

CRAIG HOSPITAL POLICY/PROCEDURE	
Approved: NPC, MEC, P&P 04/06; NPC, CIC, MEC, P&P 08/08 NPC, MEC, P&P 11/10; 11/11, 07/14, 10/14. 08/15	Effective Date: 10/97
Attachments: None	Revised Date: 04/04; 3/06; 08/08; 11/10; 11/11, 07/14, 10/14, 08/15
Forms: <ul style="list-style-type: none"> • RI40F1 – Consent for Release of Side Rails • RI40F2 – Assessment Note for Restraint/Seclusion – Physician’s Orders • RI40F3 – BA Restraint Flow Sheet 	Reviewed Date:

SUBJECT: RESTRAINTS AND SAFETY DEVICES

RATIONALE: To provide guidelines for the ordering and application of restraints and the management of patients in restraints and safety devices. Restraints may be required for treatment of some patient’s medical conditions but restraints have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of an individual’s rights, and even death. Craig Hospital will use the least restrictive and least potentially harmful way to protect the individual’s safety or that of others. In clinically justified situations when all other least restrictive methods have failed to provide desired outcomes, or if restraint is in the best interest of the patient based on clinical judgment, restraint may be used according to policy.

SCOPE: Medical Staff, All Nursing Staff, All Clinical Staff

DEFINITIONS:

Restraint – A restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body or head freely (e.g. –Safekeeper bed, Posey bed, safety mitt, locked belt, or soft limb restraint); or a restraint is a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not standard treatment or dosage for the patient’s condition. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.

Safety devices – A device that is used during a surgical, diagnostic, dental or other medical procedure or a voluntary mechanical support used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without the mechanical support or other devices to protect patients that are not restrictive (helmet, code alert, bed alarms, camera monitoring, lap boards, etc.). Safety devices do not meet requirement for restraint monitoring and documentation.

Safekeeper bed/Posey bed - Safekeeper/Posey beds provide a least restrictive environment for TBI patients, allowing freedom of movement while providing a low stimulus and safe environment. Safekeeper/Posey beds are used for patients who are potential or actual risk for unintentional injury secondary to confusion, agitation, disorientation, altered thought process, or fall related to their TBI. These beds are considered a restraint.

EQUIPMENT: Safekeeper bed; Posey bed; safety mitt; soft limb restraint; safety belt; lock belt; helmet; code alert; bed alarm; camera monitoring; lapboard; pillow splint; skin sleeve

POLICY: Least restrictive safety devices or behavior attendants are used when clinically indicated. In clinically justified situations when all other least restrictive methods have failed to produce desired outcomes, or if restraint is in the best interest of the patient based on clinical judgment, restraint may be used according to policy. Patients will receive considerate and respectful care and maintain dignity.

PROCEDURE:

- I. A Licensed Independent Practitioner (LIP) responsible for the patient's care will order a restraint.
 - A. Assess and document initial need for restraint. Include alternative/failure of alternative interventions attempted, if applicable (*RI40F2 Assessment Note for Restraint/Seclusion-Physician's Orders*).
 - B. The LIP will write the restraint order based on assessment.
 - C. The order must be signed by a physician within three calendar days.
- II. Ongoing clinical assessment and behaviors of the patient in restraint will be conducted every two hours. The RN will document this assessment at the end of each shift in Meditech.
- III. An order (*RI40F2 Assessment Note/Physician's Orders*) will be written in the medical record for use of restraint by the LIP upon initiation of restraint and will be renewed every 24 hours until the restraint is discontinued and will include

rationale for use of restraint and less restrictive methods of management attempted.

