RESTRAINT USE ALGORITHM

Patient at risk for harm to self/others?

Consider & document
Alternatives to Restraints
(Chart in Restraint Screen)

Examples of Alternatives:
1 Mitt; Unsecured
Use a 1:1 Observation/Interactions
Alarm: Bed/Chair
Assist in Transfers/Ambulation
Bladder/Bowel Program
Cover Tubes/Lines/Dressings
Decrease Visitors/Environmental Stimulation
Diversional Activities
Low Bed/Fall Matts
Pain Management
Address underlying source of distress
Allow patient's family to be involved in care of patient
Take time to listen to patient's concerns
Move for closer observation
Take time to explain procedures
Video monitoring

Alternatives Effective?

YES → Continue to monitor

NO

Notify provider &
Obtain Restraint Order
(prior to application of restraints)

In emergency application of restraints, contact provider *immediately* after applying

Non-Violent Restraint Use:

Attempting to get up/Unsafe ambulation
Pulling at lines
Pulling at tubes
Removal of equipment
Removal of dressing

A new order is required with each change in restraint device or patient condition. A face-to-face assessment needs to be completed with new order every 24 hours

Violent/Self Destructive Restraint Use:

For patients that are in danger of physically hurting themselves or others, such as: aggressive dementia, hitting, CIWA/Detox or head injury patient

Complete/document the face-to-face assessment in 1 hour of initiating restraint. Order renewal may be done over the phone, but a face-to-face assessment needs to be completed with new order every 24 hours.

Order renewals must be within:
- 4 hours for patients ≥18 years old
- 2 hours for patients 9-17 years old
- 1 hour for children < 9 years old

Non-Violent Patient Monitoring:
Visual checks of patient are ongoing

Document at Initiation and every 2 hours:

- Vital signs
- CMS checks/skin integrity
- Safety/privacy/modesty issues
- Nourishment/hydration/elimination/hygiene needs
- Level of distress/agitation, and mental status
- Need for continued restraint
- Response to interventions/patient education
- Readiness to be released
  (Note: trial release **NOT** allowed. Patient may temporarily released for toileting, ROM, positioning, assisted ambulation, and other nursing care)
- Update Restraint Plan of Care
- Face-to- face assessment required with new order every 24 hours

Violent/Self Destructive Patient Monitoring:
Visual checks of patient are ongoing

Document at initiation and then every 15 minutes:

- Vital signs
- CMS checks/skin integrity
- Safety/privacy/modesty issues
- Nourishment/hydration/elimination/hygiene needs
- Level of distress/agitation, and mental status
- Need for continued restraint
- Response to interventions/patient education
- Readiness to be released
  (Note: trial release **NOT** allowed. Patient may temporarily released for toileting, ROM, positioning, assisted ambulation, and other nursing care)
- Update Restraint Plan of Care
- Face-to- face assessment required with new order every 24 hours