Banner Health

Title: Restraint Use for Non-Violent and Violent Situations		
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Discrete Operating Unit/Facility: Banner Baywood Medical Center Banner Behavioral Health Hospital Banner Boswell Medical Center Banner Casa Grande Medical Center Banner Churchill Community Hospital Banner Del E Webb Medical Center Banner Desert Medical Center Banner Estrella Medical Center Banner Fort Collins Medical Center Banner Gateway Medical Center Banner Goldfield Medical Center Banner Heart Hospital Banner Ironwood Medical Center Banner Lassen Medical Center Banner McKee Medical Center Banner North Colorado Medical Center Banner Ocotillo Medical Center Banner Payson Medical Center Banner Thunderbird Medical Center Banner--University Medical Center Phoenix Banner--University Medical Center South Banner--University Medical Center Tucson East Morgan County Hospital Ogallala Community Hospital Page Hospital Platte County Memorial Hospital Sterling Regional Medical Center Torrington Community Hospital Washakie Medical Center Wyoming Medical Center		

I. Purpose and Population:

A. **Purpose**:

- To ensure that the use of Restraint or Seclusion promotes patient safety, rights, dignity and well-being in accordance with applicable federal and state regulations.
- To reduce the use of Restraints

B. **Population**: All employees

II. Definitions:

A. Adaptive Support: Orthopedic appliances, braces, wheelchairs, or other devices used for postural support of the patient to assist in obtaining and maintaining normative bodily functioning, or performing activities of everyday living.

B. Alternative Interventions: Preventive strategies and innovative actions that are intended to meet the patient's unmet needs and eliminate the cause of behaviors that put the patient at risk for restraint use, such as being fall-prone, wandering or interfering with medical treatment devices. (See Appendix A for Alternatives to Restraints)

C. Behavioral/Violent Restraint: Restraint or Seclusion used to manage violent or self-destructive behavior; i.e. danger to self (DTS) or danger to others (DTO) that poses an imminent danger to the physical safety of the patient, staff or others, regardless of the patient's location.

D. Chemical Restraints: Medication used to manage the patient's behavior or restrict movement and is not a standard treatment or dosage for the patient's condition or symptoms

E. Face to face is an evaluation that consists of:
- The patient's immediate situation
- The patient's reaction to the intervention
- The patient's medical and behavioral condition
- The need to continue or terminate the Restraint or Seclusion

F. Medical/Nonviolent Restraint: A physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely. Adaptive Support items are not considered to be restraints.

G. Restraints: For purposes of this policy, Restraints refers to Medical Restraints, Behavioral Restraints and Chemical Restraints.

H. Code Gray: The hospital code to assist with communication of a violent situation involving threatening or violent behavior and summoning available staff or an identified team on duty.

I. De-escalation Techniques: Non-physical interventions designed to reduce maladaptive and threatening behavior.

J. Emergency Situations: Unanticipated patient behavior that places the patient or others at serious threat of violence or injury if no intervention occurs and that calls for the use of restraint or seclusion as an immediate response. (42 CFR 483.352 Definitions).

K. Imminent Danger: Immediate harm to the patient or other(s) is likely to occur if no action is taken.

L. Involuntary Hold: Emergency detention to hold a patient who is considered a danger to self or others pending a psychiatric or approved behavioral health professional evaluation.

M. Licensed Independent Practitioner (LIP): for the purposes of this policy - a physician, nurse practitioner, physician assistant, or other individual permitted by law and by the organization to provide care, treatment, and services without direct supervision. A LIP operates within the scope of their license.

N. Quiet Room: A room where a patient may choose to go voluntarily as a means of reducing stress or anxiety.

O. Seclusion: Involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving. May only be used for management of violent or self-destructive behavior.

P. Self-destructive Behavior: Behavior that may cause self-inflicted injury. This does not include pulling out lines, tubes, etc. due to delirium, confusion, or discomfort.

Q. Validated Staff: Staff that has completed the requirements for Restraint education and are determined to be competent to restrain patients.

