

NewYork-Presbyterian Hospital
Site: All Centers
Hospital Policy and Procedure Manual
Number: R135
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TITLE: RESTRAINT

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APPLICABILITY:

This policy applies to **ALL** inpatient units (Behavioral Health and Non-Behavioral Health) and all Physicians, Nursing Staff and appropriately trained staff. In addition, Behavioral Health Units licensed by New York State Office of Mental Health must also see the policy section on Restraints for Behavioral Health Purpose.

For PSYCHIATRIC UNITS LICENSED BY NYS OFFICE OF MENTAL HEALTH
See Psychiatry Service Line Policy S20: [Seclusion](#)

I. PURPOSE

To provide the health care providers with guidelines that will assist patients in regaining behavioral self-control and protect patients from self-injury, injury to others and from interruption of care and treatment.

II. DEFINITIONS

A Restraint is - Any manual method, physical or mechanical device (material or equipment) attached or adjacent to the patient that immobilizes or reduces the ability of a patient to move his/her arms, legs, body or head freely or cannot easily be removed and restricts movement or normal access to one's body.

NOTE: To protect a patient during the provision of care, such as continuous lateral rotation therapy (CLRT) and/or percussion, four side-rails must be up in order for the electric therapeutic beds to function and as a safety measure for the patient. Use of four side rails during these treatment sessions is not considered a restraint.¹ Once therapy has concluded, one side rail should be lowered. If all four side rails are required to be up after treatment to prevent the patient from exiting the bed, then a restraint order must be obtained.

Types of restraints include:

- Mittens used to prevent dislodging tubing, etc.
- Full/four side rails - used to prevent patient from falling out of bed. Exception is use of four side rails for CLRT/percussion therapies.
- Geriatric chairs that patients cannot get out of independently used to maintain body alignment, protect patient from falls, maximize patient's freedom and independence
- Vest restraints - may be used to prevent the patient from climbing or falling out of a chair or bed, to provide proper body position and balance, or to facilitate treatment if the patient's behavior/condition (e.g., confusion, physical weakness or debilitation, etc.) so warrants.
- Elbow Restraints
- Two-point extremity restraints (NOTE: MAY NOT BE USED ON LICENSED BEHAVIORAL HEALTH UNITS) - usually refers to the application of restraints to the wrists/upper extremities; however other extremity restraints may be used as ordered - may be used to prevent patient from pulling at or dislodging tubes or catheters or to prevent self-injury
- Four-point extremity restraints - refers to restraints to both wrists and both ankles, or when fewer than four extremities are restrained but the patient's own condition renders the remaining extremities unmovable (e.g., a hemiplegics patient whose unaffected limbs are restrained is considered to be in 4-point restraints since s/he is unable to move any extremity). Patients in four-point restraints require maximum observation.- usually used for behavioral health management
- Five-point extremity restraint (used ONLY on Licensed behavioral Health Units) – Includes four point restraint with application of a fifth point soft belt across the chest. Patients in five point restraints require maximum observation.
- Physical escort if the patient cannot easily remove or escape the grasp of the escort. (i.e. escorting pt from one area to another)

¹ **Federal Register** / Vol. 71, No. 236 / Friday, December 8, 2006 / Rules and Regulations (accessed 4.19.13)

- Holding a patient in a manner that restricts the patient's movement against the patient's will. (i.e. pt at risk for injury and/or harm to others with need to contain until additional assistance arrives)
- Physical hold for forced medications – the application of force to physically hold a patient in order to administer a medication against the patient's wishes. Note: For patients with a court order mandating medications to be taken but also require application of a restraint to administer the medications – a restraint order must be obtained.

Devices NOT considered a restraint:

- Physical Escort where a "light" grasp is used to escort patient to desired location.
- At the patient's request staff may "hold" the patient in order to safely administer an injection or obtain a blood sample or insert an intravenous line or conduct a procedure.
- Pediatric patients who require a "hold" to safely administer medications or obtain a blood sample or insert an intravenous line or conduct a procedure. NOTE – any questions regarding a pediatric patient's right to refuse medications and /or treatment should be referred to Patient Services Administration or Administrator On Call **PRIOR** to taking any action.
- Use of 4 padded side rails when a patient is placed on **seizure precautions**. The use of padded side rails in this situation should protect the patient from harm; including falling out of bed should the patient have a seizure².
- Limitation of mobility or temporary immobilization related to medical, dental, diagnostic or surgical procedures included post-procedure processes, such as surgical positioning, IV boards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients.
- Adaptive support in response to assessed patient need, such as postural support, orthopedic appliances, tabletop chairs.
- Helmets.
- Methods that involve holding the patient for purposes of conducting routine physical examination or test
 - Forensic and correction restrictions used by security.
- Cribs/Side rails when utilized as a developmentally appropriate measure to reduce risk of injury for infants or children.
- The use of side rails on a stretcher as safety device to reduce the risk of falling and injury to the patient.

² **Interpretive Guidelines §482.13(e) (1) Definitions. (i) A restraint is—**

- Lap belt for transport to/from ECT at PWW.

III. POLICY

1. The use of restraints is a patients' rights issue and the benefits are weighed against the patient's inherent right to be free from restraint. Maintaining the patient's rights, dignity and well-being are a primary consideration when restraints are used. Whenever possible early identification of risks factors and prevention of patient behavior requiring restraint is encouraged.
2. All patients retain the right to be free from restraint of any form, imposed by staff as a means of coercion, discipline, convenience or retaliation. Restraints will **NOT** be employed as punishment, for the convenience of staff or as a substitute for treatment programs.
3. The hospital assesses and measures its restraint use to identify opportunities for preventative strategies, alternatives to use, and process improvements in order to reduce the risk associated with restraint use.
4. **Non-physical** techniques are always the preferred intervention in behavior management. The use of a restraint is limited to emergencies in which there is imminent risk of a patient physically harming him/her self, staff or others and less restrictive **non-physical** interventions have been found to be ineffective or not viable.
5. The use of restraint is not based on a patient's restraint history or solely on a history of dangerous behavior. The use of restraints is based on individual patient assessment and limited to clinically justified situations and must be discontinued at the earliest possible time. See Appendix: Suggested Alternatives to Restraints.
6. In all acute clinical interventions with patients, the least restrictive, safest and most effective measures will always be employed. Non-physical techniques are the preferred interaction in behavioral management.
7. Restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm; the type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient or others from harm. See Appendix: Suggested Alternatives to Restraints.
8. The use of towels to prevent spitting or biting is prohibited.
9. A patient may never be placed in a locked room while in restraints.

