

**Key: Evidence-based Practice  
Recommendations**  
R = Research-based  
N = National Practice Guideline/Protocol  
L = Literature  
E = Expert Opinion/Consensus

## **ATTACHMENT C:**

### **UCLA Healthcare - Department of Nursing General Care Guidelines**

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#### **RESTRAINTS: Care of Patients in Restraints**

##### **SCOPE**

This guideline applies to the Ronald Reagan UCLA Medical Center (RRUCLAMC) and the Santa Monica UCLA Medical Center (SMUCLAMC) and Orthopaedic Hospital. This guideline does not apply to the outpatient clinics or Resnick Neuropsychiatric Hospital (NPH).

The Restraint Guideline (Nur-G1008) for Care provides the structure and basis for the Plan of Care. It defines assessment parameters, interventions, and outcome criteria / goals. Individualized goals, specific to the patient and updated/revised as appropriate by the RN each shift.

##### **GOALS/OUTCOME CRITERIA**

1. Protection from injury to self by inadvertent endotracheal tube dislodgment or self- extubation, central venous catheter, invasive line or tube dislodgment evidenced by maintenance of airway
2. Optimal circulatory, motor and sensory functioning.
3. Care provided with dignity, preservation of rights, and well-being.
4. Basic care (toileting, hygiene, hydration, nutrition) and comfort provided.
5. No evidence of skin breakdown related to use of restraints.
6. Least restrictive alternatives are considered and restraints are used for the shortest period of time possible.

##### **ASSESSMENT**

Clinical justification for use of restraint is assessed on a case-by-case basis:

1. Assessment High Risk Patients - Specific conditions in which frequent presentation of behavior may place patient at high risk for altered mental status and potential injury to self/others including:
  - a. Altered cerebral perfusion
  - b. Hypoxia
  - c. Electrolyte imbalance
  - d. Sepsis
  - e. Post Traumatic Brain Injury
  - f. Dementia/ Alzheimer dx
  - g. Brain Lesions
  - h. Epilepsy
  - i. Drug sensitivity or medication induced delirium

- j. Alcohol / Recreational Drug ingestion
  - k. Encephalopathy
  - l. Post Anesthesia
2. Specific procedures in which restraints may be necessary to prevent harm to the patient when effectiveness of procedure is compromised and endangers the patient such as:
- a. Emergent Intubation
  - b. Insertion of invasive catheters
  - c. Magnetic Resonance Imaging (MRI), Computed Tomography (CT) Scans, Angiography procedures

## **USE OF LESS RESTRICTIVE MEASURES PRIOR TO INSTITUTING RESTRAINTS**

Note: An individualized approach to care is the best way to avoid use of restraints for patients with acute confusion and cognitive impairment. **R<sup>1</sup>**

*Consider the following alternative measures before implementing Restraints: L<sup>1</sup>, L<sup>2</sup>*

### **Alternatives Measures include: (See Appendix B)**

- Hand Mittens (unrestrained)
- Activity Apron
- Body Holder Support Device (Bed or Chair)
- Bed Check Monitoring Device or Bed Alarms
- \*Elbow Immobilizer (Freedom Splints) / \*No-No's in Pediatrics (these devices while "less restrictive" meet the definition of a restraints and require MD Restraint Order).

### **Physiologic Measures**

- Comfort measures
- Positioning/back massage
- Pain/Anxiety Relief
- Ensure patient is clean & dry
- Toileting Routinely (offer urinal)
- Check for hunger/thirst

### **Psychological Measures**

- Frequent reorientation to person, time, place with verbal redirection
- Soothing music, therapeutic relaxation techniques, Urban Zen
- Diversional activities: exercises, TV/Music, play therapy
- Companionship/Supervision: family in room, constant observational aide,
- Keep patient well informed and allow active participation in care

### **Environmental/Safety Measures:**

- Consider noise, lighting in room
- Relocate patient near nursing station
- Security in proximity (e.g. ER setting)
- Frequent checks for environmental/patient safety

## INTERVENTIONS:

### Non-Violent (Medical-Surgical) Restraints:

Non-violent restraints are used when alternatives and least restrictive methods have been ineffective to prevent injury and exhibit due to accidental dislodgment of invasive-central lines, tubes or drains, hypoxia, electrolyte/metabolic imbalance, dementia, encephalopathy, drug sensitivity, or sepsis.