R. Violent Behavior: Behavior that may cause harm to self or others, such as kicking, flailing, or punching.

III. Policy:

A. Patient Rights and Safety:
- Staff shall promote the safety, rights, dignity, and well-being of patients and shall use preventive strategies and alternative interventions whenever possible.
- All appropriate alternative measures shall be used prior to use of Restraints or Seclusion.
- Restraints and Seclusion are interventions of last resort to prevent interference with medical treatment, self-harm or physical harm to others.
- Restraints and Seclusion are used in the least restrictive manner possible.
- Restraints and Seclusion are discontinued as soon as possible.

B. Physical Holding:
- Patients may be physically held for the purpose of conducting physical examinations or tests.
- However, patients do have the right to refuse treatment, including the right to refuse physical examinations or tests.
- Holding a patient in a manner that restricts the patient's movement against the patient's will is considered a restraint.
- The use of force in order to medicate a patient against their will, even when court ordered, is considered a restraint.
- Staff may only use Banner approved physical hold techniques as taught per Workplace Violence Prevention training.

C. A physician/LIP order is required prior to the initiation of Restraints or Seclusion.
- Exception: In emergency situations, Restraints and Seclusion may be applied prior to the Registered Nurse (RN) obtaining the order; however, an order must be obtained during or immediately (within a few minutes) after the application of Restraints.

D. "PRN" orders for Restraint or Seclusion shall not be used.

E. If Seclusion rooms are available in behavioral health units or emergency departments, persons who are an imminent danger to others are placed in Seclusion only. Patients who are an imminent danger to self are placed in Restraints in the Seclusion room under direct observation by staff member.

F. Body Alignment:
- Medical Restraints are always applied in a supine position. **Exception:** pregnant patients are always placed on their side.

- Behavioral Restraints: Supine position is preferred positioning. Position wrists at side. Alternative positioning, e.g. one arm restrained over the patient's head, may be required based on the patient's behavior and risk of harm to themselves or staff.

G. Only Validated Staff may apply the use of Restraint or Seclusion and monitor the patient.
H. Banner Health (BH) does not use time-out or a time-out room. Quiet Rooms are available for patients that choose to utilize a low-stimulation area to decrease stress and anxiety. (See Quiet Room in the Seclusion topic section)
I. A written plan of care (IPOC) for the management of restraints is required with any restraint episode.
J. Staff educates patients and their families/significant others, as HIPAA allows, about the reason for Restraint use as appropriate, and alternatives to eliminate Restraints. Educational materials may be provided to educate and help reduce Restraint use.

Assessment and alternative interventions

A. Notify LIP immediately of a significant change in patient behavior. Information: There may be a physiological change that requires immediate intervention.
B. Medical: Identify behaviors that interfere with medical treatment or place the patient at risk of harm.
C. Behavioral or Chemical: Identify risk factors that might be causing escalating behavior, including:
    1. history of behavioral conditions
    2. substance abuse
    3. prior physical injury to self or others
    4. physical or sexual abuse or stimulus
D. Investigate triggers or contributing factors that may be reasons for the behavior, including: physical,
    1. physiological,
    2. psychological and
    3. environmental factors
E. Implement preventive strategies and alternative interventions to meet the patient's needs and eliminate the cause of behaviors that put the patient at risk for restraint/seclusion use. Note: Several different measures may be required. See Appendix A: Alternative Interventions.
F. Medical: When possible, notify family regarding patient condition and discuss alternatives being considered to reduce necessity for Restraint.
G. Medical: Consider services of a patient care companion (where applicable).
H. Consult with patient's physician if nursing interventions, de-escalation techniques and/or other alternative interventions are not effective. Information: Contributing factors such as pain or anxiety, or withdrawal from substances may require medication orders.
I. If additional staff are needed, initiate a Code or the identified response team.(i.e.Swift Response Team (BeH hospital only), Bert (T-bird only)
J. Document the assessment and alternative interventions that have been implemented and the results.

Non-Violent (Medical) Restraints

A. A provider order for non-violent restraints is required, and will be in effect for the duration of the episode.
B. Application: Restraint Application, Limb

1. Document the initiation of restraints, to include the type and location of restraint, and an RN assessment that the restraints are applied appropriately.

