

TITLE	RESTRAINT and SECLUSION
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REGULATORY REFERENCE: **42 CFR Part 482.13(e) and (f)** Hospital Conditions of Participation in Medicare/Medicaid programs (10/1/2007)
and State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, 06/05/09.
410 IAC Article 15 Hospital Licensure Rules; current on 2/1/2007 via Indiana IAC website.
JCAHO Standards, Hospital Accreditation Manual, electronic edition, 2009

PURPOSE: To Define the use of Restraints and Seclusion at Memorial Hospital in keeping with the above regulations. In the context of this document, restraint IS NOT a device, the use of a product called a “restraint” does not define whether it falls under this policy.

PATIENT POPULATION: Generic Patients

POLICY: The patient has the right to be free from the use of restraint and seclusion of any form.
In those infrequent situations when limitation of movement is necessary to improve patient well being and protect the patient, staff, and others, the least restrictive means of limitation of a patient's movement shall be enacted. The decision to use restraint or seclusion is based on determining the least risk for the patient between the risk of what might happen if the device is not used and what might happen if the device is used (balanced with the patient’s right to have no restraints).

DEFINITIONS: **Restraint** (Health Care, Physical) – any manual method, physical or mechanical device, material or equipment the immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely;

Chemical Restraint (Medication used as Restraint) - a 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. (Medications which are part of the patient’s regular medical regimen, even if PRN, are not considered drug restraint, even if their purpose is to control ongoing behavior)

Seclusion - is the confinement of a person alone in a room or an area where the person is physically prevented from leaving. (Seclusion is only possible at Memorial in the ECC area – refer to Behavioral Health section for requirements.)

CPI – CRISIS INTERVENTION Nonviolent Crisis Intervention is a type of physical restraint used in emergency situations, eg, Code Violet, etc. It is addressed in **the Nonviolent Crisis Intervention Training Program** and only practiced by persons trained in these activities.

BED SIDE RAILS Whether side rails on a bed are considered restraint is based on the **reasons for which they are used** and whether the patient can lower them or easily go around them. Raising of top side rails is not restraint. Use of full side rails for a patient who is not responding is also not restraint.
Raising of full side rails to limit the patient’s ability to ambulate **can be** restraint. Raising of full side rails at the patient’s request to remind the patient of the narrow bed provided side rails are lowered when requested is also not restraint.

EXCLUSIONS: from this policy

LIMITATIONS OF
MOBILITY RELATED
TO PROCEDURES

Standard practices that include placing security straps across patients and immobilization of limbs for surgical or diagnostic procedures.

CORRECTION
RESTRICTIONS

Restraint or Seclusion imposed by Police (not related to the clinical treatment of a patient.) Refer to **Care of Prisoners** policy.

Patients at Memorial Hospital have the right to be free from restraints of any form that are not medically necessary. However, when necessary, the hospital uses restraint or seclusion **ONLY** to protect the immediate physical safety of the patient, staff or others. Restraint and Seclusion are never used as a means of coercion, discipline, convenience or retaliation by staff.

ALTERNATIVES TO RESTRAINT/SECLUSION -

Every effort shall be made to avoid the use of restraints and seclusion. When interventions are needed, the least restrictive intervention - the most non physical technique - will be used as is appropriate to the situation. Failure of Alternatives **MUST** be clearly documented in the patient's medical record. (See **Appendix A** for alternatives and least restrictive consideration.)

CATEGORIES OF RESTRAINT

Physician Orders and some aspects of Care Requirements vary with the two recognized categories of restraint and seclusion. Based on HCFA, ISDH, and JCAHO regulations, Memorial has identified the 2 categories of **Med-Surg Restraint** and **Behavioral Restraint**. Determination of category of restraint is based on reason for the restraint not the patient's setting.

Med-Surg Restraint constitutes all restraint situations included in this policy which do **NOT** meet the definition of Behavioral restraint. →

Note: Behavioral Restraint is not limited to patients with defined Behavior Health diagnoses.

Restraint for the following situations would be categorized as Med-Surg Restraint

- prevention of interruption of care, ie tube removal, etc.
- control of wandering or prevention of falls
- holding of patients to force medications (non-child)
- any limitation for non-violent or non-self-destructive behavior.

