RESTRAINT USE COMPARISON CHART

BEHAVIORAL VS. MEDICAL-SURGICAL

TOPIC/ACTION	BEHAVIORAL HEALTH	MEDICAL-SURGICAL
Definitions	Applies to ALL settings (units), when restraints and seclusion are used to manage the behavior of a violent and aggressive patient, (i.e., hitting, punching, biting, kicking, throwing, choking, etc.), whether the behavior is present on admission or after admission. Behavior presents an immediate danger to the patient and others. The behavior may result from acute changes in the patient's mental status that results in non-redirectable agitation, confusion, or aggressive behavior potentially or actually injurious to the patient or others. Restraints can be physical, mechanical or medication. Seclusion is a room where the patient is physically prevented from leaving.	Applies to situations when restraint is used for acute medical/post surgical reasons to protect the patient from him/herself or others caring for the patient. Restraint can be physical, mechanical, or medication.
RN Responsibilities	• Conduct an initial assessment of the patient and document findings in the medical record. Based upon findings by using the Clinical Justification/Decision Making in the text of the policy determines whether the patient will benefit from the use of restraints (after alternative measures have failed and signs of behavior are still evident). • An appropriately trained RN may initiate the use of restraints/seclusion in case of an emergency, wherein the emergency is of such intensity that there is not sufficient time to telephone the attending physician. Note: The decision to initiate or continue restraints must be based upon a clearly illustrated set of criteria to be utilized at initial assessment and subsequent reassessments that are designed to examine the patient's medical signs and symptoms, and help to build a care plan to meet the patient's needs. • Notify the attending physician (either directly or if she/he cannot be reached by telephone, via pager) of the patient's change in mental status or medical status. • Note: Regardless of the order, the use of restraints shall be limited to the duration of the emergency situation. • Collaborate with the attending physician to determine the appropriate level of care.	same
Time allowed from initiation of restraint until telephone or written physician order is obtained.	Immediately upon/following initiation of restraint/seclusion. The treating physician must be notified as soon as possible if the restraint was not ordered by the treating physician. Must have order within 1 hr of applying the restraint.	same

Initial physician face-to-face examination of patient	The MD/LIP must see the patient in person as specified below: • Patient 18 years and older - Within 4 hours of initiation of restraint/seclusion need • Patient 17 years and younger – Within 2 hours of initiation of restraint/seclusion • If Patient is a MEDICARE patient – within 1hr of initiation of restraint/seclusion	same
Order duration/expiration (maximum duration of a restraint order)	Written or verbal orders for initial and continuing use of restraint/seclusion are time limited as indicated below, and must be renewed within this time frame: • Patient 18 years and older - to 4 hours of initiation/renewal order of restraint/seclusion • Patient 17 years and younger – to 2 hours of initiation/renewal order of restraint/seclusion • If Patient is a MEDICARE patient – to 1hr of initiation/renewal order of restraint/seclusion *Continued need for Restraint/seclusion orders must be renewed as specified above. The ordering physician must renew it and must evaluate the patient in person prior to order expiration and renewal.* No PRN orders or Standings orders are allowed	same
Family Notification	Promptly contact and notify family when restraints/seclusion is initiated – IF the patient has consented to keep the family informed Involve family when practical and advantageous to reduce need for restraint/seclusion	
MD Responsibilities	The MD does the following at the time of ordering restraints/seclusion and at the time of renewing restraints/seclusion: • Reviews with staff the physical and psychological status of the patient • Determines whether restraint or seclusion should be continued • Provide guidance in identifying ways to help the patient regain control to stop restraint/seclusion • Writes an order for restraint/seclusion • Document: Events leading to the use of restraints/seclusion Clinical justification for restraints/seclusion. Statement that the order is time-limited to 4 hours. Specification of which part of the patient's body is to be restraint. Only "soft" restraints are to be used. Do NOT write a restraint/seclusion order as a standing or PRN order. • Determine the need for psychiatric evaluation of the patient and decide upon the most appropriate setting required for meeting the patient's needs. • In the event that the patient's behavior meets the criteria for extending the restraint/seclusion for more than four hours, document the continued need for restraints/seclusion and renew the order. • If within the same 4 four period the restraints were removed or seclusion was discontinued, and the patient again exhibits the same behavior that led to the restraint/seclusion initiation, a new order must be obtained prior to reapplying the restraints/seclusion and the requirements restart.	same