C. Notify the attending physician as soon as possible if the attending physician did not order the Restraint.
D. Medical Restraint Assessments:
   1. Assessments are performed by an RN/LPN every 2 hours and PRN. A full assessment may be deferred if the patient is sleeping quietly, however there shall be no more than 4 hours between full assessments.
      a. Level of Consciousness (LOC),
         i. Orientation (as possible/when able~~applicable~~ based upon patient's LOC).
      b. Circulation, movement, sensation of restrained limbs.
      c. Pain is assessed per the Pain Management policy
   2. Readiness to discontinue restraints/continued need for restraint is assessed and documented at each shift change Restraint Hand-off (RN to RN).

E. Medical Restraint General Care:
   1. General care is offered every 2 hours and PRN. This may be deferred at the direction of the RN if the patient is sleeping quietly. When possible, coordinate the timing of general care with the RN assessments to mitigate agitation and/or allow the patient to sleep.
      a. Offer the patient food and/or water, unless contraindicated by provider orders (e.g. NPO).
      b. Encourage and/or offer ROM.
      c. Offer toileting.
      d. Notify RN of any changes in patient condition.
F. Provide education to patient and/or family. Note: Include criteria for release of Restraint.
G. Discontinue Restraint under the supervision of an RN when the condition requiring the Restraint no longer exists.
   1. Reminder: Once Restraint discontinued, further use constitutes a new episode and the procedure must start at the beginning including requiring a new order.
   2. Exception: A Restraint is NOT considered to be discontinued in the following situation:
      a. A temporary, directly-supervised release that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises).As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the Restraint.

Violent (Behavioral) Restraints and/or Seclusion

A. Orders for behavioral/violent restraints are time limited:

   1. Every four hours for patients age 18 and older
   2. Every two hours for patients ages 9 through 17
   3. Every one hour for patients less than age 9
      a. B--UMCS ONLY:
         i. Every three hours for patients who are 18 years old and over
         ii. Every two hours for patients who are 12-17 years old
         iii. Every hour for patients who are 11 and younger
   4. Orders may be renewed if necessary up to a total of 24 hours in increments stated above.

B. Application:
   1. Restraint Use for a Patient on a Psychiatric Unit

2. Restraint Use for Assaultive and Violent Behavior
3. Document the initiation of restraints, to include the type and location of restraint, and an RN assessment that the restraints are applied appropriately.

C. Face to face:
1. A face-to-face must be completed by Physician, LIP, specially trained RN, or Physician Assistant within one hour of initiating restraints and again with each NEW order (at least every 24 hours).
2. A face-to-face is not required with each subsequent restraint RENEWAL order.
   a. Exception: In the Arizona Behavioral Health Units and Behavioral Health Hospitals a face-to-face must be completed within one hour of each NEW and RENEWAL order.

D. Notifications:
1. Notify the attending physician as soon as possible if the attending physician did not order the Restraint.
2. Arizona Behavioral Health Units and Behavioral Health Hospitals:
   a. When possible, notify guardian/family regarding initiation of Restraint or Seclusion if release obtained from patient.
   b. Note: Minor patient's guardian/parents must be notified as soon as possible after initiation of Restraint or Seclusion.

E. Behavioral Restraint Monitoring:
1. Continuous monitoring by validated staff is required for patients in both behavioral restraints AND seclusion.
2. Monitoring of patients in behavioral restraints without seclusion is performed by validated staff:
   a. A minimum of every 15 minutes:
      i. Affect/behavior (e.g. calm/cooperative, agitated/combative, sleeping).
      ii. Circulation (e.g. skin pink and warm, and ability to insert 1-2 fingers between restraint and skin).
      iii. Skin integrity (e.g. intact).
   b. Every 1 hour and PRN:
      i. Vital signs.
3. Notify RN of any changes in patient condition.

F. Behavioral Restraint Assessments:
1. Assessments are performed by RN/LPN every 1 hour and PRN.
   a. Level of consciousness
      i. Orientation (as possible/when able ~~applicable~~ based upon patient's LOC).
   b. Circulation, movement, sensation of restrained limb
   c. Pain is assessed per the Pain Management policy.
2. Readiness to discontinue restraints/continued need for restraint is assessed and documented at each shift change Restraint Hand-off (RN to RN).