10. The use of restraints must be in accordance with a written MD/NP/PA order and modification to the patient's plan of care.
11. At the time the need for a restraint is identified the MD/NP/PA will evaluate the patient in-person. **NOTE: ONLY A PHYSICIAN MAY ORDER RESTRAINTS OF ANY KIND ON LICENSED BEHAVIORAL HEALTH UNITS.** The prescriber will collaborate with staff to identify what would help the patient regain control. The patient's treatment plan should be reviewed and modified as appropriate to reflect use of restraints. The treatment plan should reflect assessment of the problem which led to the intervention; list the intervention and individual responsible for implementation, include an outcome-oriented goal and document the result.
12. Restraints are generally used in two types of situations: management of violent or self-destructive behavior and medical management:
 - a. Management of Violent or Self Destructive Behavior: primarily directed to the protection of the immediate physical safety of the patient, a staff member or others and must be discontinued at the earliest possible time. **Examples:** a patient may experience a severe medication reaction that causes him/her to become violent. A patient may be withdrawing from alcohol and have delirium tremors. The patient is agitated, combative, verbally abusive and attempting to hit staff.
 - b. Medical Management: primarily directed to support medical healing associated with acute medical and surgical care. **Example:** A patient becomes confused or disoriented and unable to follow instructions, and attempts to pull out tubes or catheters, interfering with needed care. The use of less restrictive alternatives has been considered or was unsuccessful. The use of restraints in this situation is considered a restraint for the provision of medical-surgical care, regardless of the location of the patient.
13. Restraints are implemented in accordance with safe and appropriate restraint techniques outlined in this policy by an appropriately trained staff member. Security Officers, who have been trained and have been assessed as competent in restraint application, may assist in the application of restraints under visual supervision of clinical staff. Except in an emergency, security officers may not initiate application of restraint without clinical staff assessment and authorization.
14. Upon initiation of a restraint order, a 2 RN check is performed at the bedside each time to verify that restraint application is appropriate and correct. Both

RNs will document by end of shift this review of restraint use and application in the medical record; the second RN performing the verification co-signs the restraint review.

15. Patients transported in restraints must be accompanied by an individual who is competent in restraint care. See T130 – Transporting of Patient Hospital Policy.
<http://infonet.nyp.org/QA/HospitalManual/T130TransportingofPatients.pdf>
16. Patient Education will be provided and documented at the time of initial application of a restraint and re-enforced as appropriate each shift. Patient education will include reason for restraint and the condition(s) needed for removal of the restraint.

IV. EMERGENCY INITIATION OF RESTRAINT

1. In an emergency in which a patient is engaged in an activity which presents an immediate danger to him/herself or others and an physician/NP/PA is not immediately available, restraint may be used under the direction of a **Registered Professional Nurse** present at the time and only to the extent necessary to prevent the patient from injuring him/herself or others. A “two RN check” will be conducted to assess the alternatives taken and the need for emergency application of the restraint

Thereafter:

- The responsible physician/appropriately credentialed professional must be summoned immediately to perform an assessment of the patient and write the order for restraint if needed.
- The nurse caring for the patient will record the time of the call and the name of the person contacted.
- The physician/NP/PA will be advised of the reason for emergency initiation of a restraint: **either medical management, Violent or Self Destructive Behavior Management.**
- After emergency initiation the nurse caring for the patient will document in the medical record:
 - date, time and name of physician/NP/PA notified
 - a description of the facts justifying use of emergency restraints
 - the type of restraints used and any conditions for maintaining the restraints

- the reasons why less restrictive interventions could not be used; and
 - the steps taken to assure the patient's safety and comfort
 - the two RN check; with 2nd nurse verification.
 - Note: The time limits on the use of the restraint begin with the application of the restraint.
2. When emergency initiation of a restraint is applied for **Violent or Self Destructive Behavior Management** the physician is expected to evaluate the patient face to face with within 30 minutes of application. Upon the arrival of the physician, the physician will consult with the nurse about the patient's physical and psychological condition.
- If the physician has not arrived within 30 minutes, the nurse shall:
 - Notify the immediate nursing supervisor of the delay.
 - Place a note in the patient's medical record which includes:
 - time and date of entry
 - record of the delay
 - name of physician/NP/PA notified again of need to evaluate patient face to face
 - Upon arrival, the physician/NP/PA must document on the flowsheet the time of arrival and reason for delay.
3. When emergency initiation of a restraint is applied for **Medical Management** the physician is expected to evaluate the patient face to face within 60 minutes of application.
- a. In the event of such emergency application of restraints, the responsible physician/NP/PA must be summoned immediately to perform an assessment of the patient and write the order for restraint if needed.
 - b. Pending the arrival of a physician/NP/PA the patient will be kept under supervision as warranted by his/her condition **and type of restraint applied**, i.e., sufficient supervision to protect the patient from harm due to the application of the particular type of restraint, as defined in the restraint protocol in this document.
 - c. If the physician/NP/PA has not arrived within 60 minutes, the nurse shall:
 - Notify the immediate nursing supervisor of the delay.
 - Place a note in the patient's medical record which includes:
 - time and date of entry
 - record of the delay
 - name of physician/NP/PA notified again of need to evaluate patient face to face

- d. Upon arrival, the physician/NP/PA must document on the flowsheet the time of arrival and reason for delay

V. PATIENT DEATH WHILE IN OR RELATED TO USE OF RESTRAINTS

In the event of a death of a patient while in restraints, the following deaths must be report³:

- a. Each death that occurs while a patient is in restraint
- b. Each death that occurs within 24 hours after the patient has been removed from restraint
- c. Each death known to the hospital that occurs within 1 week after restraint where it is reasonable to assume that the use of the restraint contributed directly or indirectly to a patient's death.

"Reasonable to assume" includes, but is not limited to deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation."(CMS)

The Patient Care Director/Clinical Manager/Nursing Care Coordinator or Nurse Administrator must be immediately notified of any patient death, related to the above a to c. The PCD/Clinical Manager/Nursing Care Coordinator or Nursing Administrator is responsible for ensuring it is reported immediately to Patient Services Administration as a significant event.

Patient Services Administration will notify CMS upon the death of a patient while in restraints or where it is reasonable to assume that the patient's death is related to being in restraint by close of next business day and will document such report in the patient medical record.

The death of any patient in any licensed psychiatric facility will also be reported to NYS OMH and NYS Commission on Quality of Care

VI. EDUCATIONAL REQUIREMENTS

- a. All direct care staff and any other staff involved in the use of restraint will participate in training during orientation & annually and will demonstrate competency in minimizing the use of restraint and when use is indicated to use restraints safely.
- b. To minimize the use of restraint **all** clinical staff and any other staff involved in the use of restraint receive annual training in and demonstrate an understanding of the following:
 - The underlying causes of threatening behaviors exhibited by the patients

³ CMS Conditions of Participation 42 CFR 482.13

- That sometimes a patient may exhibit an aggressive behavior that is related to a treatable general medical condition and not related to his or her emotional condition (for example, threatening behavior that may result from delirium in fevers or other medical conditions)
 - How staff behaviors can affect the behaviors of the patients
 - De-escalation, mediation, self-protection, and other techniques such as time-out
 - How to recognize signs of physical distress in patients who are being held, restrained, or secluded.
- c. Staff members who are authorized to perform observations of patients in restraint receive the training and demonstrate the competence cited above.
- d. Only Staff members who have received hospital authorized annual training and assessed as competent to apply restraints are authorized to apply a restraint.

VII. RESTRAINT ORDERS

1. Written orders for initial or continuing use of restraints may **NEVER** be written as a standing order or “on as needed basis” (PRN). The attending physician must be consulted as soon as possible after the initiation of the restraint if not ordered by the patient’s attending physician. This consultation must be recorded in the medical record. The treating physician is defined as the physician who is responsible for the management and care of the patient at the time of the event. A full record of restraints, including all signed orders of physicians, must be kept in the patient's medical record.
2. The order for restraint must state the time of initiation and expiration of the authorization. For **medical management** the order shall not to exceed 24 hours for Full/four siderails, vest, 2-point wrist restraints and not to exceed 4 hours for 4-point restraints. For **violent or self destructive management** the order shall apply for a period of no more than four hours for adults, two hours for adolescent ages 9-17 and one hour for children less than 9 years of age.
3. Two registered nurses, the nurse caring for the patient and another nurse, must assess the appropriateness of use of restraints prior to each application (including any reapplication) and verify all required documentation is present. The patient’s RN and a second RN must validate the following:
 - Alternative measures instituted and assessment of effectiveness documented in the medical record.
 - A complete and signed order stating the type and reason for restraint.

