UCSF Health

ADULT
NEONATAL
PEDIATRIC
NURSING PROCEDURE

Restraint Use

Table of Contents

Critical Points

1. Immediately notify the provider if initiation of restraint is based on a significant change in the patient's condition.
2. **A new restraint order is required** if restraints are discontinued and subsequently reapplied due to a change in the patient's condition. Restraints are not able to be used PRN, however, the following is NOT considered a discontinuation of restraint:
    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). Since the patient remains under direct staff supervision, the restraint is not considered discontinued because the staff member is serving the same function as the restraint.
3. Patients in **NON-VIOLENT** restraints must be observed at least every 15 minutes for safety and well-being.

Restraint Use *(continued)*

4. Patients in **VIOLENT/4-point restraints must have continuous observation** as they are unable to protect themselves. For safety and well-being:
    a. Inpatients: 1:1 RN or qualified staff-to-patient assignment. An RN must perform assessment and documentation every 15 minutes.
    b. Emergency Department: continuous surveillance.
5. When an episode of VIOLENT/4-point restraint exceeds 12 hours, or if the patient experiences two or more separate episodes of VIOLENT/4-point restraint**,** the charge nurse, unit management team (or nursing supervisor), and the appropriate physician must be notified immediately and every 24 hours if condition continues.
6. All 4 side rails must be raised while a patient is restrained to prevent patient from sliding out of bed.
7. Only approved products may be used, as intended, to restrain a patient. Refer to Appendix A and Appendix E for list of approved products. Restraints that are ill-fitting or applied incorrectly could result in inadvertent harm to patient.
8. Refer to Reporting Requirements section for instances when an incident report is required.
9. Restraints are always secured using either a quick release knot (see Appendix G) or quick release buckle (see Appendix H) to allow for easy removal in case of an emergency.
10. **Never secure restraints to a moveable side rail.** Restraints must be secured to an immovable part of the bed or chair/wheelchair, e.g., bed frame or cross bar of wheelchair.
11. Do not apply restraints to extremities where there are pre-existing conditions which would increase the risk of harm from a restraint-related injury (e.g., post mastectomy, Scribner shunt, capillary fragility, bruising, edema, fracture, etc.).
12. If there is a need to restrain only one extremity (for example, a patient who is hemiplegic and needs the unaffected wrist restrained), consider restraining the opposite lower extremity if the patient is mobile enough to exit bed.
13. Based on child's chronological and/or developmental age, RN selects the most appropriate restraint device which may include adult restraint devices.
14. When lockable restraints are used, 2 keys must be immediately accessible to staff caring for patient.
15. In case of fire or other disaster, release patient from restraints immediately.

Supplies

Refer to Appendix A for list of supply PMM numbers

Restraint Philosophy of UCSF Health

The philosophy of UCSF Health is to promote a restraint free environment, while recognizing restraints may be required in clinically justified situations in accordance with safe techniques and parameters of utilization. Use of restraints is a temporary intervention that is only used to protect the immediate physical safety of the patient and/or others in addition to preventing interference with medical treatment. Restraints will be discontinued as soon as possible.

Restraint Use *(continued)*

Restraints are applied only after a thorough assessment by the RN and less restrictive interventions deemed ineffective. Interventions always begin with the least restrictive method and progress to more restrictive interventions, as needed, to maintain patient and/or staff safety.

Procedure

Exclusion to Restraints

The following are examples of restraint devices used as adaptive supports or medical immobilization and are exempt from the requirements of this procedure. Patients must be monitored with continued re-evaluation and precautionary measures performed while devices are utilized for medical immobilization.