G. Behavioral Restraint/Seclusion General Care:
1. General care is offered every 2 hours and PRN. When possible, coordinate the timing of general care with the RN assessments to mitigate agitation.
   a. Offer the patient food and/or water, unless contraindicated by provider orders (e.g. NPO).
   b. Encourage and/or offer ROM.
   c. Offer toileting.

H. Provide education to patient and/or family. Note: Include criteria for release of Restraint or Seclusion.

I. Seclusion:
   1. Interventions when on non-behavioral health units include:
      a. Private or semi-private rooms where the person is prevented from leaving their room due to an unrelated medical isolation protocol;
      b. 1:1 staff person for the person's safety related to self-harm/violent behaviors as ordered by the physician; and
      c. Involuntarily holding the patient in the room and preventing them from leaving.
   2. Seclusion on Behavioral Health (BeH) Units and Units with Designated Seclusion Rooms:
      a. Is designated to be used for Seclusion when the patient is determined to be danger to others (DTO) or when the patient is restrained for self-harming behaviors.
      b. Requires that the seclusion room door be locked for DTO behavior. Open door seclusion for DTO behavior on BeH units is prohibited.
      c. Will not be conducted in a patient's bedroom or a sleeping area;
      d. Allows staff members full view of the patient in all areas of the room and the Seclusion Room must be free of safety hazards;
      e. Requires at least 60 square feet of floor space;
      f. Requires a non-adjustable bed that:
         i. Consists of a mattress on a solid platform;
         ii. Is constructed of a durable, non-hazardous material;
         iii. Is raised off of the floor;
         iv. Does not have wire springs or a storage drawer; and
         v. Is securely anchored in place.
      g. Requires that if a room used for Seclusion does not contain a non-adjustable bed, an alternate piece of equipment is available for use in the room used for seclusion that:
         i. Is commercially manufactured to safely and humanely restrain a patient's body;
         ii. Provides support to the trunk and head of a patient's body;
         iii. Provides restraint to the trunk of a patient's body;
         iv. Is able to restrict movement of a patient's arms, legs, trunk, and head;
         v. Allows a patient's body to recline;
         vi. Does not inflict harm on a patient's body; and
         vii. Is described in documentation of the manufacturer's specifications for the piece of equipment and that documentation is maintained.

J. Discontinuing behavioral restraints or seclusion:
   1. Have a minimum of two staff members release locked/buckled restraints
   2. Reminder: Once Restraint or Seclusion is discontinued further use constitutes a new episode and the procedure must start at the beginning including obtaining a new order.
      a. Exception: A Restraint is NOT considered to be discontinued in the following situations:
         i. A temporary, directly-supervised release that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) is not considered a discontinuation of the Restraint or Seclusion intervention as long as the patient remains under direct staff supervision. (See Appendix F for enclosure beds)

K. Debriefing (Arizona Behavioral Health Units and Behavioral Health Hospitals must complete, it is optional for all other locations): A staff debriefing shall be completed after each behavioral restraint to identify opportunities for alternatives interventions that may have been more successful.

IV. Procedural Documentation:

A. Initial assessment, including description of behavior that necessitated initiation of Restraint or Seclusion, and alternative interventions used prior to initiation of Restraint or Seclusion and the effectiveness of alternatives.
B. Plan of Care (IPOC)
C. Face to Face evaluation.
D. Assessments.
E. Monitoring.
F. General Care.
G. Patient and/or family education.
H. Seclusion/violent restraint checklist (Form 9209-0000 or 9209-0001) *A Precautions/Observation form is ALSO required for patients who are BOTH restrained and under suicide precautions.
I. Discontinuation of restraints.
J. Debriefing (if required)