- a. Agitation Level +1 or +2 (See Agitation Scale)
- a. Pulling/Tugging at invasive lines/tubes
- b. Confusion/Disorientation
- c. Delirium/Cognitive impairment affecting safety judgment
- d. Wandering behavior w/ impaired safety judgment

Agitation Scale	
+ 3	Immediate threat to safety
+ 2	<b>Agitated, does not calm to verbal</b>
+ 1	<b>Agitated, calms to verbal</b>
0	Calm, follows commands

2. Notify the MD, NP, or PA, as **soon as possible (within 2 hours)** and obtain restraint order. The order must be entered into EMR within the 2 hour time frame of initial restraint application.
3. Non-violent (medical/surgical) restraint orders can never written as PRN or as 'Standing Orders'.
4. **Vital signs are monitored and physical assessment documented (including respiratory and cardiac status)** per nursing guidelines of care or more frequently as indicated or ordered
5. Notify the physician, NP, or PA immediately for a significant change in patient condition.
6. Renewal orders for ongoing restraints are **required each calendar day**.
5. New restraint orders are required upon patient transfers to another unit or service, upon transfer to another level of care (e.g. ICU to floor) upon examination of the patient by physician, NP, or PA.

### Flowsheet Documentation - Non-Violent (Medical-Surgical) Restraint:

The screenshot displays the Epic EMR interface for a patient named Connecticut, Ripley. The main window shows a 'Doc Flowsheets' section with a table for 'Medical Surgical/Non-Violent Restraints'. The table includes columns for 'Admission' (3/21/13) and 'Rate' (1000). The table rows are categorized into 'Justification', 'Restraint Type and Location', and 'Restraint Monitoring'. A blue arrow points to the 'Injury/LOC/Circ/Sens/Motor Q2h' row in the 'Restraint Monitoring' section. The right-hand panel shows 'Value Information' with a 'P' status and 'Last Filed Value' section with a 'P' status.

- ✓ A (P) mark (**Q2 hours – row 1**) indicates observation and monitoring of patient for presence of **injury, level of consciousness (LOC), circulation, sensory, and motor** (observe and assess more frequently as appropriate).
  - Assure that restraints are appropriately applied
  - Assess skin integrity and circulation of restrained extremity and/or torso.
- ✓ A (P) mark (**Q2 hours – row 2**) indicates **release** of restraints, **range of motion**; assessment of **need for hygiene, elimination, hydration, nutrition, position change**; and **reassessment** of need to continue restraints based on patient response to less restrictive interventions.
- ✓ For **sleeping patients, use (S)** in place of **Q2 hour** assessments when a patient is sleeping. An (S) indicates that the sleeping patient's skin color and extremities checked for adequate tissue perfusion and circulation; breathing is observed (**check that respiratory rate is within normal limits for the patient**) and documented.
- ✓ **Discontinue restraints** when criteria no longer apply. **Document restraints as “Off” on the restraint flowsheet. A new order is required** if restraints are re-applied.
- ✓ A **“Restraint Plan of Care”** is required in the **Care Plan section in the EMR**; and individualized patient goals/outcome objectives updated as outlined in this guideline (NUR-G1008).
- ✓ The **patient’s response to interventions and less restricted measures used are included in the documentation.**

**Flow Sheet Example: Directly Supervised Release (DSR)**

	10/17/15				10/18/15				10/19/15						
	2000	2200	0000	0200	0400	0600	0800	1000	1530	1600	1800	2000	2200	0000	0200
<b>Medical Surgical/Non-Violent Restraints</b>															
Order current per calendar day?	Yes						Yes					Yes	Yes	Yes	Yes
Advisement	1						4					4	4	4	4
Alternative Measures	O;CM;R						O;CM;R					O;CM;R	O;CM;R	O;CM;R	O;CM;R
<b>Justification</b>															
Clinical Justification	PI;P						PI;P					PI;P	PI;P	PI;P	PI;P
<b>Restraint Type and Location</b>															
Restraint Type	S;M						S;M	DSR		S;M	Off	M	M	M	M
Restraint Location	H;W						H;W		W;Bi			H;Bi	H;Bi	H;Bi	H;Bi
<b>Restraint Monitoring</b>															
Injury/LOC/Circ/Sens/Motor Q2h	P	P	P	P	P	P	P		P	P		P	P	P	P
Release/ROM/Needs/Reassess Q2h	P	P	P	P	P	P	P		P	P		P	P	P	P

- ✓ **Directly Supervised Release (DSR)** may be used to document when the nurse temporarily releases patient from restraints while providing direct care at the bedside or directly supervising the patient.
- ✓ DSR may be used to document when restraints are temporarily removed while family is visiting at the bedside for brief periods of time (e.g. holding patient's hand and directly supervising patient).
- ✓ If a sitter/COA is present or a family member remains at the bedside with the patient for extended periods (greater than 4 hours), it is appropriate to discontinue the restraint and documentation reflected as "OFF" on the flowsheet.
- ✓ ***When restraints are documented on the flow sheet as "Off", a new order is required if restraints are re-applied. If restraints are necessary to ensure patient safety, a NEW restraint order must be obtained within 2 hours of restraint re-application.***
- ✓ DSR is NOT to be confused with "PRN" use of restraints (**PRN is prohibited**).

