Restraints
Goals and Objectives

- Review MSHA Restraint Philosophy
- Review alternatives to patient restraints
- Review the purpose of patient restraints
- Review the risks of restraints
- Review the expected outcomes of the implementation of restraints
- Review MSHA restraint policy: Violent and Non-violent
MSHA Restraint Philosophy

- All patients have the right to be free from physical or mental abuse and corporal punishment
- All patients have the right to be free from restraints and seclusion of any form imposed as a means of coercion, discipline, convenience, or retaliation by team members.
Alternatives to Restraints

- Reality Orientation
- Structured Activity
- TV, Music, Videos
- Relaxation Techniques
- Allow Wandering (If Appropriate)
- Family, Friend, Significant Other Assistance
Purpose of Restraints

- Restraints are used to provide a safe environment in situations in which a patient is at **significant** risk of harming him/herself or others.

- Restraints or seclusion may be implemented only to ensure the immediate physical safety of the patient, team member, or other individual in proximity to the patient.
Risks of Restraints

- Nationally, multiple deaths have occurred related to the use of restraints in the hospital setting
- Restraints and seclusion have the potential to produce serious consequences such as physical and psychological harm, loss of dignity, violations of the patient’s rights, and death
- Injury or death of a patient while in restraints is considered a sentinel event
Expected Outcomes of Restraint Implementation

- Patient will be able to continue with the planning and implementation of his/her personal care plan if appropriate
- Patient’s rights, dignity, physical and/or psychological well-being will be maintained
- Injuries will not occur to the patient, team members, or others in proximity to the patient
Non-Violent Restraints

- Implemented for a non-violent, non-aggressive patient
- Implemented to promote medical/surgical healing
- Implemented secondary to the patient's inability to follow instructions or contract for safety
- The decision to implement the restraint is driven by the patient assessment, diagnosis and failure of less restrictive measures
Violent Restraints

- Implemented in an emergency or crises situation
- The patient’s behavior is aggressive or violent
- The patient is a serious danger to his/herself and others
- The decision to implement is driven by behavior not diagnosis
Chemical Restraint

- Violent Restraint
- Restraint implementing a medication
- Implemented to restrict or manage a behavior
- The medication utilized is a non-standard treatment for the patient’s condition/diagnosis
- One dose of medication/One date in time
Seclusion

- Violent Restraint
- Involuntary confinement of the patient to a private room that has been removed of all hazards
- The patient is physically prevented from the leaving the room
- Utilized in an emergency or crises situation
- Utilized for the management of violent or self-destructive behavior
Temporary Release

- Directly supervised release i.e. the patient remains under the direct supervision of a team member
- The purpose is to meet the patient’s medical needs and perform the patient's daily care routine
Non-Violent Restraint Policy/Procedure

- The RN obtains a physician’s order before implementing the restraints. The order must be authenticated within 24 hours.
- Criteria for restraint release is determined when the restraint order is written.
- New physician order is required every calendar day.
- Monitoring is required every 2 hours for the patient in a non-violent restraint.
- Monitoring is the responsibility of the RN; however, certain components of the monitoring can be delegated to other team members.
Non-Violent Restraint
Policy/Procedure

- When the patient has met the criteria for release determined at the time of the initial physician’s order, the restraints may be released by the physician or the RN.

- Once discontinued, if restraints are needed again, a new order must be obtained even if the previous order’s 24 hour time frame has not expired.
Violent Restraint Policy/Procedure

- The RN obtains a physician’s order.
- In an emergency, the RN may apply the violent restraints before obtaining the physician order.
- An order must be obtained immediately when restraints are applied emergently.
- Criteria for release will be determined at the time of the order.
- You must renew the order within the following time frames:
  - Ages 18 and older: 4 hours
  - Ages 9-17: 2 hours
  - Under 9 years of age: 1 hour
Violent Restraint Policy/Procedure

- The physician must conduct a face-to-face assessment:
  - in at least 1 hour of the application of restraints
  - at least every 8 hours for patients 18 years or older
  - at least every 4 hours for patients under age 18

- If the restraints are required for more than 24 continuous hours, the medical director or designee must conduct a face-to-face evaluation of the patient and review the medical record

- The medical director or designee must give authorization to continue the restraints

- The RN must notify his/her chain of command when 24 hours has lapsed
Violent Restraint Policy/Procedure

- Requires 1:1 staffing
- Document patient status at least every 15 minutes on the Violent Restraint Flow Sheet
- The RN or delegated LPN or unlicensed may document on the Violent Restraint Flow Sheet
- Allow opportunity to toilet and take fluids at least every hour and document
Violent Restraint Policy/Procedure

- Upon initiation of violent restraints, the RN will assess the patient’s behavior and physical condition.
- At least every one hour, the RN must reassess the patient.
- When the patient meets the criteria for release from the violent restraints, the Out of Violent Restraint Progress Note must be completed which is an SBAR note reviewing the episode.
- Within 24 hours of the initiation of violent restraints, an episode review will be conducted with the team members involved in the episode. This will include the physician, nursing team members, family, patient (if appropriate), etc.
# Key Documentation Phrases

<table>
<thead>
<tr>
<th>Violent</th>
<th>Non-Violent</th>
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<tbody>
<tr>
<td>Combative</td>
<td>Does not follow direction</td>
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<tr>
<td>Kicking</td>
<td>Related to medical condition</td>
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<tr>
<td>Hitting</td>
<td>Pulling at device</td>
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<tr>
<td>Biting</td>
<td>Attempting to get out of bed</td>
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<tr>
<td>Aggressive</td>
<td>Medical condition impairs the patient’s judgment</td>
</tr>
<tr>
<td></td>
<td>Patient’s medical condition prevents the patient from following through with directions</td>
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