V. Additional Information:

A. This policy does not apply to:
    1. Treatment immobilization (i.e., during a medical/diagnostic or surgical procedure, arm board for IV administration)
    2. Postural support devices used for proper body position and balance (i.e. prosthetic devices)
    3. Any device that can be readily removed by the patient (e.g. self-releasing lap belt)
    4. Age appropriate protective safety interventions
    5. Use of drugs, such as sedatives or psychotropic medications, within standard dosing parameters and accepted treatment protocols for the patient's medical condition
    6. Patients with forensic correctional restrictions.
B. Staff shall promote the safety, rights, dignity and well-being of the patients through:
    1. Early recognition of maladaptive behaviors.
    2. Early recognition of pain responses.
    3. Application of knowledge of the symptomatic behaviors and other manifestations of various crisis situations that may escalate violence.
    4. Use of appropriate alternative interventions needed to decrease escalating behavior before using Restraints.
C. The Restraint or Seclusion is proportionate and appropriate to the severity of the patient's behavior and the patient's:
    1. Chronological and developmental age
    2. Size
    3. Gender
    4. Physical condition
    5. Medical condition
    6. Psychiatric condition
    7. Personal history, including any history of physical or sexual abuse
D. Restraint availability: Restraint devices are available to the health care professional through the supply chain or security, dependent upon the type of restraint needed to manage the patient's behavior. The type of restraint does not determine the reason for Restraint, but rather this is determined through assessment of the patient and the identification of the behavior being demonstrated which has been unresponsive to less restrictive measures initiated by the nurse. The following is a list of types of restraint, but may not be all-inclusive:
    1. Soft limb restraints,

2. Mittens that are tethered to immobilize the arm or hand, or are applied so tightly that the patient's hand or fingers are immobilized.
3. Bed side rails, Note: See Appendix B: When Side Rails Are, or Are Not, Restraints
4. Freedom Splints (where available)
5. Enclosed beds (where available)
6. Limb restraints with hook and loop fasteners
7. Lap belts (5-point restraint), and
8. Locking or non-locking (non-leather) restraints
    a. Information: Non-locking restraints are closed with buckles rather than key and lock
9. Not all restraints are available in all facilities.
10. Spit hoods may be available for use.
11. Body nets are not to be used at Banner Health.
12. Each facility determines the mechanism for controlling the availability of restraints and has a mechanism in place to identify and monitor restraint use.

E. When a Quiet Room is used:
1. Patients will be allowed to bring items approved by the RN (e.g., book, paper, writing instrument, portable music device) during this time.
2. Assigned personnel will document every 15 minute patient observation as per the rounding protocol, or more frequently as determined by the RN or physician.
3. The RN will document in a progress note that the QUIET ROOM was used with the initial and discontinued time, date, and patient response to the intervention or situation.
4. If a seclusion room is used as a Quiet Room:
5. The designated sign "QUIET ROOM" is placed on the outside of the door:
6. If restraints are on the bed, they are removed before the room is utilized as a Quiet
7. room.
8. When the QUIET ROOM, is used as a Seclusion room, the QUIET ROOM SIGN is removed, the room is inspected for safety and any potentially dangerous objects are removed immediately.

F. Staff Education:
1. A comprehensive training program educates staff in conducting behavioral assessment and innovative alternatives to meet the patient's needs. Validated Staff are those who have successfully completed this training program and demonstrated their ability to conduct a behavioral assessment and apply Restraints.
2. The comprehensive training program is designed to allow staff to gain knowledge, skill and demonstrate competence in:
3. Behavioral assessment (Conducted by the RN)
4. Preventive strategies;
5. Alternative interventions, including de-escalation and deflection techniques;
6. Proper choice and application of restraints;
7. The monitoring and care of patients in restraints, including assessing for readiness to discontinue restraints, and supporting documentation;
8. First aid, including identification of the need for and care of patients who are injured or in distress; and
9. Cardiopulmonary Resuscitation.
10. Additional training may be provided to a select group of RNs that is designed to equip them with the skills and competencies to perform the face-to-face evaluation of patients, in accordance with applicable state and federal regulations.

11. BH educates all physicians and LIPs responsible for ordering Restraints on hospital restraint policies during orientation to the facility and following adoption of any changes to the policy that impact providers.

G. Banner Health will report to CMS:
   1. Each death that occurs while a patient is in restraint or seclusion,
   2. that occurs within 24 hours after the patient has been removed from restraint or seclusion,
   3. and each death that is known to the hospital and occurs within one week after restraint and where is reasonable to assume that the restraint or seclusion contributed directly or indirectly to a patient's death.
      a. NOTE: Banner Health has an established procedure for review of a patient's record and notification to the appropriate authorities when a patient dies while in Restraint.