1. Positioning/securing devices used to maintain position, limit mobility, or temporarily immobilize the patient during medical, diagnostic, or surgical procedures that are considered a regular part of such procedures. These devices are only applied for the duration of the procedure and the immediate post-procedure care of the patient. Devices include items for medical protection (e.g., helmets), orthopedically prescribed devices; surgical dressings or bandages; IV arm boards; arterial line arm boards; etc.
2. Protective devices intended to compensate for a specific physical deficit or prevent safety incidents not related to cognitive dysfunction (e.g., use of SOMA bed enclosure for a child/adolescent with traumatic brain injury)
3. Age or developmentally appropriate safety interventions for the pediatric patient, such as strollers, safety belts, highchair, raised crib rails, and crib covers. A safety conscious childcare provider outside a health care setting would utilize these to protect an infant, toddler, or preschool-aged child.
4. Pediatric elbow immobilizers, such as “No-No’s”, are not considered restraints in children 4 months old and younger or when used during a time-limited procedure to provide medical immobilization. In all other cases they are considered restraints and must be managed in accordance with this procedure.
5. Voluntary mechanical support, based on assessed patient need, used to achieve proper body position, balance or alignment to allow greater freedom of mobility than possible without the use of such a mechanical support.
6. Forensic/correctional devices used for security purposes (e.g., handcuffs)
7. Side rails are NOT considered a restraint device when used to enable patient access to bed functions (head up and down, nurse call controls, etc.), to reposition self in bed, or to safely maintain equipment in the bed (e.g., CPM machine). Similarly, side rails are not considered a restraint device when used for patients who are comatose/unresponsive, during transport, on gurneys, recovering from anesthesia or while sedated, experiencing involuntary movement, or experiencing seizures when side rails are padded.

Ordering and Renewing Restraints

Patient Assessment:

1. Determine the most appropriate intervention by incorporating assessment data and plan of care.
    a. Use restraints only when alternative, less restrictive measures have been unsuccessful or cannot be employed without jeopardizing patient safety or care or the safety of others.
    b. Refer to the Restraint Decision Tree (Appendix C) and Alternatives to Restraints (Appendix D).

Restraint Use *(continued)*

2. **PEDIATRIC** patients: use assessment of developmental age to guide decision to restrain and selection of type of restraint device. A child's understanding of, reaction to, and ability to cope with stress associated with immobilization and restraint, is influenced by their cognitive abilities and limitations. May consult Child Life Specialist for assistance in determining appropriate device selection to minimize the potential psychological trauma.
3. Once patient is restrained, initiate restraint documentation. Refer to Documentation and Education section for additional information.

Initial Order for Restraints:

Restraints require an order written by the treating physician, Nurse Practitioner (NP), or Physician Assistant (PA) in APeX (EMR). During downtime, use paper form (602-114Z). Each order is limited to 24 hours and must include restraint type and clinical justification.

1. **Non-violent Restraint**
    a. RN will:
        i. Obtain MD, NP, or PA order prior to use of non-violent restraint except in emergency situations
        ii. Apply appropriate restraint device
        iii. If MD/NP/PA is not available, notify MD/NP/PA as soon as possible and obtain a completed order by the provider (must be within 12 hours of restraint application).
    b. MD/NP/PA will:
        i. Enter an order for RN-initiated restraint within 12 hours of application.
        ii. Complete and document their face-to-face patient assessment within the next calendar day.
2. **Violent Restraint**
    a. RN will:
        i. Apply appropriate restraint device.
        ii. Notify physician immediately and obtain a completed order by the MD (no longer than one hour) upon application of restraints.
    b. MD (Only MDs can order Violent restraints) will:
        i. Examine patient to evaluate patient's immediate situation.
        ii. Enter a restraint order within one hour of application of restraints.
        iii. Complete and document their face-to-face assessment of patient in restraints.
    c. MD and RN collaboratively:
        i. Review the physical and psychological status of patient
        ii. Consider strategies to facilitate discontinuation of restraints as soon as clinically appropriate.
3. If MD/NP/PA other than the primary team orders restraints (non-violent or violent), they must notify the primary team as soon as possible.
    a. For example, if patient is restrained in the Emergency Department and subsequently transferred to an acute care unit while still restrained, the primary team must be notified by the Emergency Department provider that the patient is restrained.

Restraint Use *(continued)*

Renewal Orders:

Restraints may not be written as a standing order or on an as needed (PRN) basis.

1. **Non-violent Restraints:**
    a. An order to renew restraints is based on the MD/NP/PA reassessment of patient and is placed at least once each CALENDAR DAY.
2. **Violent Restraints:**
    a. Restraint orders to manage behavior requiring VIOLENT/4 point restraints must be renewed with the frequency outlined in Table 1 below.
    b. A physician conducts and documents a face-to-face assessment of a patient in VIOLENT/4 point restraints as outlined in Table 2 below.