Behavioral Restraint is the restraint or seclusion resulting from an emergency or crisis situation when a patient's behavior becomes **aggressive or violent, presenting an immediate, serious danger to his/her safety or that of others.**

Restraint for the following situations would be categorized as Behavioral Restraint

- **violent** outburst resulting in Code Violet or any use of Therapeutic Physical Management.
- **violent or self-destructive behavior** in patients awaiting transfer to Madison Center.

Consideration related to Restraint:

Restraint may be considered only:

1. If needed to improve the patient's well-being (ie, based on the patient's assessed needs)
2. If less restrictive interventions have been determined to be ineffective
3. If implemented in the least restrictive manner possible
4. If discontinued as soon as possible
5. After comprehensive assessment of the patient with a conclusion that restraint benefits outweigh the risks of restraint.

Physician Orders

1. A physician order for restraint – either med-surg or for violent or self-destructive behavior – is required prior to or, in an emergency situation, immediately after placing a patient in restraints. (Emergency situation placement requires obtaining an order during the emergency or within minutes after the emergency.)
2. Orders for restraints must come from Memorial recognized licensed independent practitioners who

can Admit and/or Attend patients, ie, a medical student can not order restraints.

3. Orders for restraints must never be written as standing orders or as PRN or otherwise “as needed” order. Per CMS regulations, a patient may be limited to Restraining as needed when using a Geri Chair. That is, the patient in a Geri Chair is being restrained by the chair but is not otherwise needing to be restrained, such as, when in bed.
4. A new restraint order must be obtained for each Episode of restraints. (If a staff member ends an episode of restraint, the staff member must obtain a new order if another episode of restraint is needed.)
5. If a physician other than the Attending (or Covering) physician wrote the order for the restraint, the Attending (or Covering) physician must be notified as soon as possible. (For violent or self-destructive behavior, this notification should be within an hour. For med-surg reasons, the notification should be also be within an hour except during the night when, depending on the reason for restraint, it is acceptable to wait until morning to notify the Attending physician.
6. For Med-Surg Restraints, the restraint order automatically has a one calendar day time limit. For the Med-Surg Restraint order to still be in force, the order **MUST** be renewed prior to midnight of the next calendar date. *(Note – the longest possible order would be one written at 0001 on Day 1 and expiring at 2400 on Day 2, which would be 47 hours and 59 minutes).* Physicians may indicate specific time limits of less than one calendar day if desired.

Restraint Order forms is provided and encouraged to be used, see Appendix C.

Discontinuation of Med-Surg Restraint

Restraints must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

A Registered Nurse may discontinue the Restraint as soon as the unsafe situation ends or a less restrictive measure can be used.

Patient Plan of Care Modification

Patients placed in restraint will have their plan of care modified to assure appropriate assessment during restraint use and evaluation for removal from restraints as soon as safe to do so.

(Note: This Plan of Care documentation may be evident in Physician Orders, Profile, and/or Tasks (as for Cerner users) and/or PowerPlans.

Safety

1. Patients placed in med-surg restraint should be dressed in a hospital gown
2. Patients are not restrained face-down in bed.
3. Soft, non-locked restraints, are always tied with a **quick-release tie**.
4. Refer to Restraint Devices section of this document for specific instructions on the application of various devices.

Patient Education

1. Patients need to have constant reinforcement of why restraints are used and what can be done to eliminate the use of restraints, as is appropriate to the patient’s understanding.
2. Reinforce the reason for restraint and activities required in order for restraints to be removed.

Family Education and Involvement

Due to the nature of med-surg Restraints, the appropriate family member shall be well informed of the reason for restraint, process used, and expected result. Explain to family / significant others (s.o.) the need for limitation of patient activity for the reason identified.

Patient Rights, dignity, and well-being are protected even when restraints are used

Recognize that patients in restraints may have strong feelings about the treatment they are receiving - elderly patients may feel they are being treated as a child, etc. Patients need to know that restraints are never used as punishment or to make the life of a staff member easier. As is possible, help the patient

understand why restraints are being used and how we are working to help the patient no longer need the restraints.