VI. References:

A. CMS §482.13(e) thru (g)
B. Joint Commission Comprehensive Accreditation Manual for Hospitals.

VII. Other Related Policies/Procedures:

A.

VIII. Keywords and Keyword Phrases:

A.

IX. Appendix:

A. Alternatives to Restraints
B. Side Rails and Specialty Beds
C. Exception – PRN Orders per CMS Rules
D. Quick reference on Medical and Behavioral Restraint/Seclusion
E. Enclosure Beds

APPENDIX A: Alternatives to Restraints

Physical modification Approaches to reduce restraint use through physical modification.

Alternative	Examples
Modify environment	• Increase/decrease lighting • establish wandering paths • disguise exits • room or bed change • If applicable: take outside
Adapt wheelchairs	• Wedge pillow Lap buddy.
Provide body props / postural enhancer	• Wedge pillow • Lap buddy
Install alarm/safety devices	Bed or chair alarm.

Reduce unnecessary visual or auditory stimuli	• Eliminate buzzers • Bells • Intercoms • Television • Shut doors • If applicable: Use of the "Quiet Room"
Personalize rooms	Personal photos. approved personal items
Use secured unit	Behavioral Health Units

Activities

Activity related approaches to reduce restraint use.

Activity	Example
Consider PT/OT/RT consult.	If applicable: Pet therapy, increase contact with RT staff
Structure daily activities	• Utilize orientation boards in rooms. • Increase staff 1:1 time with patient
Permit or encourage wandering/pacing	
Provide physical exercise	Ambulation, Stretches
Provide appropriate assistive devices	• Cane • Walker • Wheelchair • Slide board **On BeH:** units ensure appropriate devices are allowed
Provide appropriate stimulation/socialization	• Radio, TV, Video • Headphones, hand held games

Alternative measures for all patients

Examples:

- Ask patient what would help
- Increase frequency of engagement w/patient
- Moving patient closer to nursing station
- Reduce external stimuli
- De-escalation strategies
- Need for appropriate medication such as pain medicine, psychotropic meds(anxiolytics, antipsychotics)**
- Re-orientation. Diversional activities
- Ambulation/exercise
- Bed alarms/ wander-guard alarms
- Staff/family/friend involvement with patient

***Sedation is not considered an alternative – sedation may be a form of chemical restraint*

Physiological and nursing care approaches to reduce Restraint use that would be appropriate for the type of setting may include:

- Evaluate underlying physical or psychological problems.
- Relieve fear and remind the patient they are safe; allow a safe object for comfort
- Evaluate sleep patterns**;**
- Schedule daily nap.
- Relieve pain, anxiety
- Relieve hunger; provide snacks
- Relieve boredom; play cards, games, increase engagement through scheduled 1:1 contact *("I will be back to talk to you at 2:00")*
- Provide frequent reminders and choices to avoid a specific behavior
- Provide repeated reassurances or limits as needed
- Use appropriate footwear such as slipper socks, supportive shoes
- Use eyeglasses, hearing aids, or dentures
- Adequate hydration (consider consult with Clinical Dietitian).
- Relocate near nursing station for increased engagement
- Institute toileting schedule.
- Implement repositioning techniques.
- Reevaluate drug use/medications
- Take out of room as appropriate.
- Provide diversion/recreation (e.g. busy box, book, journal writing, contacting a friend).
- All personal items within reach
  - Water, Hearing aide, glasses, dentures, Kleenex, call light, Urinal.
- Provide bath/shower/massage
  - Back rub, foot rub.
- Consider Social Services/Case Management consult
- Actively listen / explore feelings and perceptions of patient.
- Encourage independence in other aspects of care.
- Provide reality orientation (e.g. orientation boards, clocks).
- Accept patient's perceptions of their reality and relieve distress if possible
- Provide additional engagement
  - Family and friends to sit with patient.
  - Phone Calls to support persons

APPENDIX B: Side Rails and Specialty Beds

The risk of using side rails

1. **When deciding whether or not to use side rails remember that the risk presented by side rail use should be weighed against the risk presented by the patient's behavior.**

2. Risks of using side rails:

   - Frail elderly patients may be at risk for entrapment or entanglement between the mattress or bed frame and the side rail.