- IV. When restraints are utilized, a modification will be made to the patient's plan of care.
- V. Nursing Care of the patient:
 - A. The patient in restraint or with safety devices will have a call light within reach or other means of obtaining assistance or making needs known.
 - B. All restraints and devices are to be applied to a body part but should not interfere with circulation or cause pressure on a nerve. Restraint must be released every 2 hours and reapplied as necessary.
 - C. Hygiene and toileting needs are assessed and provided as needed with each assessment.
 - D. If an upper and lower extremity requires restraint, apply to one upper and opposite lower extremity if possible.
 - E. Tie restraints securely and out of reach of the patient. For bedridden patients the restraint should be tied under the bed, to the bed frame only, not to the side rails, and tied for easy release by healthcare providers.
 - F. If a patient is in a Posey bed, the zipper must be zipped at all times, unless a one-to-one attendant is present or trained family is present at the bed side. Documentation must include individual family members that have gone through this training.
 - G. If a patient is in a Safekeeper bed, the door must be locked at all times, unless a one-to-one attendant is present or trained family is present at the bed side. Documentation must include individual family members that have gone through this training.
 - H. Plan for progression of a patient out of a restraint device will be discussed and implemented by interdisciplinary team decision, and will not be made independently by a shift or discipline.
 - F. An order to discontinue the restraint will be written in the medical record by a LIP when the restraint is no longer indicated.
- VI. Use of Safety Devices:
 - A. Safety interventions and devices may be implemented after thorough assessment and documentation by a RN.

- B. The physician will be notified of the implementation of the safety device in AM rounds.
- C. The patient's condition will be assessed and documented every shift by an RN, while a safety device is in use.

VII. Role of the RN in the patient's safety management:

- A. Assesses patient and collaborates with team members to develop and implement an individualized safety care plan upon admission.
- B. Meets with patient and/or family members on a regular basis to review the safety management care plan and make any modifications or changes.
- C. Serves as a role model and resource for members of the nursing team.
- D. Provides direction and supervision of nursing staff, demonstrates professional judgment, uses problem-solving techniques and safety management principles and delegates patient care appropriately.
- E. Shares information and reinforces safety management strategies with nursing staff every shift.
- F. Continually evaluates the effectiveness of the safety care plan and meets with appropriate team members to tailor the plan to the specific needs of the patient in order to achieve measurable goals and objectives.
- G. Contributes to a safe and therapeutic environment and supports activities that promote the patient's independence, return of function and prevention of complications.

VIII. Role of the behavior attendant in the patient's safety management:

- A. Models a calm, non-threatening, serene style of patient interaction while maintaining a safe, structured environment.
- B. Observes and records target behaviors identified by the RN team leader and neuropsychologists.
- C. Assists in implementing safety treatment plan.
- D. Demonstrates effective oral and written communication skills.
- E. Attends appropriate therapy sessions with patient.

- F. Assists in follow through of treatments planned by interdisciplinary team including: writing in planner, orienting patient, engaging patient in recreational and therapeutic games, communicating with specialty devices, applying and monitoring splints, performing range of motion exercises and working on independence with ADL skills.
- G. Uses safety devices/restraints per policy and procedure.
- H. Applies physical or mechanical restraint, as a last resort, to protect patient from harming self or others as directed by LIP (see *IP 34 Management of Agitated Behavior*).
- I. Assists with feeding and monitoring of patients requiring help.
- J. Assists patient with bowel and bladder retraining program.
- K. Attends to and assists patient with personal hygiene and grooming needs.
- L. Turns and pads dependent patients; assists with weight shifts; observes and reports changes in skin appearance.
- M. Assists with education and teaching of family.
- N. Participates in case planning meetings and behavior meetings.
- IX. Restraint use is measured and assessed to identify performance improvement opportunities. Data is reviewed quarterly as a part of the open Medical Record review.
- X. Restraint or seclusion of patients with violent or self destructive behaviors will be per policy *IP 34 Management of the Agitated Patient*.
- XI. The hospital will report the following information to the Centers for Medicare and Medicaid Services no later than the close of the next business day following knowledge of the patient's death (Fax to 443-380-8868).
 - A. A death that occurs while a patient is in restraint or seclusion.
 - B. A death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
 - C. A death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death.
 - D. The date and time that the patient's death was reported to CMS is documented in the patient's medical record.

References:

www.CDPHE.state.Co.us/op/regs/healthfacilitiesregs.asp

Joint Commission 2014 Comprehensive Accreditation Manual for Hospitals,
PC.03.05.01 through PC.03.05.19; Glossary definitions of Restraint and Seclusion