Table 1. Renewal Order Time Limits

Patient age	Order time limit
≥ 18 years	4 hours
9-17 years	2 hours
< 9 years	1 hour

Table 2. Face to Face Assessment Time Limits

Patient age	Face-to-face assessment
≥ 18 years	At least every **8** hours
≤ 17 years	At least every **4** hours

Restraint Devices, Indications, and Application Technique

Refer to Appendix A and Appendix E for information on approved restraint devices, indications for various devices and application techniques.

Monitoring and Care of Patient in Restraints

1. Qualified staff (RN or PCA) will monitor patients through observation, interactions with patient, or related direct examination.
    a. RN is responsible for assessing their patient to determine the ongoing need for restraints and possibility for discontinuation of restraints.
2. Monitor patients who are restrained as follows:
    a. Non-violent restraint:
        i. Every 15 minutes the patient will be observed for the need for: vital signs, body alignment adjustment, and correct application of restraints.
    b. Violent restraints:
        i. Continuously observe patient with 1:1 qualified staff to patient ratio.
        ii. At restraint initiation and every 15 minutes the patient will be observed for the need for: vital signs, correct application of restraints, and absence of injury from restraints.
    c. Non-violent or Violent restraints:
        i. At least every two hours (or more frequently if warranted by patient's condition), perform a safety and well-being check, which includes:
            1. Limb assessment for maintenance of adequate circulation

Restraint Use *(continued)*

2. Assessment of skin integrity
3. Offer fluids/food (as appropriate) and opportunity for toileting
4. Active (if safe to remove restraints) or passive (if unsafe to remove restraints) range of motion exercises
5. Reposition patient, maintaining proper body alignment and comfort
6. Coughing and deep breathing exercises, as appropriate. Ensure breathing and airway are not compromised by restraints
7. Assess physical and psychological status and comfort
8. Collaborate with patient to achieve behavior necessary for restraint discontinuation
9. Reassess need for continued restraint and possibility for restraint discontinuation

d. For patients receiving chemical restraint:

i. Assess efficacy of medications and any adverse reactions. Document and report findings to provider.

Discontinuing Restraints

1. Discontinue restraints as soon as clinically appropriate, which may occur before the order has expired.
2. Document date and time of removal in APeX (EMR).
3. After removing restraints, continue to monitor patient behavior. If patient resumes exhibiting the behavior that originally required restraint, a new order must be obtained and all requirements restart.
4. Dispose of restraints as appropriate. **Never give restraints to patient or family to take home.**
    a. Exception: elbow immobilizers ordered by MD for two-week period of time after pediatric cleft lip/palate surgery for use at home. RN provides caregivers with instructions for use of "Pedi-wrap" elbow immobilizers (refer to Appendix I).

Documentation and Education

1. **Non-violent restraint** (refer to Figure 1)**:**
    a. At start of first order:
        i. Less restrictive alternatives that were attempted prior to restraint application
        ii. Time restraints applied
    b. With every order (including first order):
        i. Clinical justification for restraints
        ii. Type of restraint used
    c. Every 2 hours:
        i. Document visual checks for safety and well-being were performed every 15 minutes
        ii. Nursing assessment of behavior and whether restraints will be continued or discontinued
        iii. Type and location of restraint devices
    d. As completed:
        i. Patient/family education

Restraint Use *(continued)*

ii. Provision of nursing care (outlined in Monitoring and Care of Patient in Restraints section)

e. Restraint Discontinuation:
   i. Time restraints discontinued
   ii. Assessment of patient's behavior

