The Stone Institute of Psychiatry should refer to departmental policy on restraint use.

I. PURPOSE:

To guide the safe, appropriate, and clinically justified use of restraints. The reason for the restraint use is not driven by the treatment setting of the patient nor is it determined by the patient’s diagnosis. Different standards exist for the use of restraints in medical and post-surgical care and when restraints are used for behavior management.

There are two reasons for restraint use:
A. Restraint for behavioral management: Initiated in emergency or crisis situations if a patient’s behavior becomes aggressive or violent, presenting an immediate, serious danger to his/her safety or that of others.
B. Restraint for acute medical and post-surgical care: Initiated to limit mobility, temporarily immobilize a patient related to medical, post-surgical or other procedure, and/or to address safety risks such as wandering for a non-violent patient who is otherwise cooperative.

II. DEFINITION:

Restraints restrict freedom of movement of the whole or a portion of the patient’s body. Restraints shall only be used in a therapeutic manner to prevent harm or injury to the patient and/or others.

This policy does not apply to restraint use that is only associated with, and used during, medical, dental, diagnostic, or surgical procedures (e.g., medical immobilization during a surgical procedure). In addition, this policy does not apply to the use of adaptive and protective devices (postural support, orthopedic appliances, tabletop chairs, and bed rails) when the device can easily be removed by the patient and the patient’s freedom to move when the device is in place has not been reduced. In this context, these devices are not considered involuntary restraint.

This policy also does not apply to the use of handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons, which are not involved in the provision of health care. Refer to Safety Manual Security Management Policy 6.78 “Prisoner / Patient Hospitalization / Forensic Staff Orientation” (Effective 04/16/04)

III. RESTRAINT DEVICES COVERED UNDER THIS POLICY:

A. Locked Restraint Devices
B. Soft Restraint Devices
   1. Mitten Restraints
   2. Soft Wrist Restraints
   3. Vest-Type/Chest Restraints
   4. Lap Belt

IV. INDICATIONS FOR USE:

The application of restraints must be based on the assessed needs of the patient and used in conjunction with or after exploring alternatives to the use of restraints. The immediate objective is to 1) promote healing and 2) protect the patient and others from harm or injury.

A. Explore alternatives prior to the initiation of restraints. Use the algorithm (Appendix) as a guide for assessment of need and possible alternatives.
B. Document this process on the Physician’s Order Form for Restraints and on appropriate flow sheets.
C. Restraints will be discontinued as soon as it is safe to do so based on needs assessment.
V. ORDERS:
Restraint is used upon the order of a physician and/or qualified staff (resident or APN).
A. For ordering, **only** use the applicable Restraint Order Set in PowerChart. During PowerChart downtime, utilize the Physician’s Restraint Order Form.
B. In a clinically urgent situation, an RN can make the decision to apply restraints. A physician’s order must be obtained (written or verbal) **within two hours of application for medical/surgical reasons**.
C. When restraints are used for **behavioral reasons**, a physician and/or qualified staff (resident or APN) must see and evaluate the individual in person **within one hour**.
D. PRN orders for restraints are prohibited.

VI. RELEVANT REGULATORY REFERENCE
None referenced

VII. POLICY UPDATE SCHEDULE
Every five years

VIII. KEY WORDS and CROSS REFERENCE
use of restraints behavioral management restraint handcuffs detention custody immobilization soft-restraint seclusion
IX. CARING FOR THE PATIENT IN RESTRAINTS:

RERAINT ORDERS

Acute Medical/Post-Surgical Restraint Application

- An order must be obtained within 2 hours of restraint application.
- A physician and/or qualified staff (Resident or APN) must see and evaluate the individual in person within 24 hours of initial restraint application. Therefore, verbal orders must be signed within 24 hours of restraint application.
- A physician and/or qualified staff (resident or APN) must assess the need for continued restraint use, document and rewrite subsequent orders at least q 24 hours.
- The physician and/or qualified staff initiating the order will notify the attending physician in a timely manner of the restraint order.
- **Total restraint time for each order is not to exceed the 24-hour limit.**