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- The two RN check will be documented in the medical record. Each nurse will document in the patient’s medical record that “Two RN check completed prior to restraint application.”
- In an emergency situation, the two RN check will assess the alternatives taken and the need for application of the restraint and follow steps outlined on page 5 of this policy for Emergency Initiation.

The second RN performing the validation must document this review by co-signature of the restraint initiation note.

4. The required components of restraint orders have been incorporated into the computerized order entry program.

SAMPLE ORDER

RESTRAINT ORDER	
1. DATE: _____	2. TIME: _____ AM _____ PM
3. Behavior/condition requiring restraint (Choose A or B):	
A. Medical Management: <ul style="list-style-type: none"> <input type="checkbox"/> Agitation/restlessness/confusion <input type="checkbox"/> Attempts to interfere with treatment/medical devices <input type="checkbox"/> Other (specify) _____ 	B. Violent or Self Destructive Behavior Management: <ul style="list-style-type: none"> <input type="checkbox"/> Physically assaultive/combative <input type="checkbox"/> Attempts to injure self or others <input type="checkbox"/> Other (specify) _____

RESTRAINT ORDER	
<p>Type and Duration: (Record time limit if less hours desired)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Full/four side rails for 24 hours (or) _____ hours (<i>not to exceed 24 hours</i>) <input type="checkbox"/> Vest restraint for 24 hours (or) _____ hours (<i>not to exceed 24 hours</i>) <input type="checkbox"/> 2-point wrist for 24 hours (or) _____ hours (<i>not to exceed 24 hours</i>) <input type="checkbox"/> 4-point (<i>not to exceed 4 hours</i>) <input type="checkbox"/> Other: _____ for 24 hours (or) _____ hours (<i>not to exceed 24 hours</i>) <input type="checkbox"/> Physical escort - one episode only <input type="checkbox"/> Physical hold - one episode only for: <ul style="list-style-type: none"> <input type="radio"/> Forced medication <input type="radio"/> Prevent harm to self <input type="radio"/> Prevent injury to other 	<p>Type and duration of restraint Type:</p> <ul style="list-style-type: none"> ___ Full/four side rails ___ Vest restraint ___ 2-point wrist ___ 4-point ___ Physical Escort one episode ___ Physical hold one episode <ul style="list-style-type: none"> <input type="radio"/> Forced medication <input type="radio"/> Prevent harm to self <input type="radio"/> Prevent injury to other ___ Other: _____ <p>Duration:</p> <ul style="list-style-type: none"> ___ Not to exceed 4 hours (18 yrs and older) ___ Not to exceed 2 hours (9-17 yrs) ___ Not to exceed 1 hour (< 9years old) ___ One episode only - episode only

5. For paper orders, a preprinted Doctor’s order sheet that includes the required components is used for writing restraint orders. The Doctor’s Order Sheet is completed by the physician/appropriately-credentialed professional. Restraint orders written not using the preprinted orders sheet cannot be implemented.
On Behavioral Health units orders for medical surgical management are written on the pre-printed Doctor’s order sheet

6. Restraint Flowsheet Documentation requirements:

Initiation of restraint type:

Upon initiation of a restraint, the RN will document within the Restraint Status and Protocol "**Restraints Initiated and Protocol Initiated**"; the RN must obtain a second RN co-signature when restraints are initiated on the "**Restraints Initiated and Protocol Initiated**".

Plan of Care:

Upon initiation of a restraint, the RN will update the patient's plan of care to reflect the type of restraint, plan, goals, interventions and desired outcomes.

Maintenance of restraint type:

For each restraint type if the order is re-written, without any time gaps, the RN will document "**Restraint Maintained and Protocol Maintained**" parameter each shift until the order is discontinued. A second RN co-signature is not required for a restraint maintenance parameter.

NOTE - if the restraint is removed prior to the order's expiration time, and later becomes necessary to reapply the restraint or type is changed, i.e. a change from a 2 point to a vest restraint, then a "**Restraint Initiated and Protocol Initiated**" will be documented.

Both the initiation and/or the maintenance documentation fulfill the shift documentation requirements.

Discontinuation of restraint:

Upon written discontinuation or expiration of the restraint order, the RN will document the discontinuation within - "**Restraint Discontinuation and Protocol Discontinued**" parameter. The RN will update the plan of care to reflect patient outcomes.

7. **On Licensed Behavioral Health Units:** restraint order for violent or self destructive behavior must be written by a physician on the Restraint Flowsheet (child, adolescent and adult) in the MD Evaluation/Order Section. The order must include:
- a note documenting the results of the physician's personal examination of the patient
 - the time of the examination
 - justification for the use of restraint,
 - any conditions for maintaining the restraint and the frequency of vital signs (no less than every two hours for adults, one hour for adolescents ages 9-17, and 30 minutes for children less than 9 years of age).
 - The physician will explain the rationale for the selected intervention to the patient at the time of initiation and the reasons for continuation of the intervention.
 - The physician will indicate if family contact should be made after he or she reviews the notification form and speak with the patient.
 - The physician is responsible to notify the patient's family and document all attempts. If family is not able to be reached then the

physician will consult with the charge nurse and determine a plan for notification.

The physician must consider any information regarding restraint gathered during the initial assessment and also provide staff with guidance in identifying the ways to help the patient regain control so that the restraint can be discontinued.

8. When used, restraints are removed at the earliest possible time.
 - a. A registered professional nurse may release a patient from restraints prior to the order's expiration time if the patient's condition so warrants, i.e., when the patient no longer exhibits the behaviors for which s/he was placed in restraints or the reason for the restraints no longer exists.
 - b. When a restraint is removed prior to the order's expiration time, that episode of restraint is finished; if it later becomes necessary to reapply the restraint, **a complete new order is required.**
9. While in restraints, the patient is observed and assessed as stated in the restraint protocol and his/her physical needs, privacy, comfort and safety are attended to.
10. The nurse will write a progress note describing the patient's behavior prior to the initiation of restraint. Alternative interventions prior to initiating restraint must be tried or considered prior to the use of restraint. Alternate methods to assist the patient in regaining behavioral control as well as the individual's response to the interventions will be documented on the monitoring form.
11. The physician will explain the rationale for the selected intervention to the patient at the time of initiation and the reasons for continuation of the intervention throughout the course of its implementation. The RN will re-enforce the rationale for selected intervention upon application and with each re-assessment, along with behavior needed in order to have the restraint removed.
12. For Medical/Surgical management, documentation of observation of the patient's condition including any significant changes in health status is done at least every 15 minutes for 4-point restraints, at least every 30 minutes for 2-point or vest restraints and at least every 2 hours for all other types of restraints. More frequent observation is done according to nursing judgment or as per physician/appropriately credentialed professional's order.
13. If a patient's clinical condition warrants the use of 2 point restraints on the ankles for the purpose of delivering safe care, a restraint order is needed. A staff member will remain with the patient while in 2 point ankle restraints

until the care is delivered. Once care has been delivered the staff member will release the two point ankle restraint prior to leaving the patient's bedside. **(NOTE: 2 point restraints may not be used on licensed behavioral health units).**