Assessment, Monitoring, and Evaluation While Restrained

1. Patients in Med-Surg Restraints receive direct visual observation at the bedside at least once an hour
2. Assess the patient for response to restraints, eg, agitation, calm, abusive, tearful.
3. Circulation of restrained extremities is checked at least every 2 hours. For patients with waist restraint, safe positioning is also assessed at least every 2 hours with correction if sliding, etc.
4. Vital signs (P, R, BP) are assessed at least twice day; temp as per order or usual area procedure.
5. Assessment for skin integrity will take place with physical care and turning and with other activities as appropriate.

Provision of Care While Restrained

1. Patients will have fluids provided/offered at least every 2 hours.
2. Meals will be provided at regular meal times and snacks provided as indicated.
3. Patients will be offered toilet/bedpan/urinal usage at least every 2 hours.
4. Bathing and mouth care will be offered/provided at least every 24 hours.
5. Patients will have the ability to change their positions at least every 2 hours. Patients unable to change positions will be turned at least every 2 hours.
6. Patients will have range of motion movement to any restrained extremity at least every 2 hours. Each restrained extremity will be released for range of motion for at least 2 minutes each 2 hours. As appropriate to the situations, only one extremity need be released at a time.
7. Patients will be assessed for injuries as a result of the restraint and, any observed injury, will be reported promptly.

For specifics on Application of Restraint Device - See **Appendix B**

Documentation

For Adult and Peds Inpatient Nursing Areas, refer to PowerChart documentation – See Appendix F

For documentation on the ICU paper Flowsheet – See Appendix G

Refer to ECC and NICU procedures for documentation in those areas, respectively.

BEHAVIORAL RESTRAINT

Following Guidelines for Behavioral Restraint (Violent or self-destructive behavior) are IN ADDITION to the above MED-SURG Restraints.

1. The physician's order must be time limited and can not exceed:

age 18 and over:	can not exceed 4 hrs
age 9 to 17:	can not exceed 2 hrs
under Age 9:	can not exceed 1 hour
2. The physician may order the renewal of restraint up to a maximum of 24 consecutive hours. An RN will evaluate the patient at the end of the ordered time limit for the patient's age (ie, 4, 2, or 1 hrs) and the RN may extend the restraint based on patient behavior and the time limit ordered by the physician.
3. A physician must provide an in-person evaluation initially* (within 1 hour of restraint) and every 24 hours and determine whether to renew the restraint orders. The Behavioral Health Nurse (or other specially trained nurse) may provide the initial evaluation and, if so, will consult with the attending physician as soon as possible (within 1 hr) after the evaluation. (within 2 hours of the restraint for adults – within minutes for persons under 18)
4. The in-person evaluation, conducted within one hour of initiation of restraint includes at least the following:
 - a. An evaluation of the patient's immediate situation

- b. The patient's reaction to the intervention
- c. The patient's medical and behavioral condition
- d. The need to continue or terminate the restraint or seclusion

Actual Restraining Process

1. Patients in 4-point restraints should usually also have a waist restraint to prevent 'buckling' - ie, would be in 5-point restraints. Patients in full (5 point) restraints, ie, extremities and waist restraints, shall have full siderails up when unattended.
2. Upon initial seclusion, consider whether it might be necessary to search the patient and environment. Involve Security staff as needed. Refer to **Search and Seizure of property** documents

Patient Education

1. Special attention needs to be given to patients in Behavioral restraints.
2. It is advised to have the Behavioral Health Nurse assist in communication with patients to help the patient understand behaviors necessary to eliminate the use of the restraints.

Assessment, Monitoring, Evaluation and Care While in Behavioral Restrained

In addition to other Assessment and Care, Behavioral restraint patients receive continuous monitoring with direct visual observation at the bedside at least every 15 minutes.

REPORTING OF INJURY OR DEATH

- 1 All injuries related to restraint or seclusion are to be reported to Risk Management.
- 2 Patient deaths related to Restraint must be reported to CMS. Reporting will occur thru the Risk Management office. Any of the following Deaths need to be reported to Risk Management IMMEDIATELY:
 - a. Death of a patient in restraint or seclusion
 - b. Death of a patient within 24 hours after the patient has been removed form restraint or seclusion
 - c. Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death – such as, restriction of breathing, asphyxiation, chest compression, etc.
- 3 The date and time the CMS was notified is to appear in the patient's medical record.
- 4 Deaths from Restraints or Side Rails are also reportable events in Indiana (410 IAC 15-1.4-2.2)