Behavioral Health Restraint Application

- A physician and/or qualified staff (resident or APN) must see and evaluate the individual in person within one hour of restraint application and write an order.
- Each written order for a physical restraint is limited to:
  - Every 4 hours for individuals 18 and older
  - Every 2 hours for children/adolescents 9-17
  - Every 1 hour for children under 9
- The physician and/or qualified staff (resident or APN) must provide and document that the patient was provided with a copy of Notice Regarding Restricted Rights of Individual IL462-2004 (Copies will be available to the units).
- Encourage appropriate consult for behavioral issues.
- If the RN assesses the patient to need continued restraint beyond 4 hours, the RN must contact the physician, and obtain a new order. This may be done via phone and would continue the order for an additional 4 hours.
- The need to continue restraints beyond 8 hours must be determined by the physician and/or qualified staff (resident or APN) through a face to face assessment before a new restraint order is written.
- **Total restraint time for each order is not to exceed time limits above.**
- The department manager or HOA (after hours) is to be immediately notified of any instance in which a patient remains in restraint or seclusion for more than 12 hours.
- Thereafter, the manager or HOA (after hours) is notified every 24-hours if either of the above conditions continues

PATIENT EVALUATION/ASSESSMENT

Acute Medical/Post-Surgical Restraint Application

- When placing a patient in restraints, assess the patient (patient’s clothing) and areas within the patient’s reach (e.g., bedside table and drawers) to assure that he/she does not possess or have access to items that could cause harm (sharp objects, matches, lighters).

Behavioral Health Restraint Application

- When placing a patient in restraints, assess the patient (patient’s clothing) and areas within the patient’s reach (e.g., bedside table and drawers) to assure that he/she does not possess or have access to items that could cause harm (sharp objects, matches, lighters).
- The physician and/or qualified staff (resident or APN) must evaluate and document that the restraint does not pose an undue risk to the patient’s health in light of his/her physical/mental health.
## DOCUMENTATION

<table>
<thead>
<tr>
<th>Acute Medical/Post-Surgical Restraint Application</th>
<th>Behavioral Health Restraint Application</th>
</tr>
</thead>
</table>
| • RN/LPN to observe and document on patient at least every hour, using the restraint flow record. These observations are necessary to assess for the continued safety, well being, comfort, and dignity of the patient.  
• Assess and document circulation (including skin integrity), movement, and sensation (CMS) every one hour. Offer appropriate range of motion (ROM), hydration, toileting, and other relevant care every two hours while awake. | • Individuals in restraint (or seclusion) are monitored continuously through in-person observation by an assigned staff member who is competent and trained. Documentation of this monitoring occurs every fifteen minutes on the restraint flow record.  
• Assess and document circulation (including skin integrity), movement, and sensation (CMS) every one hour. Offer appropriate range of motion (ROM), hydration, toileting, and other relevant care every two hours while awake. |

## PATIENT MANAGEMENT

<table>
<thead>
<tr>
<th>Acute Medical/Post-Surgical Restraint Application</th>
<th>Behavioral Health Restraint Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide all usual and customary care for patients in restraints</td>
<td>• Provide all usual and customary care for patients in restraints</td>
</tr>
</tbody>
</table>
**APPENDIX A:** (Review related policies/protocols if applicable (i.e. Falls, Suicide)

<table>
<thead>
<tr>
<th>Interventions/Alternatives to Restraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of behaviors that may warrant intervention for Medical/Surgical Reasons – to promote healing and safety</td>
</tr>
</tbody>
</table>

### Potential Causes of Behavior

<table>
<thead>
<tr>
<th>Drug Interaction</th>
<th>Physiologic Reaction</th>
<th>Pain and/or Discomfort</th>
<th>Reaction to Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review drug profile</td>
<td>• Hypoxia</td>
<td>• Surgical Pain</td>
<td>• Lighting</td>
</tr>
<tr>
<td></td>
<td>• Metabolic</td>
<td>• Chronic Pain</td>
<td>• Equipment</td>
</tr>
<tr>
<td></td>
<td>• Neuro impairment</td>
<td>• Presence of tubes, lines and/or drains</td>
<td>/ noise level</td>
</tr>
<tr>
<td></td>
<td>• Sundowner</td>
<td>• Full bladder</td>
<td>• Room temp</td>
</tr>
<tr>
<td></td>
<td>• Wandering</td>
<td>• Constipation</td>
<td>• ICU psychosis</td>
</tr>
</tbody>
</table>