Nursing Assessment and Documentation	Patient is to be assessed with documentation at the initiation and every 15 minutes thereafter: • Hydration – offer fluids • Signs of injury from restraints/seclusion - examination • Nutrition – review intake • ROM/circulation/skin integrity - examination • Vital signs (per unit routine/order or at least every shift) • Hygiene/Elimination – review record/ask patient • Physical and psychological status - examination • Comfort – ask patient/examine • Readiness for discontinuation of restraints/seclusion at the earliest possible time. If reassessment findings are that the patient does not meet restraint criteria, the restraint may be removed. Upon initiation of restraints the following is documented: • Actual behavior observed-reason(s)-circumstances for initiating restraint/seclusion. • Each episode of restraint use • Determination that the patient's behavior is potentially injurious to themselves or others. • Alternative methods attempted to avoid restraint/seclusion and the effectiveness of those methods. • Discussion with the patient and/or family concerning the use of restraints/seclusion and policy education provided. • The rational/and patient response to the type of restraint/seclusion use. • Written order verified/ or telephone/verbal order obtained • Review of pre-existing medical conditions, sexual or physical abuse history • Behavior criteria for discontinuing restraint or seclusion use, and patient education of such • Patient aid in meeting behavior criteria to d/c restraints • Each in-person evaluation and re-evaluation • Each 15 minute assessment of patient status • Staff debriefings • Any injuries and treatment • Any deaths as a result of restraints Note: Documentation in the patient's record should indicate a clear progression in how techniques are implemented with less restrictive interventions attempted (or considered prior to the introduction of more restrictive measures). A restraint/seclusion log will be maintained to aid with data collection for quality improvement.	same
Plan of Care	Restraint use must be in accordance with a written modification to the patient's plan of care, in the least restrictive manner possible. The RN will collaborate with the attending physician regarding the appropriate level of care and develop the plan of care to meet the patient's needs. Once a patient is in restraints for more then 12hrs or the patient has been placed in restraints/seclusion twice or more the Clinical Nurse Coordinator is notified. The nurse coordinator thereafter is notified every 24 hrs if the need for restraints/seclusion continues. The Clinical Nurse Coordinator will then arrange for staff debriefings to determine/review circumstances leading to restraint use and determine of things could be or can be handled differently; modify plan of care,	same

	treatment, or services; ensure patient well being, comfort, and patient rights preservation.; and review/evaluate if any trauma resulted to the patient from restraint use.	
Safety measures	To decrease the opportunity for the patient to inflict injury to self, staff or others, the following should occur: o Closely observe the patient; practice one-to-one nursing care as needed. o Remove from the patient's possession or midst, all items of potential danger (e.g. razors drugs, nail files, belts, scarves, credit/plastic cards, sharp objects, glass objects, solutions (e.g. Peroxide, alcohol). o Provide patient with plastic flatware and plates, if appropriate. o Frequently orient the patient to person, place, and time of day/evening, if indicated. o Observe/assist patient while he/she attends to self-care or toileting o Carefully observe to ascertain that patient swallows medications prescribed by staff physician.	same
Discontinuation or Removal of Restraints	Continued need for restraints/seclusion is evaluated frequently by nursing assessment or the MD assessment. Every time a restraint order is renewed. Only individuals who are trained in the use of and placement of restraints are to remove them. Removal may be done in order to facilitate treatment (ie. Nursing personnel, Respiratory Therapist, Physical Therapist, etc.). After treatment, the restraints should be replaced properly.	same
Clinical Coordinator Notification	Clinical Coordinator is to be notified when: • Restraints or seclusion are used for more than 12 hours. • There are two or more restraint/seclusion episodes with the patient within twelve hours. • Every 24 hours, if either time frame/number of episodes above is met. •	same
Reporting	The hospital must report to HCFA any death that occurs while a patient is in restraints/seclusion for behavioral management reasons or when it is reasonable to assume that the patient's death is a result of restraint use for behavioral reasons. The hospital should report these deaths to their HCFA regional office by the next business day following the patient's death. NOTE: All reports, including the above, of any unexpected events while a patient is in restraint/seclusion, shall be reported immediately to the Director of Quality Management (or his/her designee).	same
Performance Improvement	The following data MUST be aggregated and analyzed: • Date of each restraint • Time of each restraint • Shift • Day of week episode was initiated • Staff initiating process • Length of each usage	same

	• Patient Age/gender • Any injuries • Type of restraint used • # of episodes per patient individual • Multiple episodes within 12 hour period • Use more than 12 hours • Psychoactive meds as alternatives to, or to allow discontinuation of restraint or seclusion. • The MD is involved in measuring and assessing restraint need and use	