RESTRAINT USAGE EVALUATION

Incidents of restraint and seclusion will be evaluated for appropriateness and compliance with this document. Opportunities to decrease the incidence of use of restraint or seclusion and to promote safe use of restraints and seclusion will be pursued. This includes incident management and reporting. See **Appendix D**

STAFFING AND STAFF COMPETENCE

Staff members who restraint or provide care to restrained patients have been trained to do so. Staffing levels and assignments are aimed at minimizing the circumstances of restraint use and maximizing safety of patients who must be restrained. Appropriate to their role, all clinical staff will have ongoing education and training in the proper and safe use of seclusion and restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that in the past may have been treated through the use of restraints or seclusion. See **Appendix E**

Document History:

<u>Date:</u>	<u>Author:</u>	<u>Summary:</u>	<u>Approval Date:</u>	<u>Approval Person or Group:</u>
original			7/1/87 1/29/97	Behavioral Health & Risk Management Care of Patient Committee and Medical Executive Committee
7/10/2000	L Betz, C McCahill	Revisions to current standards	7/10/2000	C McCahill, C Wibbens, MD, D Neufelder
3/2001	L Betz, C McCahill	Revisions to current standards	3/2001	C McCahill, C Wibbens, MD, D Neufelder
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6/2005	L Betz, C McCahill	Revisions to current standards	6/2005	C McCahill, C Wibbens, MD,
9/2008	L Betz	Revisions to current standards	9/2008	C McCahill, C Wibbens, MD,
7/2009	L Betz	Revisions to current standards and PowerForm documentation.		

Appendix A - ALTERNATIVES TO RESTRAINT/SECLUSION OR Least Restrictive approaches

Restraint Risk: Disruption of Therapy

Patient Assessment:

Is patient delirious or demented?

Are there reversible causes of agitation or confusion?

Medications

Acute illness, ie, hypoxia, infections, neurologic event

Physical discomfort: urinary retention, fecal impaction, musculoskeletal pain, limb ischemia

Interventions:

Treat underlying cause

Maximize communication with patient - calm, comforting voice, etc

Assistive devices as appropriate – hearing aids, glasses, communication boards, etc.

Orient and reassure patient

Maintain anxiety-reducing techniques – calm manner, gentle touch, pleasant demeanor

Involve family in bedside care of patient is appropriate/possible

Use hand mitts if possible to avoid pulling tubes

Use Distraction activities to keep hands busy.

Modify environment to decrease attention to interventions, examples, long sleeve shirt over IV, tubing out of patient's vision, etc.

Restraint Risk: Accidental Falls

Patient Assessment:

Conley or Modified Conley fall risk assessment

Confusion or inability to follow instructions to ask for assistance to ambulate

Interventions:

Locate patient where increased monitoring is possible, such as, closer to nursing station.

Adjustment in care scheduling to accommodate patient's patterns for eating, elimination, etc.

Assure safe environment – non-slip floors, lighting, call light in reach, bed in low position

Instruct patient to use grab bars when ambulating or other devices as needed.

Reorient to environment as needed

Restraint Risk: Wandering

Patient Assessment:

Confusion or inability to follow instructions to not leave unit

Interventions:

Reality orientation and psychosocial interventions, verbal redirecting, etc.

Providing someone in attendance (family member or volunteer)

Incorporation of activity, exercise, or diversion, depending on patient capability

Restraint Risk: Violent or Self-Destructive Behavior

Patient Assessment:

Determine basis of behavior, ie, fear, confusion, etc.

Interventions:

Active listening to elicit the patient's underlying feelings, concerns, and fears.

Decrease in negative environmental and sensory stimuli

Frequent positive interaction with staff

Incorporation of activity, exercise, or diversion, depending on patient capability

Use of relaxation techniques such as massage, therapeutic touch, warm drinks.

Patient education in calming manner to reduce fear and promote self care.

Appendix B - Application of Devices

Waist Restraint - Belt - aka "POSEY"

Instructions below are for "Posey" Soft Belt - foam padded, 2-loop style (4125). If using a different style, follow instructions with that product.