## **Violent / Self-Destructive (Behavioral) Restraints:**

**Violent / Self Destructive Behavioral** restraints apply to patients who exhibit new onset, unanticipated and unexpected, violent, abusive, aggressive or combative behavior with a sustained/marked agitation level of **+3 (Immediate threat to safety)** posing an immediate danger to self for others.

**1. Contact MD, NP, or PA immediately**; MD must **evaluate patient face-to-face (in-person) within 1 hour of** VIOLENT (BEHAVIORAL) RESTRAINT application. The actual time of face-to-face assessment must be documented in Violent (Self Destructive) Restraint Order Set.

<b>Agitation Scale</b>	
<b>+ 3</b>	<b>Immediate threat to safety</b>
+ 2	Agitated, does not calm to verbal
+ 1	Agitated, calms to verbal
0	Calm, follows commands

**2. Violent / (Behavioral) Restraint orders are "Time limited"** and require new orders at specific intervals in accordance with regulatory requirements.

- a. Every 4 hours for adults;
- b. Every 2 hours for 9-17 years of age
- c. Every 1 hour for under 9 years of age

3. When the order is about to expire, the RN must contact the MD/designee to report the results of his/her assessment and request the renewal order (not to exceed time limits established).
4. The restraint orders may be renewed within the specified time limit for up to 24 hours at which time the patient must see and assessed by MD/NP/PA (face-to-face) before issuing a new order.
5. **“Tuff Cuffs”** have replaced **“Hard/leather”** for violent/behavioral restraints in the inpatient setting. Patients admitted from the Emergency Department in Hard (or locked) Restraints must have ER restraints replaced with Tuff Cuffs upon arrival to acute care nursing units.



**Tuff Cuffs” (Quick Release) – Available on your Materials Management carts or obtained through Materials Management for Violent/Self Destructive Behavioral Restraint Patients.**

Wrist (Blue Color Coded) - **“Restraint (Wrist) Tuff Cuff”**

Ankle (Red Color Coded) - **“Restraint (Ankle) Tuff Cuff”**

6. As soon as **patient de-escalates** (Agitation less than +3), **use least restrictive measures** (e.g. change to "non-violent (medical-surgical)" restraints or discontinue patient restraints.
7. Collaborate with patient and staff to help patient regain control & revise patient's treatment plan as needed
8. **Criteria for Early Removal:** The RN may discontinue restraints when the original behavior identified in the MD/designee orders is no longer exhibited. However, new restraint orders are required if restraints need to be reapplied and alternatives remain ineffective.
9. **Transporting “Violent/Self Destructive Restraint” Patients to Procedures:** Any patient Violent (Behavioral) restraints must be **accompanied** by and **continuously monitored** by a registered nurse. To ensure patient safety, the patient must not be left unattended

## Flow Sheet Documentation - Violent/Self-Destructive Restraints:

The screenshot displays the Epic Hyperspace interface for a patient named Connecticut Ripley. The flow sheet is titled 'Behavioral/Violent Restraints' and includes a table with the following data:

Behavioral/Violent Restraints	Value
Length of Order	4
Immediate MD Notification	Yes
Face to Face Within 1 Hour	Yes wit...
Advisement x1	D
Alternative Measures	R;O;F;E
Retired - Alternative Measures (View Only)	
<b>Justification</b>	
Clinical Justification	+3Ag
<b>Restraint Type and Location</b>	
Restraint Type	T
Restraint Location	4 - pt
Retired - Restraint Type (View-only)	
Retired - Restraint Location (View-only)	
<b>Restraint Monitoring</b>	
Continuous Obs/Q15 LOC/C/S/M	PPPP
Release/ROM/Needs/Reassess Q2h	P
Retired - Release/ROM/Needs/Reassess Q2h	

The 'Value Information' panel on the right shows the following details for the 'PPPP' entry:

- Taken by: Kim Plantain, RN at 03/21/13 1000
- Recorded by: Kim Plantain, RN at 03/21/13 1037
- Last Filed Value(s) - Within Last 24 Hour(s): PPPP by Kim Plantain, RN at 03/21/13 1000
- First Filed Value: PPPP by Kim Plantain, RN at 03/21/13 1000

- ✓ **Continuous observation with q 15-minute documentation is documented EACH hour as (PPPP).** Each (P) mark indicate the following assessments were “performed” Q15 minutes o flow sheet reflects continuous observation of the patient, and assessment of LOC, circulation, sensory, and motor.(CSM)
- ✓ **A (P) mark Q2 hours** on the flow sheet indicates assessment of patient’s need for hygiene, elimination, hydration, nutrition, position change and skin integrity; release of restraints, range of motion and reassessment of need to continue restraints
- ✓ Vital signs, including respiratory and cardiac status are assessed and documented per unit standard
- ✓ **Sleeping patients require continuous monitoring. Use (S) in place of Q2 hour** assessments when a patient is sleeping. An (S) indicates that the sleeping patient's skin color and extremities checked for adequate tissue perfusion and circulation; breathing is observed (**check that respiratory rate is within normal limits for the patient**). Document respiratory rate (RR) in Vital Signs (VS) record as appropriate to patient condition and per unit standard.

