- The patient is continually assessed to ascertain his or her condition and to determine if restraint can be discontinued.
- If a patient, who was recently restrained, must be placed back into restraints, a new physician order is required.
- 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.

Assessment, Care, and Monitoring Definitions:

Each aspect of patient assessment and care is considered complete and may be initialed when the following criteria have been met:

- Position: Proper alignment of the restrained limb(s) is maintained.
- Circulation: The affected limb(s) has been checked and device application has been determined not to impair circulation to the extremity:
  a. Nail bed blanched in less than 3 seconds
  b. Pulse is present above and below restraint.
  c. Skin Integrity: Skin integrity has been checked under and around the device(s), and at all bony prominences and no pressure or reddened areas have developed.
  d. The patient is covered either by gown, sheet, or curtain and is protected from public view.
  e. Temperature: The patient’s skin is comfortable to the touch. The patient's body temperature is checked as ordered by the physician, and the room temperature is maintained as appropriate to patient’s condition (generally 68-72° F on the room thermostat).
  f. Device Application: The device is applied according to the manufacturer’s guidelines and in a manner that is secure but not tight. Straps are secured to bed or chair frame (never to side rails or other moveable parts); and quick release is possible.
g. **Fluid Needs:** Fluids are administered as ordered by the physician. If the patient is not on fluid restriction, oral fluids are offered at least every two hours. If the patient is nothing-by-mouth (NPO), oral care is provided at least daily to maintain integrity of oral mucosa.

h. **Toileting Needs:** Elimination needs are attended to, either by foley catheter (*only if ordered for other medical necessity*) or by offering the patient the bed pan or assistance to bathroom or bedside commode chair.

i. **Nutrition Offered:** Nutritional needs are met as ordered by the physician. If oral intake is allowed, the patient is offered and assisted with meals and snacks.

j. **Range of Motion:** Active or passive range of motion in the affected limb(s) is completed either by the patient or the caregiver. For patients requiring limb restraints, ROM is recommended at least every 2 hours.

k. **Evaluation for Restraint Reduction or Removal:** Need for the use of restraint(s) is evaluated frequently (at least every two hours) and restraints are discontinued at the earliest possible time.

l. **Restraint Status:** A plus sign (+) is recorded when restraints are on; a minus sign (-) when they are off.

m. Caregiver initials are recorded at the bottom of the column to indicate the caregiver completing the assessment of care. The full signature, title, and initials are recorded at the bottom of the page.

n. **Narrative note space** is used for detail the care giver deems relevant, e.g., additional assessment data, explanation of patient/family discussions, exceptional findings in ongoing care and monitoring, etc.

o. A narrative note is recommended at the time restraints are discontinued and should reflect any changes in patient condition related to the decision to discontinue the use of restraints.

**Guidelines for Chemical Restraints**

Chemical restraints are any medication used for the purpose of restraining patients involuntarily to prevent them from harming themselves or staff. The intent of such medications is long duration of action compared to the brief conscious sedation commonly used to facilitate procedures such as suturing, scanning, and joint reduction.
Advantages of chemical restraints

- Control violent behavior and patient agitation
- May reduce need for physical restraints
- Allow examination and performance of radiographic imaging

Disadvantages of chemical restraints

- May result in complications, such as respiratory depression and loss of gag reflex
- Occasional paradoxical reaction results in increased agitation
- Limit mental status assessment and neurologic examination during sedation

Agents

A myriad of medications can be used to sedate patients. The ideal agent would last hours, be easily reversible, be available intravenously (IV) and intramuscularly (IM), not depress respirations or gag reflex, not result in hypotension, and not require cardiac monitoring. Unfortunately, no agent is ideal.

Agents commonly used to achieve rapid tranquilization fall into categories of major tranquilizers/neuroleptic agents and benzodiazepines.

- Major tranquilizers/neuroleptic agents
  - Haloperidol (Haldol) decreases agitation and violent behavior and often is prescribed for acutely psychotic patients. Haloperidol can be used to reduce violent behavior in severely intoxicated patients.
    - Adult dose is 2-5 mg IM; depending on patient response, subsequent doses can be administered as often as every hour, although every 4-8 hours may be satisfactory.
    - Onset of action occurs within 1 hour.
    - Duration of action is 4-8 hours.
    - Adverse effects include extrapyramidal symptoms (eg, dystonic reactions, akathisia), hypotension, prolongation of QT interval, lower seizure threshold, and anticholinergic effects.
Benzodiazepines
  o Diazepam (Valium) is widely used for sedation, treatment of agitation secondary to alcohol withdrawal and treatment of seizures. It has a high therapeutic-to-toxic ratio. Respiratory depression and impaired gag reflex are rare when used alone.
    ▪ Adult dose is 2-10 mg IV/IM; titrate dose if IV.
    ▪ Onset of action is 1-5 minutes for IV dose.
    ▪ Duration of action is 30-60 minutes for IV dose.
    ▪ Adverse effects include interactions with other sedatives, which commonly result in respiratory depression and loss of gag reflex, exacerbation of glaucoma, and paradoxical reactions.
  o Lorazepam (Ativan) is commonly used to sedate elderly patients and has a wide safety margin. Respiratory depression and loss of gag reflex usually do not result if recommended doses are used. Duration of action is long.
    ▪ Adult dose is 0.5-4 mg IV/IM; titrate dose if IV.
    ▪ Onset of action is 5-10 minutes for IV dose.
    ▪ Duration of action is 4-8 hours.
    ▪ Adverse effects include exacerbation of glaucoma, respiratory and gag reflex, depression (especially when combined with other sedatives or narcotics), and fetal damage.
  o Midazolam (Versed) is commonly used for rapid sedation in emergency settings because of its rapid onset and brief duration of action.
    ▪ Adult IV dose is 1-2.5 mg initially over 2 minutes; reduce dose if patients are elderly or debilitated; allow 2 or more minutes to evaluate response; titrate slowly.
    ▪ Adult IM dose is approximately 5 mg; reduce dose if patients are elderly or debilitated.
    ▪ Onset of action is 1-5 minutes for IV dose and 15 minutes for IM dose.
    ▪ Duration of action is 30-60 minutes.
    ▪ Adverse effects include respiratory depression (especially when combined with other sedatives or narcotics) and exacerbation of glaucoma.
Precautions

- Patient dosing is very variable. More medication may be administered if inadequate sedation results after initial dose.
- Monitor for respiratory depression and loss of gag reflex.
- Immediate inadequate sedation may not mean that medication is inappropriate for the patient. The peak effect may be delayed, or additional doses may be required.
- Consult appropriate references for full prescribing and adverse effect information.
- Chemical restraints can be an effective adjunct or replacement for physical restraints.

This definition does not apply to (1) interactions with patients that are brief and focus on redirection or assistance in activities of daily living, such as hygiene and (2) the use of any psychoactive medication that is a usual or customary part of a medical diagnostic or treatment procedure, and that is used to restrict a patient's freedom of movement (JCAHO, 2000).