Bed, Cart, Stretch:

1. Put the belt over the patient's waist (in front) with the soft foam side toward the patient.
2. Bring the straps behind the patient in a "criss-cross" fashion on the patient's back and pull the ends through the loops at the end of the blue foam pad.
3. Secure the ends of the belt to the bed, stretcher, or cart frame at the waist level.. Do not fasten to side rails. If the cart or bed is adjustable, fasten belt to a part of the bed that will move with the patient. Belt is to be secured out of reach of the patient in a quick release-type knot and in a fashion so as not to slip out of position.
4. Check security and safety of the belt. It is to be smooth on the patient's back, not so restrictive as to obstruct breathing or cause patient discomfort, but secure enough to prevent patient from slipping out of the belt. As a general rule, application is correct if a hand can be passed between the patient's skin and the belt.

Chair

5. Belt is to be positioned around patient as #1 and #2 for bed above but is to be applied lower - over the patient's lap rather than waist. Do not use in chairs with movable cushions.
6. Pull the ends of the belt over the hips, down under the back of the chair at a 45 degree angle around the back legs and secure at a point that will not all the straps to slide in any direction. Secure out of reach of the patient in a quick release-type knot.
7. Check security and safety of belt as in #4 for bed above.

Wrist and Ankle Restraint (obtained from SPD)

Instructions below are for "DeRoyal" Patient Care Wrist Restraint - foam padded, velcro hold, "D" ring. If using a different style, follow instructions with that product.

1. Place wrist or ankle in limb holder with foam side against the skin and the strap on the outside.
2. Bring long tail around limb and secure with velcro. Check tightness to prevent circulation difficulty while ensuring security of strap on wrist or ankle. As a general rule, application is correct if a finger can be passed between the patient's skin and the limb holder.
3. Pull strap through "D" ring and tie - again check circulation and tightness. Adjust so that "D" ring and/or knot is lateral to patient and limb will not be lying on ring or knot.
4. Secure strap to the bed, cart, or stretcher frame or to chair. Do Not secure the strap to side rails. Also, if the bed or cart is adjustable, secure the strap to portions of the frame that move with the patient.

Note: The strap is to be applied so as to easily be untied to free the patient if needed.

NET Bed - Enclosed Bed System

Refer to Document "The Net Bed" procedure

Net Restraint - Net-type physical restraint

Refer to Document "The Net" procedure

Locked Restraint

Important: This is a very undesirable restraint device used only if no other choice works. The Administrative Supervisor and Behavioral Resource Nurse are to be notified of patients requiring this restraint device.

1. Place wrist or ankle in leather restraint with padding side against the skin and the strap on the outside.
2. Secure wrist with lock. Check tightness to prevent circulation difficulty while ensuring security of strap on wrist or ankle. As a general rule, application is correct if a finger can be passed between the patient's skin and the limb holder.
3. Adjust so that buckle is lateral to patient and limb will not be lying on it.
4. Secure strap by lock to the bed, cart, or stretcher frame. Do Not secure the strap to side rails. Also, if the bed or cart is adjustable, secure the strap to portions of the frame that move with the patient.
5. The Key must always be available for all persons caring for the patient while the patient is in locked restraints.

Appendix C – Physician Order Form:

Restraint Order Forms

1. There are 2 Restraint Physician Order forms - separate forms for Med-Surg Restraint and Behavioral (violent, self-destructive) Restraint.
2. For either form, attach the patient identification label and write on the patient's current room number

Med-Surg Restraint Event Order form

- 1 The RN initiating the Restraint enters initial information and contacts the physician (if the physician was not present to give the order.)
 - a. Indicate whether this is the Initial Order for this event or a Continuation Order
 - b. If Initial Order, enter the Primary Reason.
 - c. Enter the Order from the physician and the Restraint Type
 - d. If per Phone, enter the Phone Order information.
- 2 Upon next visit, the Physician signs the order for Restraint and, if the next day, considers whether restraints are to be continued and enters a Continuation Order (ie, 2nd order sheet) if so.

Behavioral Restraint Event Order Form

- 1 The RN initiating the Restraint enters whether there is an imminent risk.
 - a. The Order is then entered along with the time limit based on patient age.
 - b. The time the patient is placed in Restraint or Seclusion is noted.
 - c. The Physician is notified and the Order is obtained for the initial placement.
- 2 The Physician or qualified RN completes the face-to-face Evaluation within 1 hours of placing the patient in Restraint / Seclusion. The Behavior which resulted in the restraint, the Current Status, and the Reaction to Intervention are all documented.
- 3 If the evaluation is by a qualified RN, the RN consults with the physician following the evaluation and the status of continuing restraints or seclusion is determined. If per phone order, the phone order information is documented.
- 4 Upon next visit, the Physician signs the order for Restraint and, if the next day, considers whether restraints are to be continued and enters a Continuation Order (ie, 2nd order sheet) if so.