## Nursing Plan of Care for Restraints: Flowsheet Example

The screenshot displays the Epic Hyperspace interface for a patient named Connecticut Ripley. The main window shows the 'Care Plan' section, which is expanded to show 'Restraints'. The 'Restraints' section includes a 'Medical Surgical Restraints' section with a description: 'This guideline/care plan applies to Ronald Reagan UCLA Medical Center and the Santa Monica UCLA Medical Center and Orthopaedic Hospital.' Below this, there are several 'Goal' statements: 'Goal: Protection from injury to self by inadvertent endotracheal tube dislodgment or self-extubation, central venous catheter, invasive line or tube dislodgment.', 'Goal: Optimal circulatory, motor, and sensory functioning.', 'Goal: Care will be provided with dignity, preservation of rights, and well-being.', 'Goal: Basic care and comfort will be provided. This includes: toileting, hygiene, hydration, and nutrition.', 'Goal: No evidence of skin breakdown relative to use of restraints.', and 'Goal: Least restrictive alternatives are considered and restraints are used for the shortest period of time possible.' The interface also shows a 'Web Links' section with a link to 'UCLA Nursing Guideline Nur-HS G1008: Restraints Guidelines Alerts & Considerations'. The bottom of the window shows a status bar with 'Showing all problems, goals, and interventions.' and buttons for 'Expand All', 'Collapse All', 'Problems', and 'Goals'.

- ✓ **Activate Restraint Plan of Care for Patients in Non-Violent or Violent Restraints:** in the Care Plan section of EHR. Individualized patient goals and plan of care are updated reflecting nursing guidelines of care identified in this document (Nur-G1008).
- ✓ Restraint patients are at high risk for skin breakdown as well as potential aspiration.
- ✓ Preventative measures to prevent skin breakdown and aspiration risk are included in the plan based upon individual patient assessment per Population and Nursing Guidelines and standard of care.
- ✓ Nursing interventions and patient progress toward the goals are included in nursing documentation. Patient progress (patient's responses to interventions) are summarized in the *End of Shift Summary* in narrative format every shift. Incorporate related nursing interventions into the *Nursing Clinical Notes, Assessment, and the Daily Care/Safety Flowsheet* (Doc Flowsheets Activity Tab).

### **PATIENT/ FAMILY EDUCATION**

1. Patient /Family will be informed of purpose/reason for restraint, alternative measures taken prior to restraint use, potential risk benefits, behaviors conditions required for removal of restraints, and care/monitoring provided to patient during restraint use.
2. Patient/Family will express understanding of purpose/staff commitment to insuring basic rights and human dignity.
3. Patient/Family Education is documented under the Patient Education Navigator.

**RESOURCES**

UCLA Department of Nursing Constant Observation Algorithm

UCLA Healthcare – Department of Nursing Restraint Competency for RNs/LVNs

[MC Policy # 1321 – Restraint Policy](#)

[MC Policy # 1313 – Involuntary Detention of Mentally Disordered Persons for Evaluation and Treatment](#)

[MC Policy # 1491 – Medical Incapacity Hold \(NEW\)](#)

The Joint Commission Comprehensive Accreditation Manual 2011. Provision of Care, Treatment and Services. Standards PC 03.05.01 through PC 03.05.19.

Hospitals – Restraint/Seclusion Interpretive Guidelines & Updated State Operations Manual (SOM) Appendix A, April 11, 2008.

**REFERENCES**

Key: **R** = *Research-based*    **N** = *National Practice Guideline/Protocol*    **L** = *Literature*    **E** = *Expert Opinion/Consensus*

- R**<sup>1</sup> Sullivan-Marx EM, Achieving restraint-free care of acutely confused older adults. J Gerontological Nursing 2002; 27(4): 56-61.
- L**<sup>1</sup> Rader J: Modifying the environment to decrease use of restraints. J Gerontol Nursing 17(2):9-13, Feb 1991.
- L**<sup>2</sup> JCAHO: Restraint and Seclusion. Complying with Joint Commission Standards. 2001.

**Contact**

RR 8ICU Content Expert

**REVISION HISTORY**

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**APPROVAL**

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