14. All patients in restraints who are in isolation rooms must be observed every 30 minutes or more frequently if indicated.
15. Patients in 4-point restraints for violent or self destructive management require Maximum Observation (direct eyesight) and require observations documented every 15 minutes. Observations will be performed by clinical staff; security officer's may be also be assigned to perform security observations until such time as the patient is assessed to be no longer demonstrating the violent and self destructive behaviors.
16. Patients in 4-point restraints with a 5th point soft belt restraint require a separate physician order for the 5th point. **NOTE 5TH POINT RESTRAINTS MAY ONLY BE APPLIED ON A LICENSED BEHAVIORAL HEALTH UNIT.**
17. The documented observation need not be conducted by a registered professional nurse. A licensed practical nurse, patient care technician or nurses' aide/attendant with appropriate training can perform this function under the general supervision of an RN.
18. If a patient requires the use of restraints beyond the time limit of an order, the MD/NP/PA must reassess the patient and enter/place a complete new order, including all of the required components listed above.
19. Special consideration is given to use of restraints with vulnerable populations such as the elderly, the physically and cognitively impaired, and the pediatric and emergency patient. These patients may require additional monitoring or intervention, according to their assessed needs.
20. The reason(s) for using the restraint is explained to the patient or to an appropriate person acting on behalf of the patient to the extent feasible depending upon the emergency nature of the use of the restraint, including the conditions/ situation required for removal of the restraint.
21. Restraints are initiated by a MD/NP/RN and applied by competent individuals who have received appropriate training. The RN will check that restraints are applied correctly if applied by a deemed competent individual other than an RN. Staff receives ongoing education related to the use of restraints, including annual assessment of competency.

22. Only Hospital approved restraints may be used. A list of approved restraints may be found at: <http://infonyet.nyp.org/lawson/Pages/index.aspx>
23. Use of restraints is monitored through the hospital's performance improvement process.

VIII. RELEASE

1. In the event of a medical emergency the patient will be immediately released from a restraint.
2. A patient shall be released from a restraint as soon as he/she no longer appears to be a danger to self or others.
 - a. The patient will be evaluated for the continued need and potential release from restraint at least every two hours for adults and one hour for adolescents.
 - b. At those times, a registered professional nurse will assess the patient's behavior, determine the need to continue the restraint episode and document the findings and outcome of that assessment.
3. Early release:
 - a. If a patient, upon being routinely released from restraint is determined to be a continued danger to self or others, the intervention may be continued. This is considered part of the same episode.
 - b. If the licensed professional staff member on duty determines that the patient is no longer a danger to self or others, the order for restraint will terminate and a physician will be so notified. The original order is still considered active for 15 minutes following the release. In this case, the patient may be returned to restraint if necessary. If after 15 minutes of release it is determined that the patient must be returned to restraints, this would be considered a new episode, and a new order must be obtained for implementing the restraint.
 - c. If a patient who is restrained (**emergency initiation**) for aggressiveness or violence quickly recovers and is released before the physician arrives to perform an assessment, the physician must still see the patient face-to-face to perform the assessment within 30 minutes after the initiation of the intervention. The fact that the patient's behavior warranted the use of a restraint indicates a serious medical or psychological need for prompt assessment of the situation that led to the intervention, as well as the physiological and psychological condition of the patient.
 - d. If an individual remains in restraint for violent or self destructive behavior management reasons more than 12 hours, or experiences two or more

separate episodes of restraint of any duration within 12 hours and the responsible attending psychiatrist is not present on the unit, the physician who writes the order must notify the attending immediately. If the attending psychiatrist responsible for the patient at that time writes the order, the attending psychiatrist must notify the unit chief or director of the situation immediately. Thereafter, this procedure must be followed every 24 hours if either of those conditions continues.

4. Release during a Fire Emergency:

In the event of an emergency evacuation resulting from a fire emergency, the charge nurse will rapidly assess the patient's behavior and risk to self and others and decide how to safely evacuate the patient.

Options include, but are not limited to:

- a. Release patient from restraints
- b. Transfer patient to portable restraints (e.g. stretcher with restraints)
- c. Notify Security or Fire Department responders for additional direction

IX. PROCEDURE

NOTE: THE FOLLOWING RESTRAINT PROCEDURE DOES NOT APPLY TO LICENSED BEHAVIORAL HEALTH UNITS.

A. VEST RESTRAINT (Criss-Cross Vest):

- Vest restraints may not be applied over a chest or abdominal drainage tube.
- Careful application of the vest restraint and subsequent observation of the patient must be done to verify that placement of the vest restraint does not constrict the neck, axilla or waist.
- Patients are not to be restrained in the prone position.
- The HOB should be elevated at least 30° degrees unless contraindicated.
- Two (upper) siderails should be up when patient is in vest restraint.

- A1. Select vest restraint of appropriate size for comfort and safety.
- A2. Have patient slip arms through arm holes of vest. Criss-Cross type vest should always criss-cross in the front.
- A3. Adjust waist straps for snug but comfortable fit.
- A4. Tie free ends to each side of frame of bed. Be sure that ends have been placed between mattress and siderails prior to tying and that tie cannot be easily untied by patient. Do not anchor restraints to

siderails. If patient is in a chair, tie free ends of the restraint under the chair as described in the manufacturer's instructions.

B. EXTREMITY RESTRAINTS (2-point restraints) NOTE NOT TO BE USED ON LICENSED BEHAVIORAL HEALTH UNITS:

- Limb restraints should not be applied to an extremity that has an arteriovenous (AV) fistula or shunt.
- Patients are not to be restrained in the prone position.
- Two (top) siderails should be up when patient is in 2-point restraints.
- If a patient's clinical condition warrants the use of 2 point restraints on the ankles for the purpose of delivering safe care
- A staff member must remain with the patient while in 2 point ankle restraints until the care is delivered. Once care has been delivered the staff member will release the two point ankle restraint prior to leaving the patient's bedside.

B1. Wrap disposable limb holder around wrist or ankle (as described in the Manufacturer's instructions). *If a cloth restraint is used, apply restraint with flannel side against skin and smooth out wrinkles. A combine pad may be placed between patient's skin and restraint for comfort.*

B2. Secure the disposable limb holder on extremity (as described in the manufacturer's instructions). **Be sure that restraints are secure but not constricting. The restraints should not tighten around the extremity when pulled.** *If cloth is used, secure the restraint on extremity by tying a knot on top of the wrist or ankle while making sure that the restraint is not constricting and does not tighten around the extremity when pulled.*

B3. Bring the strap down between the mattress and side rail, and tie securely on frame of bed or the arm of the chair when out of bed. Allow maximum amount of mobility possible without interfering with purpose of restraint.

C. 4-POINT RESTRAINTS:

- Limb restraints should not be applied to an extremity that has an arteriovenous (AV) fistula or shunt.
- Patients are not to be restrained in the prone position.
- All siderails are to be down when patient is in 4-point restraints.

C1. Apply disposable or cloth restraints with assistance as required for patient and staff safety. For patients exhibiting violent behavior, leather restraints may be required.