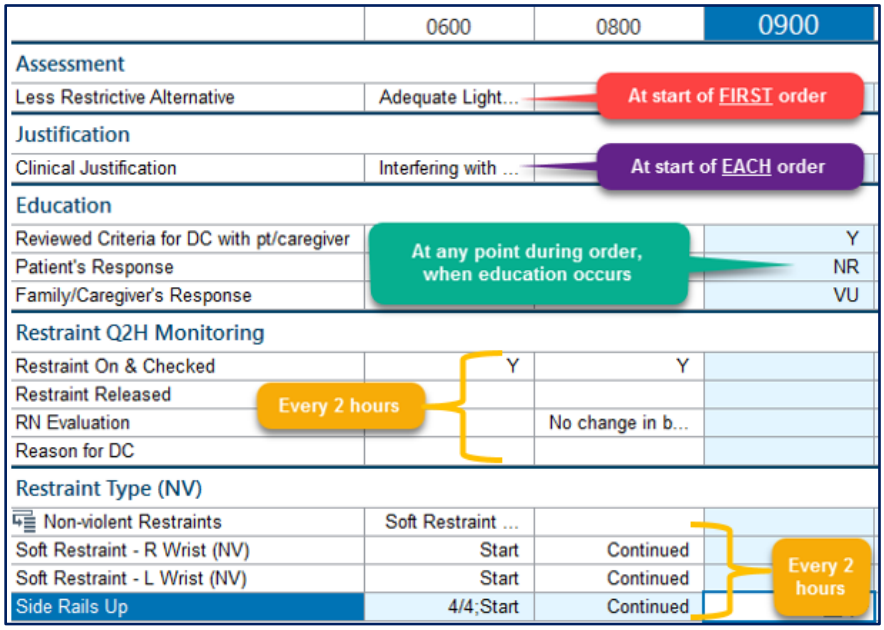

Figure 1: Non-Violent Restraint Documentation

2. **Violent, 4 point, and chemical restraint** (refer to Figure 2)**:**

   a. At start of first order:
      i. Less restrictive alternatives that were attempted prior to restraint application
   b. With every order (including first order):
      i. Time of MD notification of restraints
      ii. Time that MD order was obtained
      iii. Clinical justification for restraints
   c. Every 15 minutes:
      i. Document continuous observation of patient
      ii. Method of achieving continuous observation
   d. Every 2 hours:
      i. Document visual checks for safety and well-being were performed every 15 minutes
      ii. Nursing assessment of behavior and whether restraints will be continued or discontinued
      iii. Type and location of restraint devices
   e. As completed:
      i. Patient/family education

Restraint Use *(continued)*

ii. Provision of nursing care (outlined in Monitoring and Care of Patient in Restraints section)

f. Restraint Discontinuation:

i. Time restraints discontinued

ii. Assessment of patient's behavior

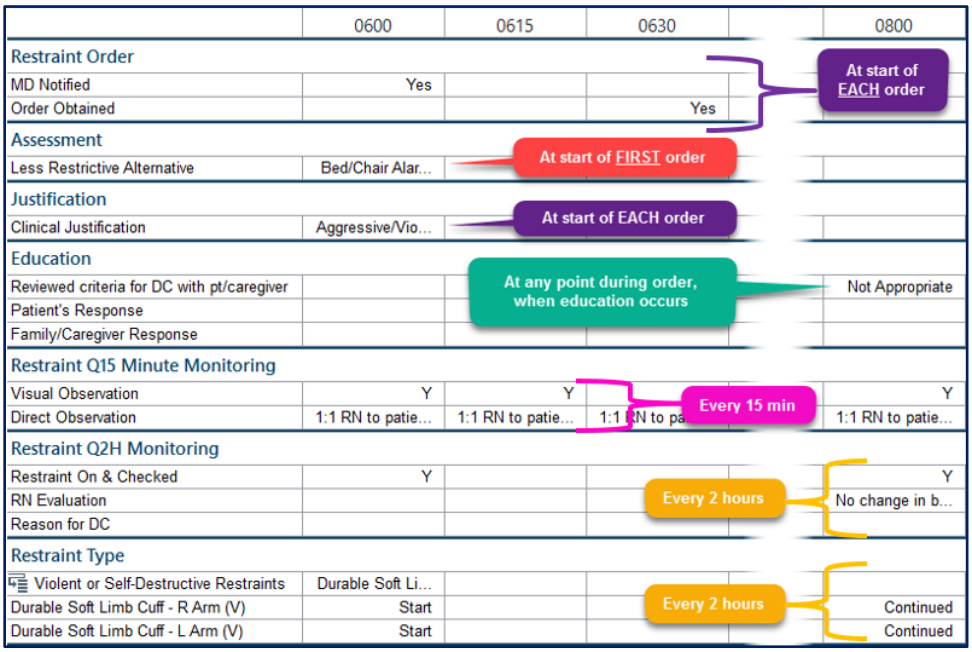

Figure 2: Violent, 4 Point, or Chemical Restraint Documentation

3. Care planning:
   a. Upon restraint application: activate and individualize the "Restraint Use" care plan
   b. Routinely update general progress on standardized care plan Restraint Use.
   c. Include assessment, intervention, evaluation and re-intervention information.
   d. Close problems when resolved (i.e., restraints discontinued).