- Disoriented patients may
    - View a raised side rail as a barrier to climb over,
    - Slide between raised, segmented side rails,
    - Scoot to the end of the bed to get around a raised side rail and exit the bed.
- Falls from the greater height posed by the raised side rail
    - Possibility for sustaining greater injury or death than if the patient had fallen from the height of a lowered bed without raised side rails.

Determining whether or not Side Rails or a Specialty Beds are a Restraint

Side Rail/Specialty Beds ARE a Restraint **if**	**Side Rail/Specialty Beds ARE NOT a** Restraint **if**
The purpose of the side rails/specialty bed is to restrict the patient's freedom to exit the bed. Example: • All side rails are up to prevent the patient from exiting the bed. • The patient is placed in a Posey enclosure bed to prevent the patient from exiting the bed.	The purpose of the side rails/specialty bed is to prevent the patient from falling out of the bed. Examples include when the patient is: • On a stretcher, • Recovering from anesthesia, • Sedated, • Experiencing involuntary movement, • On certain types of therapeutic bed (e.g. low air loss mattress). • Not physically able to get out of bed regardless of whether the side rails are raised or not. • On seizure precautions. • An infant/toddler in a crib.

APPENDIX C: Exceptions – PRN Orders per CMS Rules

Geri Chairs

If a patient requires the use of a Geri chair with the tray locked in place in order for the patient to safely be out of bed, a standing or PRN order is permitted.

Note: Given that a patient may be out of bed in a Geri chair several times a day, it is not necessary to obtain a new order each time.

Raised side rails	If a patient's status requires that all bedrails be raised (restraint) while the patient is in bed, a standing or PRN order is permitted. It is not necessary to obtain a new order each time the patient is returned to bed after being out of bed.
Repetitive self-mutilating behavior:	Repetitive self-mutilating behavior. If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyham Syndrome, and the patient engages in repetitive self-mutilating behavior, a standing or PRN order for restraint to be applied in accordance with specific parameters established in the treatment plan would be permitted. Since the use of restraints to prevent self-injury is needed for these types of rare, severe, medical and psychiatric conditions, the specific requirements (1-hour face-to-face evaluation, time-limited orders, and evaluation every 24 hours before renewal of the order) for the management of violent or self- destructive behavior do not apply.

APPENDIX D: Quick Reference on the Difference between Medical/Non-Violent and Behavioral Health/Violent Restraint/Seclusion, Continued

	Medical/Non-Violent Restraint	Behavioral/Violent Restraint (DTO/DTS)
Determine cause for restraint use	**If restraint is being used to:** • Allow medical treatment to continue without interruption • Prevent accidental or deliberate removal of essential tubes or drains • Provide medical safety when the patient is unable to follow direction o ALOC RELATED TO MEDICAL CONDITION (i.e.: hypoglycemia, altered blood gasses, altered electrolyte, ICU psychosis)	**If restraint is being used to:** • **Non-BeH Units:** Control behaviors that pose an imminent danger to the physical safety of the patient, staff or others • **BeH Units:** Control behaviors that pose an imminent danger to the physical safety of staff, others (SECLUSION) • **BeH Units:** Control behaviors that pose an imminent danger to the physical safety of the patient or staff and others (RESTRAINT)

Restraint Classification	**Medical/Non-Violent Restraint**	**Behavioral/Violent Restraint (DTO/DTS)**
Emergency Application	RN WITH documentation of reason for use, patient condition and failed/ ineffective alternative measures attempted	RN WITH documentation of reason for use, patient condition and failed/ ineffective alternative measures attempted
Telephone or Verbal Order	RN to notify provider as soon as possible after initiating restraints	RN to notify provider as soon as possible after initiating restraints
Provider Trained RN Face-to-Face Assessment		A face-to-face must be completed by Physician, LIP, specially trained RN, or Physician Assistant within one hour of initiating restraints, and again with each NEW order (at least every 24 hours). A face-to-face is not required with each subsequent restraint RENEWAL order. EXCEPTION: In the Arizona Behavioral Health Units and Behavioral Health Hospitals a face-to-face must be completed with one hour of each initiation and renewal order.