### Alternatives to Restraint Use

<table>
<thead>
<tr>
<th>Drug Interaction</th>
<th>Physiologic Reaction</th>
<th>Pain and/or Discomfort</th>
<th>Reaction to Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Make adjustments to medications as indicated</td>
<td>• Treat as appropriate to physiologic factor based on assessment (i.e. correct electrolyte imbalance)</td>
<td>• Administer analgesics</td>
<td>• Adjust lighting</td>
</tr>
<tr>
<td></td>
<td>• Treatment of fever</td>
<td>• Repositioning of patient or equipment</td>
<td>• Adjust noise level</td>
</tr>
<tr>
<td></td>
<td>• Reorientation to room</td>
<td>• Facilitate elimination</td>
<td>• Adjust room temperature</td>
</tr>
<tr>
<td></td>
<td>• Allow familiar possessions</td>
<td>• Treatment of fever</td>
<td>• Reorientation to room</td>
</tr>
<tr>
<td></td>
<td>• Facilitate family/ significant others presence</td>
<td></td>
<td>• Allow familiar possessions</td>
</tr>
<tr>
<td></td>
<td>• Toileting, incontinence aids</td>
<td></td>
<td>• Facilitate family/ significant others presence or involvement</td>
</tr>
<tr>
<td></td>
<td>• Relocate pt. closer to nursing station</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Frequent observation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Re-Assess the Need for Restraints

- **YES**
  - Alternatives implemented, patient still exhibiting behavior that is deemed a threat to self or others.
  - Continue use of restraints and follow monitoring & documentation requirements as outlined in policy.

- **NO**
  - Patient no longer exhibiting behavior that is deemed a threat to self or others.
  - Remove restraints and document removal, note date/time on restraint log.
APPENDIX B: (Review related policies/protocols if applicable (i.e. Falls, Suicide)

Interventions/Alternatives to Restraints

Types of behaviors that may warrant intervention for Behavioral Health Reasons – Emergent use, imminent danger or physical harm to self or others.

<table>
<thead>
<tr>
<th>Potential Causes of Behavior</th>
<th>Chemical Dependence</th>
<th>Psychiatric Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviors</td>
<td>Substance abuse, acute withdrawal, not aware of where they are, delirious, combative, aggressive, striking out.</td>
<td>Dementia patient who becomes aggressive, throwing objects, striking out at staff/others.</td>
</tr>
</tbody>
</table>

Alternatives to Restraint Use

- Obtain psychiatry consult
- Family/significant other at bedside as appropriate
- Medication therapy for detoxification
- See interventions for “Reactions to Environment” on previous page
- Low stimulus
- Soft lighting
- Hydration

Re-Assess the Need for Restraints

- YES
  - Alternatives implemented, patient still exhibiting behavior that is deemed a threat to self or others.
  - Continue use of restraints and follow monitoring & documentation requirements as outlined in policy.

- NO
  - Patient no longer exhibiting behavior that is deemed a threat to self or others.
  - Remove restraints and document removal, note date/time on restraint log.
RESPONSIBLE PARTY:  Michelle Janney  
Vice President and Chief Nurse Executive  
Electronically Approved: November 7, 2005

REVIEWERS:  Members, Sitters and Restraints Task Force  
Directors of Nursing

COMMITTEES:  Patient Care Committee, September 15, 2005  
Medical Executive Committee, October 10, 2005

APPROVAL PARTIES:  Chuck M. Watts  
Senior Vice President, Medical Affairs  
Approved: November 9, 2005 (Signature on file)

Dean M. Harrison  
President and CEO  
Northwestern Memorial Hospital  
Approved: November 9, 2005 (Signature on file)