- C2. To secure limbs for restraints and to promote safe, efficient application, one staff member should immobilize the limb at the joint while another staff member applies the restraint to the respective wrist or ankle. Head and shoulders should be manually immobilized until all restraints are secure.
- C3. Arms are to be positioned down at the side and secured tightly enough to the side of the bed to prevent patient's biting at hand or restraints when sitting up. Patient's head should not be in contact with the bed's headboard.
- C4. Legs should be secured in the following manner:
 - a) Legs should be placed perpendicular to the bottom of the bed.
 - b) Each should be secured with its own restraint to the center bottom or sides of the bed, (i.e. not tied together) to facilitate removal of each limb from restraint, one at a time for range of motion exercises and safe evaluation of need for further restraint.
 - c) Since the patient has some freedom of movement of the upper torso, the bed should be moved away from walls and furniture. Siderails should be down so the patient can be observed more effectively and to prevent the patient from injury due to contact with the rails.
- D. Elbow Restraints (Adults, Pediatric only – at MSCHONY 4Tower-Room 419, PACU, PICU and CICU; at Komansky – General Pediatrics, PACU & PICU):
 - Elbow restraints are used to protect the surgical site (Pediatrics) and protect from interference with external medical devices (Adults).
 - Select elbow restraints for their appropriate size for comfort and safety.
 - D1. To apply elbow restraints hold patient's arm straight out.
 - D2. Wrap the elbow restraint around arm by overlapping the Velcro to secure the device. Verify the Velcro side of the elbow restraint is away from the patient's body.
 - D3. Verify that the elbow restraints are secure but not constricting
- E. Physical Escort:
 - E1. Alternative less restrictive measures must be assessed and implemented before a physical escort order is written.
 - E2. A written order is required for each episode of physical escort.
 - E3. Patient requiring physical escort must be accompanied by staff competent in physical hold/escort technique and patient care.
 - E4. Staff assigned to physical escort will remain with patient **at all times** until the patient returns to the patient care unit.
 - E5. The patient's behavior requiring physical escort must be assessed for each episode to determine the need for physical escort.

- E6. The patient behavior needing physical escort, the duration of physical escort (amount of time start/end) and patient behavior and response to physical escort will be documented in the medical record.
- E7. Patient education will include reason for physical escort and the condition(s) needed for not using physical escort.

F. Physical Hold:

- F1. Alternative less restrictive measures must be assessed and implemented before a physical hold order is written.
- F2. A written order is required for each episode of physical hold.
- F3. Staff assigned to physical hold remain with patient at all times until the patient's behavior requiring physical hold no longer is present or other alternative measures are ordered.
- F4. The patient's behavior requiring physical hold must be assessed for each episode to determine the need for physical hold.
- F5. The patient behavior needing physical hold, the duration of physical hold (amount of time start/end) and patient behavior and response to physical hold will be documented in the medical record.
- F6. Patient education will include reason for physical hold and the condition(s) needed for not using physical hold.

G. Physical hold for forced medications:

- G1. Alternative less restrictive measures must be assessed and implemented before a physical hold for forced medication order is written.
- G2. A written order is required for each episode of physical hold for medications.
- G3. Staff assigned to physical hold will remain with the patient until the episode of medication administration is completed.
- G4. The patient's behavior requiring physical hold for forced medication must be assessed for each episode to determine the need for physical hold.
- G5. The patient behavior needing physical hold for forced medication, the duration of physical hold (amount of time start/end) and patient behavior and response to physical hold will be documented in the medical record.
- G6. Patient education will include reason for physical hold for forced medication and the condition(s) needed for not using physical hold.

X. RESTRAINT PROTOCOLS

Full or Four (4) Siderails, Geri chair, other restraint not including vest or extremity restraint. APPLIES TO: LICENSED BEHAVIORAL HEALTH UNITS AND NON- BEHAVIORAL HEALTH UNITS

Observation	Restraint Care	Documentation
<p>A. On initiation of each episode of siderails or other restraint for medical/surgical management, and EVERY 2 hours & PRN observe patient for:</p> <ol style="list-style-type: none"> 1. Behavior (e.g. calm, restless, agitated, confused). 2. Proper positioning. <p>All patients in isolation rooms must be observed every 30 minutes or more frequently if indicated.</p> <p>Any changes or variations from above are reported to RN immediately. RN must immediately assess patient's condition and make changes as indicated.</p>	<p>A. EVERY 2 hours & PRN:</p> <ol style="list-style-type: none"> 1. *Evaluate need for continued use of side rails or other restraint. 2. Reposition patient PRN 3. Provide privacy, hygiene and toileting. 4. Explain reason for siderails or other restraint, and conditions needed for removal to patient and family. 5. Provide reassurance to patient/family that staff will monitor patient frequently to assure that patient's needs are met. 	<p>A. On initiation of siderails or other restraint, document on the Restraint Flowsheet:</p> <ol style="list-style-type: none"> 1. *Patient behavior/condition requiring siderails. 2. *Reason for siderails. 3. *Alternatives and/or less restrictive measures used. 4. *2 RN check performed – co-signature required. 5. * Patient Education on condition(s) needed for the removal of restraint to patient and/or family. <p>B. With ongoing use:</p> <ol style="list-style-type: none"> 1. EVERY 2H document observation on the Restraint Flowsheet. 2. EVERY 2H document restraint care on Restraint Flowsheet 3. *EVERY Shift document patient's vital signs, intake/output, behavior/condition, and continued need for siderails in progress note. Document any teaching provided and learning outcomes.

- C. Plan of Care: update to include use of restraint; plan/goal and desired outcome.
- D. **Discontinuation:**
*When siderails or other restraint, are removed, document time and behavior/condition leading to the discontinuation. Update plan of care to reflect current patient status.

NOTE: Statements preceded by an asterisk (*) are performed only by an RN

RESTRAINT PROTOCOL: VEST RESTRAINT
APPLIES TO NON-BEHAVIORAL HEALTH UNITS ONLY. MAY NOT BE USED
ON LICENSED BEHAVIORAL HEALTH UNITS

Observation	Restraint Care	Documentation
<p>On initiation of each episode of restraint for medical/surgical management, every 30 minutes & PRN, observe patient for:</p> <ol style="list-style-type: none"> 1. Behavior (e.g. calm, restless, agitated, confused) 2. Body alignment/positioning – HOB elevated at least 30 degrees unless contraindicated 3. Respirations/Any breathing discomfort 4. Circulation – skin warm 5. Skin condition at restraint site (e.g. no redness or breakdown) 6. Proper application of vest restraint. 7. Two (top) siderails are up <p>Any changes or variations from above are reported to RN immediately. RN must immediately assess patient’s condition and make changes as indicated.</p>	<p>A. Every 2 hours & PRN:</p> <ol style="list-style-type: none"> 1. *Evaluate need for continued use of restraint 2. Reposition patient 3. Provide privacy, hygiene and toileting 4. Explain reason for the restraint and conditions needed for removal of the restraint to the patient and/or family 5. Provide reassurance to patient and/or family that staff will monitor patient frequently to assure that patient’s needs are met and that the restraint is still required. 6. Provide skin care to restraint sites 7. Offer moderate temperature foods and fluids frequently, if allowed 8. Provide ROM <p>B. Additional measures:</p> <ol style="list-style-type: none"> 1. Keep two (2) upper siderails up when patient is in bed 	<p>A. On initiation of restraint, document on Restraint Flowsheet:</p> <ol style="list-style-type: none"> 1. *Patient behavior/condition requiring restraint 2. *Reason for application of restraint 3. *Alternatives and/or less restrictive measures used 4. <u>*2 RN check performed – co-signature required.</u> 5. * Patient Education on condition(s) needed for the removal of restraint to patient and/or family. <p>B. With ongoing use:</p> <ol style="list-style-type: none"> 1. EVERY 30 minutes document observation on Restraint Flowsheet 2. EVERY 2 hours document restraint care on Restraint Flowsheet 3. *EVERY shift document patient’s vital signs, intake/output, behavior/condition, continued need for restraint, any teaching provided and learning outcomes. <p>C. Plan of Care: update to include use of restraint;</p>

plan/goal and desired outcome.