Appendix D - Restraint Usage Evaluation

The objectives of restraint usage evaluation process are:

1. Decrease the use of restraints.
2. In situations where restraints may still be warranted, assure the use is appropriate and that the least restrictive means are used.
3. Assure requirements of this document are followed.

Prevalence of restraint use is monitored to assure the incidence of use is remaining low. If prevalence shows a shift in restraint use, reasons and appropriate action are taken.

Random evaluation of Med-Surg restraint to assure compliance with standards are met. Data will be compiled for trends.

Each incidence of restraint use for violent or self-destructive behavioral is reviewed by the Behavioral Resource Nurse. In addition to monitoring for appropriate physical safety, the BHN also assesses for meeting assessment and patient care requirement and consults on methods of avoiding future restraint situations. Where indicated, the BHN also facilitates post-restraint debriefings.

Appendix E - Staffing and Staff Competence

Staffing:

Restraints are never used to due the staffing shortages. In certain situations, sitters may be employed to promote patient safety in order to avoid the use of restraints.

Staff Competence:

Appropriate to their role, clinical staff will receive education and training in the proper and safe use of restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that in the past may have been treated through the use of restraints or seclusion.

Physician training includes:

- definitions of restraint, seclusion, and medications as restraint and what is not included in restraint.
- who is authorized to order, discontinue, and initiate restraint and/or seclusion
- the circumstances under which restraint or seclusion is discontinued and the requirement for it to be as soon as possible,
- who can assess and monitor patients in restraint and seclusion and time frame for assessment/monitoring.
- a 'working knowledge' of Memorial's policy.

Staff Training for RNs includes:

- definitions of restraint, seclusion, and medications as restraint and what is not included in restraint.
- requirements for trying alternatives and using the least restrictive restraint measure.
- who is authorized to order, discontinue, and initiate restraint and/or seclusion
- requirements for obtaining a physician order and notification of attending or covering or attending physician.
- use of each Physician Order form
- the circumstances under which restraint or seclusion is discontinued and the requirement for it to be as soon as possible,
- documentation processes in PowerChart (or on paper if not using PowerChart in area)
- if tie restraints are used, the ability to tie the restraint in the Quick Release fashion and understanding that this is the only way to tie the restraint.
- Understanding of Patient Rights issues and balancing this with Patient Safety issues.
- each requirement for patient care while in restraints, ie, monitoring, fluids, toileting, ROM, etc,
- education on the process of determining whether patients should remain in restraint.
- understanding of Behavioral Restraints additional requirements including time limits, extending of restraints if ordered, and the need for the Face-to-Face assessment.
- knowledge of requirement to report injury or death from restraints.
- understanding that restraint and seclusion are never used in place of adequate staffing or as punishment, etc.

Staff Training for Nurse Extenders includes:

- instruction that placement of a restraint is not permitted without RN approval.
- if tie restraints are used, the ability to tie the restraint in the Quick Release fashion and understanding that this is the only way to tie the restraint.
- how to release restraints safely and obtaining RN approval before release
- assessment of patients in waist restraints for respiratory difficulty
- assessment of patients in extremity restraints for circulatory difficulty
- timing requirements for restraint assessment and care, ie, how often to assess, turn, provide fluid, ROM, etc, and the ability to do each of these.
- documentation of restraint care in Cerner (or on paper if used in the area)

Staff Training for RNs who Provide the Face-to-Face within 1 hour of Behavioral Restraint assessment includes:

- understanding of all factors to be considered in the Face-to-Face Interview.
- understanding of timing, reporting, and documenting requirements.

Ideally, this person is a Behavioral Health Nurse (BHN). When the BHN is not available...

Staff Training for Staff who provide Nonviolent Crisis Intervention Training is noted in documents specific to that program.

Appendix F - Restraint Documentation; PowerForm.

Documentation of Restraint use in PowerChart is found under the Results Review menu, 48 hr Results tab.

Refer to ECC and NICU procedures for documentation in those areas, respectively.