APPENDIX D: Quick Reference on the Difference between Medical/Non-Violent and Behavioral Health/Violent Restraint/Seclusion, continued

Restraint Classification	Medical/Non-Violent Restraint	Behavioral/Violent Restraint (DTO/DTS)
Order Set Orders	Initiate as soon as possible (within a few minutes); and Renew daily if needed.	Initiate as soon as possible **Limited to:** 4 h- 18yrs and older; 2 h- 9yrs-17yrs; 1 h- less than 9 yrs. old **B--UMCS ONLY**: 3 h – 18 yrs. old and older 2 h – 12-17 yrs. old 1 h – 11 years and younger Each order for Violent restraint may only be renewed in accordance to the above limits up to 24hrs.
Discontinuing Restraints	May be done by RN/ Provider	May be done by RN/Provider based on assessment. All Restraints are removed when the patient meets the criteria for removal

Observation	Minimum every 2h	Q 15 min documentation; 1:1 or more as clinically needed (i.e. pregnant, obesity, etc.)
RN Must Document	Nursing Care Plan Update – IPOC: Restraint Use Management. RN full assessment every 2h.	Nursing Care Plan Update – IPOC: Restraint Use Management. --- RN full assessment every 1h

Document by Assigned Nursing Staff (RN, BHS, CNA, Observer)	A minimum of every 2 hours: Offer of food and/or water, unless contraindicated by provider orders (e.g. NPO). ROM. Toileting.	<u>A minimum of every 15 minutes</u>: Affect/behavior (e.g. calm/cooperative, agitated/combative, sleeping). Circulation (e.g. skin pink and warm, and ability to insert 1-2 fingers between restraint and skin). Skin integrity (e.g. intact). <u>Every 1 hour and PRN</u>: Vital signs. <u>Every 2 hours</u>: Offer of food and/or water, unless contraindicated by provider orders (e.g. NPO). ROM. Toileting
Notification	Medical: When possible, notify family regarding patient condition and discuss alternatives being considered to reduce necessity for Restraint.	**Adult:** Notification of Guardian/Family regarding initiation of restraint or seclusion if release obtained from patient. **Minor:** notification of patient's guardian/parents within 1 hour after initiation of restraint or seclusion
Education	*Education* provided to patient (and family if appropriate)	*Education* provided to patient (and family if appropriate)
Patient and Staff Debriefing	Debriefing, if one was conducted.	Patient debriefing: within 24 h to be held *with staff* & patient (and family if appropriate) after event.[1] Staff debriefing: within 24 h to be held with staff
Body Alignment	Supine position only. Follow manufacturer instructions. Pregnant patients are placed on their left side.	Supine position is preferred positioning. Position wrists at side. Alternative positioning, e.g. one arm restrained over the patient's head, may be required based on the patient's behavior and risk of harm to themselves or staff.

Physical Hold		**On BeH units**, no physical holds on ground or carrying patients to seclusion room.

APPENDIX E: Enclosure Beds

An enclosed bed is considered **medically necessary** for individuals with seizures, disorientation, vertigo, and neurological disorders, where the individual needs to be restrained in bed. Clinical documentation must be provided that states less invasive strategies (i.e., bed rails, bed rail protectors, or environmental modifications) have been tried and have not been successful. A physician order is required for the use of an enclosure bed.

CMS defines a restraint in 42CFR 482.13.e.1

A physical restraint is any manual method, or physical, or mechanical device, material, or equipment, attached or adjacent to the patient's body that he or she cannot easily remove, that restricts freedom of movement or normal access to one's body. Therefore, since the patient cannot remove him or herself from the Bed Canopy system on their own, it is considered a restraint under CMS regulations. The same is also true for the Joint Commission regulations, and requires implementation of the facility's restraint policies and procedures.

The Posey Bed Canopy System or other enclosed beds are considered restraints and meet the above definition of restraint. The above documentation and monitoring requirements for medical/nonviolent restraint also apply to the patient in an enclosure bed.

If the enclosure bed is unzipped and the patient is able to get out of the bed even if the patient has a 1:1 observer, the restraint is considered to be removed and a new order is required if the patient is returned to the zipped enclosure bed. The patient may be temporarily removed from the bed for ADL activities such as toileting and feeding and returned to the bed. This is considered continuous use and a new order is not required.