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

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.
- 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
- I. 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^1

Consider the following alternative measures before implementing Restraints: L1, L2

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.

- 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

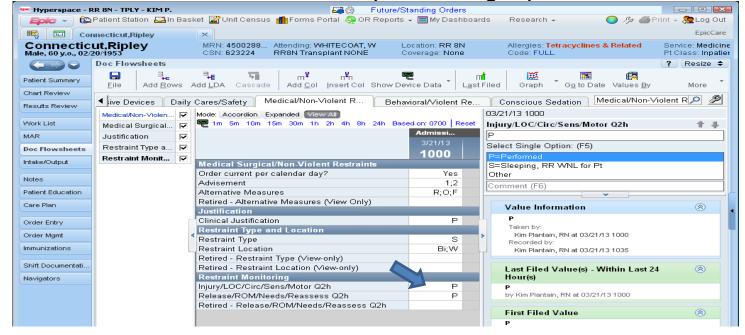
Agitation Scale

- + 3 Immediate threat to safety
- + 2 Agitated, does not calm to verbal
- + 1 Agitated, calms to verbal
 - 0 Calm, follows commands

. 1

- 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:



- √ A (P) mark (<u>Q2 hours row 1</u>) 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
 - o Assess skin integrity and circulation of restrained extremity and/or torso.
- ✓ A (P) mark (<u>Q2 hours row 2</u>) indicates <u>release</u> of restraints, <u>range of motion</u>; 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 <u>new order is required</u> 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) kestrami type 0200 Previous: S;M Medical Surgical/Non-Violent Restraints Select Multiple Options: (F5) Yes Order current per calendar day? Yes Yes Yes Yes Advisement S=Soft Restraints Alternative Measures O:CM:R O:CM:R O:CM:R O:CM:R O:CM:R O:CM:R M=Mittens - Restrained Justification V=Vest - Chest/Waist Clinical Justification PI:P PŀP PŀP PŀP PŀP SR=Side Rail Restraint Type and Location EI=Elbow Immobilizer - Freedo Restraint Type S:M ∃,M DSR 1 🎾 S:M Off M NN=No-No's - Peds only Restraint Location H:W H:W W:Bi H:Bi H:Bi H:Bi H:Bi SR=Direct Supervised Rele Restraint Monitoring Other (Comment) DSR=Direct Supervised Release Injury/LOC/Circ/Sens/Motor Q2h Release/ROM/Needs/Reassess Q2h 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 <u>immediately</u>; MD must evaluate patient <u>face-to-face</u> (in-person) <u>within</u> <u>1 hour of</u> VIOLENT (BEHAVIORAL) RESTRAINT application. The actual time of face-to-face assessment must be documented in Violent (Self Destructive) Restraint Order Set.

Agitation Scale

- + 3 Immediate threat to safety
- + 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.

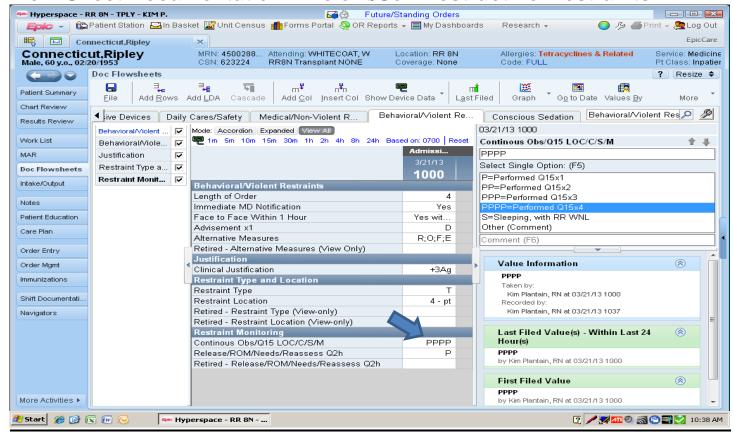


Tuff Cuffs" (Quick Release) – Available on your Materials Management carts or obtained through Materials Management for Violent/Self Destructive Behavioral Restraint Patients.

Wrist (Blue Color Coded) - "Restraint (Wrist) Tuff Cuff" Ankle (Red Color Coded) - "Restraint (Ankle) Tuff Cuff"

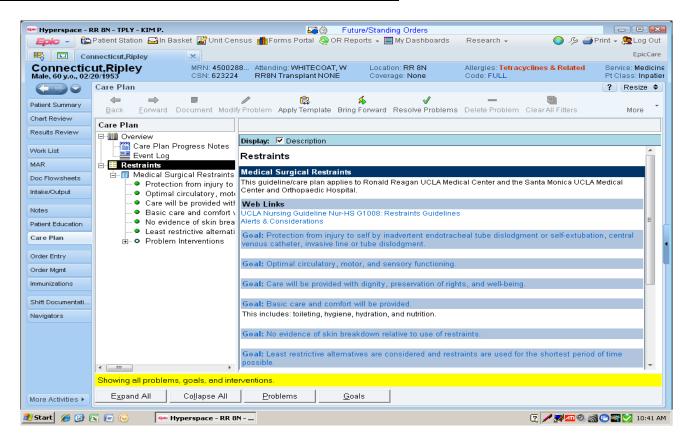
- 6. As soon as *patient de-escalates* (Agitation less than +3), *use least restrictive measures* (e.g. change to "non-violent (medical-surgical)" restraints or discontinue patient restraints.
- 7. Collaborate with patient and staff to help patient regain control & revise patient's treatment plan as 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:



- ✓ 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



- ✓ 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 Cares/Safety Flowsheet (Doc Flowsheets Activity Tab).

PATIENT/ FAMILY EDUCATION

- 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: $\underline{\mathbf{R}} = Research-based$ $\underline{\mathbf{N}} = National\ Practice\ Guideline/Protocol$ $\underline{\mathbf{L}} = Literature$ $\underline{\mathbf{E}} = Expert$ Opinion/Consensus

R¹ Sullivan-Marx EM, Achieving restraint-free care of acutely confused older adults. J Gerontological Nursing 2002; 27(4): 56-61.

L¹ Rader J: Modifying the environment to decrease use of restraints. J Gerontol Nursing 17(2):9-13, Feb 1991.

L² JCAHO: Restraint and Seclusion. Complying with Joint Commission Standards. 2001.

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RR 8ICU Content Expert

REVISION HISTORY

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APPROVAL

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