For Inpatient Nursing areas, documentation of Assessment and Care Provided will be noted on the Cerner record, on Restraint PowerForms. The hourly or q15 minute visualization of the patient may also be noted on the Visual Check PowerForm or IView options.

Restraint PowerForms There are 3 restraint PowerForms for Med-Surg Restraint,

Restraint Initiation – used by the RN upon initiation of the restraint event for Med-Surg Restraint

Obtained from Initiate Restraint task

Restraint Assessment/Discontinuation – used by the RN for q 12 hour assessment for continuation of the restraints and used for Discontinuation of the restraints.

Obtained from Restraint Assessment per RN task which is set for each 8 hours.

Restraint Monitoring – used by the RN or Nurse Extender to document patient care.

Obtained from Restraint Care task which is set for every 2 hours.

Appendix G – Restraint FlowSheet

1. ICU has a section on their paper flow sheet which uses a Restraint Flowsheet:

- the checkmark used on this form indicates that the activity was done (visual check), was correct (alignment is good) or would otherwise be answered yes (ie, fluids offered).
 - initials also can be used to mean the activity was done (visual check), was correct (alignment is good) or would otherwise be answered yes (fluids offered).
 - arrow indicates the assessment or activity is the same for each subsequent assessment, example - toileting offered might have diaper in first space with an arrow for the rest of the shift. **Arrow can not be used in 1st assessment of a shift nor in the Visual Check spaces. Arrow use is primarily for ease of noting situations which do not change during the shift, ie, foley or NPO.**
 - asterisk or NN refers the reader to a continuing notation in the narrative notes.
Note: There is a need for narrative notation upon initial placement of restraint and at points of assessment for re-orders, etc. There is no requirement that asterisks be indicated on the flow sheet for each narrative documentation, however if the writer wishes to clarify that there is a continuation of charting on the narrative notes, using the * may be desired.
 - Accepted, Refused, and Sleeping may be coded with A, R, S, respectively, in the Toileting, Fluids and Position spaces, as appropriate.
 - a plus sign used in the ROM spaces means Acirculation is not altered negatively by restraint, restraint to this extremity has been removed for at least 2 minutes, and range of motion, either active or passive, has occurred.®
Note: a checkmark can also be used to indicate this is true.
2. The only difference in use of this form for Med-Surg Restraint and Behavioral Restraint is the frequency of Visual Check. For a Med-Surg Restraint, the Visual Check qhr will be completed and the q15min checks left blank.
 3. For a Behavioral Restraint, the q15min checks will be completed and the qhr left blank. The Behavioral Visual Check spaces are appropriate for q15 minute checks as 0-14 min is from the start of the hour in this column until 14 minutes into the hour, 15 to 29 min is the 2nd 15 minute section of this hour, 30 to 44 min covers the 3rd 15 minutes of time and 45 to 59 minutes concludes the last 15 minutes of the hour. The 0-14 in the 2300 column represents 2300 to 2314 on the date of this form. The last 15 minute time period on this form would be 2245 thru 2259 on the day after the date on this form. Dating this form for the 2 days involved is acceptable but not required.)
 4. A checkmark or initials in the visual check means the patients was *“observed visually with no concerns for safety noted.”*
 5. The arrow code is not an appropriate code for the visual check spaces. When it is used in other categories on the form, it is not used as the 1st assessment in the shift.
 6. Enter an appropriate word or code for the categories of Toileting, Fluids, and Position.
 7. Under Waist, note whether the waist restraint is on or off.
 8. For Alignment is Good, a checkmark or initials indicates that the patient *is in a proper alignment to be safe and comfortable*® which includes not sliding down in the bed or chair which might result in decreased breathing ability, etc.
 9. For Wrist and Ankle Left and Right spaces, indicating whether the restraint is on or off on the extremity. (Left and Right are the patient’s left and right)
 10. For Wrist and Ankle ROM, the specific space refers to the location immediately prior. Entering the plus sign means that the *“circulation is not altered negatively by restraint, restraint to this extremity has been removed for at least 2 minutes, and range of motion, either active or passive, has occurred.”*

11. The initial space for each time is completed with the initials of the primary person completing the assessment.
These initials identify the person who entered the checkmark under visual checks if a checkmark was used.
12. All initials used on the form are defined at the bottom of the page with Signatures (and job class initials) to correspond to the initials.