D. Discontinuation:

*When restraint is removed, document time and behavior/ condition or situation leading to discontinuation. Update plan of care to reflect current patient status.

NOTE: Statements preceded by an asterisk (*) are performed only by an RN

RESTRAINT PROTOCOL: 2 POINT RESTRAINTS
APPLIES TO: NON- BEHAVIORAL HEALTH UNITS ONLY- MAY NOT BE USED
ON LICENSED BEHAVIORAL HEALTH UNITS

Observation	Restraint Care	Documentation
<p>On initiation of each episode of restraint for medical/surgical management, EVERY 30 minutes & PRN, observe patient for:</p> <ol style="list-style-type: none"> 1. Behavior (e.g. calm, restless, agitated, confused) 2. Body alignment / proper positioning 3. Circulation – skin warm; pulses present 4. No numbness or weakness of extremity; ability to wiggle fingers/toes 5. Skin condition at restraint sites (e.g. no redness, or breakdown) 6. Proper application of restraints. 7. Two (top) siderails are up. <p>Any changes or variations from above are reported to RN immediately. RN must immediately assess patient’s condition and make changes as indicated.</p>	<p>A. EVERY 2 hours & PRN:</p> <ol style="list-style-type: none"> 1. *Evaluate need for continued use of restraint 2. Reposition patient 3. Provide privacy, hygiene and toileting 4. Explain reason for the restraint and conditions needed for removal of the restraint to the patient and/or family 5. Provide reassurance to patient and/or family that staff will monitor patient frequently to assure that patient’s needs are met and that the restraints are still required 6. Release and reposition restraints one at a time. Note: For a patient, who uses sign language, release both hands from restraint at least every 30 minutes, when clinically indicated to allow for communication with staff. If patient is assessed to be a serious threat to self or others the restraint will not be released. 7. Check pulses distal to restraint 8. Provide skin care to restraint sites. 	<p>A. On initiation of restraint document on Restraint Flowsheet:</p> <ol style="list-style-type: none"> 1. *Patient behavior/condition requiring restraint 2. *Reason for application of restraint 3. *Alternatives and/or less restrictive measures used 4. *2 RN check performed – co-signature required. 5. * Patient Education on condition(s) needed for the removal of restraint to patient and/or family. <p>B. With ongoing use:</p> <ol style="list-style-type: none"> 1. EVERY 30 minutes document observation on Restraint Flowsheet 2. EVERY 2 hours document restraint care on Restraint Flowsheet 3. *EVERY shift document patient’s vital signs, intake/output, behavior/condition, continued need for restraint, any teaching provided and learning outcomes. <p>C. Plan of Care: update to include use of restraint; plan/goal and desired outcome.</p>

Observation	Restraint Care	Documentation
	<p>9. Offer moderate temperature foods and fluids frequently, if allowed.</p> <p>10. Provide ROM</p> <p>B. Additional measures:</p> <ol style="list-style-type: none">1. Keep two (2) upper siderails up when patient is in bed.2. EVERY shift: measure Intake & Output and record vital signs	<p>D. Discontinuation:</p> <p>*When restraints are removed, document time and behavior/condition or situation leading to discontinuation. Update plan of care to reflect current patient status.</p> <p>NOTE: Statements preceded by an asterisk (*) are performed only by an RN</p>

RESTRAINT PROTOCOL: 4 POINT RESTRAINTS
APPLIES TO: LICENSED BEHAVIORAL HEALTH UNITS AND NON-BEHAVIORAL HEALTH UNITS

Observation	Restraint Care	Documentation
<p>A. On initiation of each episode of restraint, EVERY 15 minutes & PRN, observe patient for:</p> <ol style="list-style-type: none"> Behavior (e.g. calm, restless, agitated, confused) Body alignment / proper positioning Circulation – skin warm; pulses present No numbness or weakness of extremity; ability to wiggle fingers/toes Skin condition at restraint sites (e.g. no redness, or breakdown) Proper application of restraints. Siderails are kept down. <p>Any changes or variations from above are reported to RN immediately. RN must immediately assess patient’s condition and make changes as indicated.</p> <p>B. Additional measures:</p>	<p>A. EVERY 2 hours & PRN:</p> <ol style="list-style-type: none"> *Evaluate need for continued use of restraint Reposition patient Provide privacy, hygiene and toileting (use fracture pan) Explain reason for the restraint and conditions needed for removal of the restraint to the patient and/or family Provide reassurance to patient and/or family that staff will monitor patient frequently to assure that patient’s needs are met and that the restraints are still required Release and reposition restraints one at a time. Note: For a patient, who uses sign language, release both hands from restraint at least every 30 minutes, when clinically indicated to allow for communication with staff. If the patient is assessed to be a serious threat to self or others the restraint is not released. 	<p>A. On initiation of restraint, document on Restraint Flowsheet:</p> <ol style="list-style-type: none"> *Patient behavior/condition requiring restraint *Reason for application of restraint *Alternatives and/or less restrictive measures used *2 RN check performed co-signature required. * Patient Education on condition(s) needed for the removal of restraint to patient and/or family. <p>B. With ongoing use:</p> <ol style="list-style-type: none"> EVERY 15 minutes document observation on Restraint Flowsheet EVERY 2 hours document restraint care on Restraint Flowsheet *EVERY shift document patient’s vital signs, intake/output, behavior/condition, continued need for restraint, any teaching provided and learning outcomes. <p>C. Plan of Care: update to include use of restraint; plan/goal and desired outcome</p> <p>D. Discontinuation:</p>

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1:1 Maximum Observation (within arm's length and direct eyesight) is required

7. Check pulses distal to restraint
 8. Provide skin care to restraint sites
 9. Offer moderate temperature foods and fluids frequently, if allowed, with head of bed elevated
 10. Provide ROM
 11. Take vital signs
- B. Additional measures:**
1. Decrease external stimuli
 2. Keep siderails down
 3. **EVERY Shift:** measure Intake & Output

*When restraints are removed, document time and behavior/condition or situation leading to discontinuation. Update plan of care to reflect current patient status

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NOTE: Statements preceded by an asterisk (*) are performed only by an RN

RESTRAINT PROTOCOL: 4 and 5 POINT RESTRAINTS
APPLIES TO LICENSED BEHAVIORAL HEALTH UNITS ONLY
MAY NOT BE USED ON NON-BEHAVIORAL HEALTH UNITS

Observation	Restraint Care	Documentation
<p>A. On initiation of each episode of restraint, EVERY 15 minutes & PRN, observe patient for:</p> <ol style="list-style-type: none"> 1. Behavior (e.g. calm, restless, agitated, confused) 2. Body alignment / proper positioning 3. Circulation – skin warm; pulses present 4. No numbness or weakness of extremity; ability to wiggle fingers/toes 5. Proper application of restraints. <p>Any changes or variations from above are reported to RN immediately. RN must immediately assess patient’s condition and make changes as indicated.</p> <p>Nursing staff member, who is responsible for observation, will immediately report to RN if patient behavior is calm so that RN can reassess need for restraints.</p>	<p>A. EVERY 2 hours for adult, 1 hour for adolescent and 30 minute for children & PRN:</p> <ol style="list-style-type: none"> 1. *Evaluate need for continued use of restraint 2. Reposition patient 3. Provide privacy, hygiene and toileting 4. Explain reason for the restraint and conditions needed for removal of the restraint to the patient and/or family 5. Provide reassurance to patient and/or family that staff will monitor patient frequently to assure that patient’s needs are met and that the restraints are still required 6. Release and perform ROM reposition one limb at a time. Document when patient is clinically unable to perform ROM exercises. Note: For a patient, who uses sign language, release both hands from restraint at least every 30 minutes, when clinically indicated to allow for 	<p>A. On initiation of restraint, document on Restraint Flowsheet: (Review MD order on the restraint flowsheet to verify that all elements are met)</p> <ol style="list-style-type: none"> 1. *Patient behavior/condition requiring restraint 2. *Reason for application of restraint 3. *Alternatives and/or less restrictive measures used 4. Name of physician notified and time of notification. 5. Medication offered and/or received. 6. *2 RN check performed – Co-signature required. 7. * Patient Education on condition(s) needed for the removal of restraint to patient and/or family. <p>B. Ongoing documentation:</p> <ol style="list-style-type: none"> 4. EVERY 15 minutes assigned nursing staff member will document observation and care given on Restraint Flowsheet 5. EVERY 2 hours for adults, 1 hour for adolescents and 30 minute for children or more often as clinically indicated: RN will perform assessment for discontinuation of restraints

B. Additional measures:

Maximum Observation (MO) (within arm's length and direct eyesight) is required

- communication with staff. If the patient is assessed to be a serious threat to self or others the restraint is not released.
7. Check pulses distal to restraint
 8. Provide skin care to restraint sites
 9. Offer moderate temperature foods and fluids frequently, if allowed, with head of bed elevated
 - 10.**Take vital signs

and will document on Restraint Flowsheet

C. Plan of Care: update to include use of restraint; plan/goal and desired outcome

D. Discontinuation:

*When patient is removed from restraints, document time and behavior/condition or situation leading to discontinuation and that the prescribing physician was notified. Update plan of care to reflect current patient status.

NOTE: Statements preceded by an asterisk (*) are performed only by an RN

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RESTRAINT PROTOCOL: ELBOW RESTRAINTS

APPLIES TO ADULTS AND PEDIATRIC PATIENTS ONLY (0 – 8 years)

Observation	Restraint Care	Documentation
<p>On initiation of each episode of restraint for medical/surgical management, EVERY 2 hours & PRN, observe patient for:</p> <ol style="list-style-type: none"> Behavior (e.g. calm, restless, agitated, confused) Body alignment / proper positioning Circulation – skin warm; pulses present No numbness or weakness of extremity; ability to wiggle fingers/toes Skin condition at restraint sites (e.g. no redness, or breakdown) Proper application of restraints. Two (upper or lower) siderails are up as appropriate to age/patient. <p>Any changes or</p>	<p>A. EVERY 2 hours & PRN:</p> <ol style="list-style-type: none"> *Evaluate need for continued use of restraint Reposition patient Provide privacy, hygiene and toileting Explain reason for the restraint and conditions needed for removal of the restraint to the patient and/or family Provide reassurance to patient and/or family that staff will monitor patient frequently to assure that patient’s needs are met and that the restraints are still required Release and reposition restraints one at a time. Note: For a patient, who uses sign language, release both hands from restraint at least every 30 minutes, when clinically indicated to allow for communication with staff. If patient is assessed to be a serious threat to self or others the restraint will not be released. Check pulses distal to restraint 	<p>A. On initiation of restraint document on Restraint Flowsheet:</p> <ol style="list-style-type: none"> *Patient behavior/condition requiring restraint *Reason for application of restraint *Alternatives and/or less restrictive measures used *<u>2 RN check performed – co-signature required.</u> * Patient Education on condition(s) needed for the removal of restraint to patient and/or family. <p>B. With ongoing use:</p> <ol style="list-style-type: none"> EVERY 2 hours document observation on Restraint Flowsheet EVERY 2 hours document restraint care on Restraint Flowsheet *EVERY shift document patient’s vital signs, intake/output,

<p>variations from above are reported to RN immediately. RN must immediately assess patient's condition and make changes as indicated.</p>	<p>8. Provide skin care to restraint sites.</p> <p>9. Offer moderate temperature foods and fluids frequently, if allowed, as appropriate to age/patient.</p> <p>10. Provide ROM</p> <p>B. Additional measures:</p> <p>1. Two (upper or lower) siderails are up as appropriate to age/patient</p> <p>2. EVERY shift: measure Intake & Output and record vital signs</p>	<p>behavior/condition, continued need for restraint, any teaching provided and learning outcomes.</p> <p>C. Plan of Care: update to include use of restraint; plan/goal and desired outcome</p> <p>D. Discontinuation:</p> <p>*When restraints are removed, document time and behavior/condition or situation leading to discontinuation. Update plan of care to reflect current patient status.</p> <p>NOTE: Statements preceded by an asterisk (*) are performed only by an RN</p>
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XI. ADDITIONAL POLICY REQUIREMENTS ON LICENSED BEHAVIORAL HEALTH UNITS

This section of the policy describes additional requirements that apply to all Behavioral Health Units licensed by the New York State Office of Mental Health.

APPLICABILITY

All physicians, nursing staff and appropriately trained staff on psychiatric units licensed by NYS Office of Mental Health

A. ADMISSION ASSESSMENT FOR LICENSED PSYCHIATRIC UNITS

1. Each patient admitted to a psychiatric unit will be assessed for immediate risk of harming him/herself or others, history of violence and techniques to manage behavioral problems
 - Patient History of restraint use.
 - techniques, methods or tools that would help the patient control his/her behavior;
 - pre-existing medical conditions or physical disabilities and limitations that would place the patient at greater risk of harm during a restraint episode; and any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint.
 -
2. At the time of admission, all patients will be informed about the policy on the use of restraints.
3. The role of the family, including their notification of a restraint episode, will be discussed with the patient and, as appropriate, with the family (family is defined as the person(s) who plays a significant role in the individual's life and may include person(s) not legally related to the patient). This will be done with consideration of the patient's right to confidentiality.
- 4a. At NYP/CU, NYP/AH, PWM the admission assessment will be completed as part of the Nursing Admission Assessment when the patient arrives on a licensed psychiatric unit.
- 4b. At the NYP/WD, the admission assessment will be completed in the Evaluation Center if the admission is completed by a RN otherwise the admission assessment will be completed as part of the nursing admission assessment when the patient arrives on a licensed psychiatric unit.

5. If the patient has consented to have the family kept informed regarding his or her use of restraints and the family has agreed to be notified, at the time an intervention is ordered the physician who wrote the order will promptly attempt to contact the family to inform them of what has occurred.
6. The physician/NP/PA is responsible for contacting the family if consent has been given to use restraints.

B. IMPLEMENTATION OF INTERVENTION* AND DOCUMENTATION PROCEDURES

(*Refer to Behavioral Health Nursing procedure for implementation of physical of restraints.) <http://infonet.nyp.org/Nursing/Standards/M/Management-of-Patient-Requiring-Phys.pdf>

1. Restraints:
 - a. 4-point soft, leather or synthetic leather limb holders or 5-point (all limbs and a strap across the patient's chest)
 - d. The patient's physical response to being in restraints will be documented to insure that the restraints have been applied in a proper and safe manner.
 - e. Patients in restraint have 1:1 staff monitoring maintained
2. The patient is monitored to see that his/her physical needs, comfort and safety are properly met. A registered nurse is responsible for supervising the restraint episode and the staff assigned to perform observations. Ongoing documentation during each episode includes the patient's response to the use of restraint.
3. An observation of the patient's condition is made at least every 15 minutes (as appropriate to the type of restraint employed) and includes the following:
 - any signs of injury associated with the intervention
 - physical and psychological status and comfort
 - readiness for discontinuation of the intervention.

Frequency of vital sign monitoring is determined on an individual basis which includes consideration of the individual patient's medical needs and health status. Vital signs are monitored at least every two hours for adults, every one hour for adolescent ages 9-17 and every 30 minutes for children under age 9. They may be monitored more frequently when ordered by the physician or as needed during the intervention.

Staff members who perform 1:1 observation of patients must be trained to observe patients for physical or behavioral changes which would necessitate immediate or more frequent monitoring of vital signs than required by the original physician order.

4. A patient in restraint shall have each limb (one limb at a time) released from restraint at least every 2 hours. When released from restraints, the patient will be examined to confirm full range of motion. This is documented on the Restraint/Seclusion monitoring form.
5. A patient who uses sign language as their only means of communication will have both of their hands released from restraint when clinically indicated (at a minimum every 30 minutes) to allow communication with staff. If a patient is assessed to be a serious threat to self or others, the restraints will not be released. This is documented on the Restraint/ Seclusion monitoring form.

C. DEBRIEFING

1. Staff debriefing:

- A. The staff debriefing will occur as soon as possible and appropriate after the event, but must be within 24 hours.
- B. The staff debriefing session will be organized and documented by nurse in charge or designee at the time of the intervention. The Debriefing Form will be used to document:
 - Identification of what led to the incident and what could have been handled differently
 - Assess whether the patient's physical well-being, psychological comfort, and right to privacy were addressed
 - Assess if the patient involved sustained any trauma as a result of the restraint episode.
 - Modify the patient's treatment plan to reflect the specific intervention, the assessment of the identified problem and the goal of using the intervention (expressed as expected outcomes).
- C. All staff involved in the restraint episode will participate in the staff debriefing.
- D. The Staff Debriefing form will be sent to the Quality Coordinator on each site for processing. Significant findings will be reported at staff and administrative meetings.

2. Patient Debriefing:

- A. The patient will be asked to participate in the debriefing, along with family members if available.
- B. The Patient Debriefing Form will be use to assess the restraint episode a separate review within 24 hours after the intervention has ended. The RN will be responsible for completing the patient interview.
- C. The Patient Debriefing Form will become part of the patient's medical record.

D. PERFORMANCE IMPROVEMENT

- 1. A system is maintained for tracking patients for whom these interventions have been used and the lengths of time involved in each episode.
- 2. Episodes of restraint are reviewed during unit rounds and/or at staff meetings.
- 3. Data is collected on all restraint episodes.
- 4. The RN on the unit at the time of initiation of the event is responsible for completion of the form. The following data will be collected for each episode and periodically analyzed:
 - unit
 - shift
 - staff who initiated the intervention
 - length of each episode
 - day of week, date and time of initiation
 - type of restraint
 - injuries sustained by patient or staff
 - age and gender of patient
- 5. The following data are collected and analyzed for trends or patterns:
 - multiple episodes of restraint within a 12-hour period
 - number of episodes per individual
 - episodes of restraint lasting greater than 12 consecutive hours
 - use of psychoactive medications as an alternative for or to enable discontinuation of restraint.
- 6. The Patient Care Director is responsible for reviewing these forms as they are completed and submitting the data collection forms as per each site's procedure.
- 7. Findings from these reports are reviewed at departmental and administrative meetings on a monthly and/or quarterly basis.
- 8. Significant incidents (to be determined on a case-by-case basis) will be reviewed at special review committee meetings.
- 9. Information obtained from debriefings will be used in performance improvement activities.

Appendix: SUGGESTED ALTERNATIVES TO RESTRAINT USE

1. ASSESS PATIENT FOR RISK AND INVOLVE OTHERS IN THE PATIENT'S CARE
 - Assess patient for fall risk, and correct preventable causes of falls.
 - Watch for signs of confusion in high-risk patients.
 - Ask family, friends, or volunteers to stay with the patient.
 - Provide increased nursing rounds for patients with high risk for falls or pulling out tubes.
 - Teach significant others and caregivers about the patient's clinical condition, (e.g., acute confusion, closed head injury, etc.) and appropriate interventions to manage behavior.
2. CHANGE OR ELIMINATE OFFENDING MEDICATIONS OR BOTHERSOME TREATMENTS
 - Initiate oral (as opposed to IV or NG) feedings. (order required)
 - Remove catheters and drains as soon as possible. (order required)
 - Monitor medications and side effects, and discuss alternatives with MD/appropriately credentialed professional.
 - Treat reversible changes in mental status.
 - Keep IV solution bags and tubing behind the patient's field of vision
 - Initiate pain/symptom treatment.
3. MODIFY THE ENVIRONMENT
 - Place bed in lowest position.
 - Reduce environmental noise and stimuli.
 - Keep the call button accessible.
 - Pin call bell to gown and re-emphasize frequently how to use it.
 - Position the bedside commode so that the patient can use it easily.
 - Develop toileting routines to facilitate elimination and reduce falls related to elimination.
 - Increase or decrease the amount of light in the room, depending on glare and the patient's preference or needs.
 - Select appropriate room assignment (e.g. near nurses station).
 - Limit the number of people who interact with the patient.
4. PROVIDE REALITY ORIENTATION AND PSYCHOSOCIAL INTERVENTIONS
 - Involve the patient in conversation. Don't talk over him/her.
 - Explain procedures to reduce fear and convey a sense of calm.
 - Provide reality links when appropriate (TV, radio, calendar, clock)
 - Use active listening to elicit the patient's feelings.
 - Attempt to verbally redirect behavior.
5. OFFER DIVERSIONARY AND PHYSICAL ACTIVITIES
 - Use TV, radio or music for diversion (according to the patient's cognitive capacity and individual preferences).
 - Provide exercise, ambulation and strengthening exercises whenever possible.

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- Initiate training in activities of daily living.
 - Use physical and occupational therapists to help the patient increase his/her strength and endurance and feel a sense of accomplishment. (Requires order).
6. OTHER
- Consult with other disciplines about appropriate interventions.
 - Use appropriate medications as ordered by the physician.
 - Provide companion

Reference:

[Federal Register / Vol. 71, No. 236](#) / Friday, December 8, 2006 / Rules and Regulations, accessed April 19, 2013

[New York State Public Health Law](#) § 2803-c
[New York State Mental Health Law](#) § 33.04 Restraint of patients

Abstracted for CSR® Education-- Source of Materials—Taken directly from *CMS Manual System Pub. 100-07 Operations Provider Certification, Department of Health & Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS): Transmittal 37 Issued: 10-17-08.*

http://www.azhha.org/educational_services/continuous_service_readiness/documents/CMS_RestraintInterpretiveGuidelines10-27-08.doc
Accessed April 19, 2013

RESPONSIBILITY:

Nursing Board
Medical Board

REVIEW/REVISION DATES:

Reviewed: November 2006
Revised: Aug 2007, Mar 2008, Mar 2009, May 2010, Aug 2010, Feb 2011, Jul 2011

APPROVALS:

Nursing Board: Mar 2008, Oct 2008, Mar 2009, Jun 2010, Aug 2010, Mar 2011, Aug 2011
Medical Board: Dec 2008, Apr 2009, Jun 2010, Oct 2010, May 2011, Aug 2011