Staff Competency: Education and Training

1. Staff who have direct patient care responsibilities are oriented to this nursing procedure and Medical Center Restraint Policy.
2. Training in proper and safe application and use of restraints for RNs occurs during initial orientation and annually thereafter. Training and demonstration include the following elements:
   a. Safe use of restraints including application and removal of physical restraints
   b. Taking vital signs and interpreting their relevance to physical safety of patient in restraints
   c. Recognizing nutritional and hydration needs
   d. Checking circulation and range of motion in extremities
   e. Addressing hygiene and elimination
   f. Addressing physical and psychological status and comfort

Restraint Use *(continued)*

g. Helping patient meet behavior criteria for discontinuing restraint
h. Recognizing readiness for discontinuing restraints

3. Competency validation related to proper and safe application and use of restraints is documented prior to independent restraint application and monitoring a patient requiring restraint and annually thereafter.

Reporting Requirements

1. CMS and CDPH have requirements for hospitals to report deaths of patients who were restrained either at the time (or prior to) expiration. However, an incident report is no longer required for this purpose.
2. All instances of VIOLENT/4-point restraint are reported via the Incident Report system.
3. All instances of patient harm from restraints (regardless of whether harm results in death).
   a. Example: A disoriented patient with both wrists restrained (non-violent restraint) moves both of his legs and lower torso over the upright side rails in an attempt to get out of bed. His chest and neck become restricted and breathing ceases. Regardless of patient outcome, an Incident Report is required.

References

Level of Evidence (FAME*)	Level*	Reference
	E4	The Joint Commission. (2021). *The Joint Commission e-dition*. https://e-dition.jcrinc.com/MainContent.aspx
	E4	Centers for Medicaid and Medicare Services. (2021). Conditions for participation: Patient's rights, 42 CFR § 482.13.
	E3	Minnick, A. F., Mion, L. C., Johnson, M. E., Catrambone, C., & Leipzig, R. (2007). Prevalence and variation of physical restraint use in acute care settings in the US. *Journal of Nursing Scholarship, 39*(1), 30-37.
	E4	Park, M., Tang, J. H. C., Adams, S., & Titler, M. G. (2007). Evidence-based guideline: Changing the practice of physical restraint use in acute care. *Journal of Gerontological Nursing*, *33*(2), 9-16.
FAME Scale details: See nursing policy *Policy, Procedure, & Competency Development, Review, & Approval*		

Procedure History

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Reviewed:	

Restraint Use *(continued)*

Reviewed / Revised: 6/96, 6/98, 4/00, 10/00, 4/01, 11/03, 2/04, 8/05, 1/06

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5/13: Mary Moore RN, MS; Maureen Buick RN, MS; John Pearson, RN, CNIII; Restraint Workgroup; approved by the Patient Care Standards Committee

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Appendix A: Supply PMM Table

Item	PMM #
Activity Apron	2411
Velcro Belt	4683
Finger Control Mittens	47018 – Adult 146645 – Pediatric S 163721 – Pediatric M 169602 – Pediatric L
Elbow Immobilizer - Adult	2403
Elbow Pedi-Wrap - Newborn	44390
Elbow Pedi-Wrap – Small	44395
Elbow Pedi-Wrap - Medium	4389
Elbow Pedi-Wrap - Large	44390
Knee Immobilizer	4652
Soft Waist Belt	2401
Soft Limb Restraints	4263
Durable Soft Limb Restraints	20215 – Ankle 20213 – Wrist
Locked Restraints	28855 – 1 limb per box – Order 4

Appendix B: Restraint Definitions

1. **Physical Restraint**: any manual method, 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.

2. **Chemical Restraint**: a drug or medication used to restrict/manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's condition.

3. **Seclusion**: involuntary confinement of a person in a room or area where the patient is physically prevented from leaving. Seclusion is used only for behavior management reasons and in an appropriate area/room that is safely equipped. ***Seclusion is not used at UCSF Health***.

4. **Emergency**: an unexpected or sudden occurrence resulting in the need for immediate intervention to prevent further illness or injury.

5. **Post-Operative or Post-Procedural Care**: phases of care during the emergence from anesthesia or sedation and abatement of the acute signs of anesthesia and surgery. If there is continued need for restraint upon recovery from anesthesia/sedation, a restraint order would be necessary and restraint requirements described in this document met.

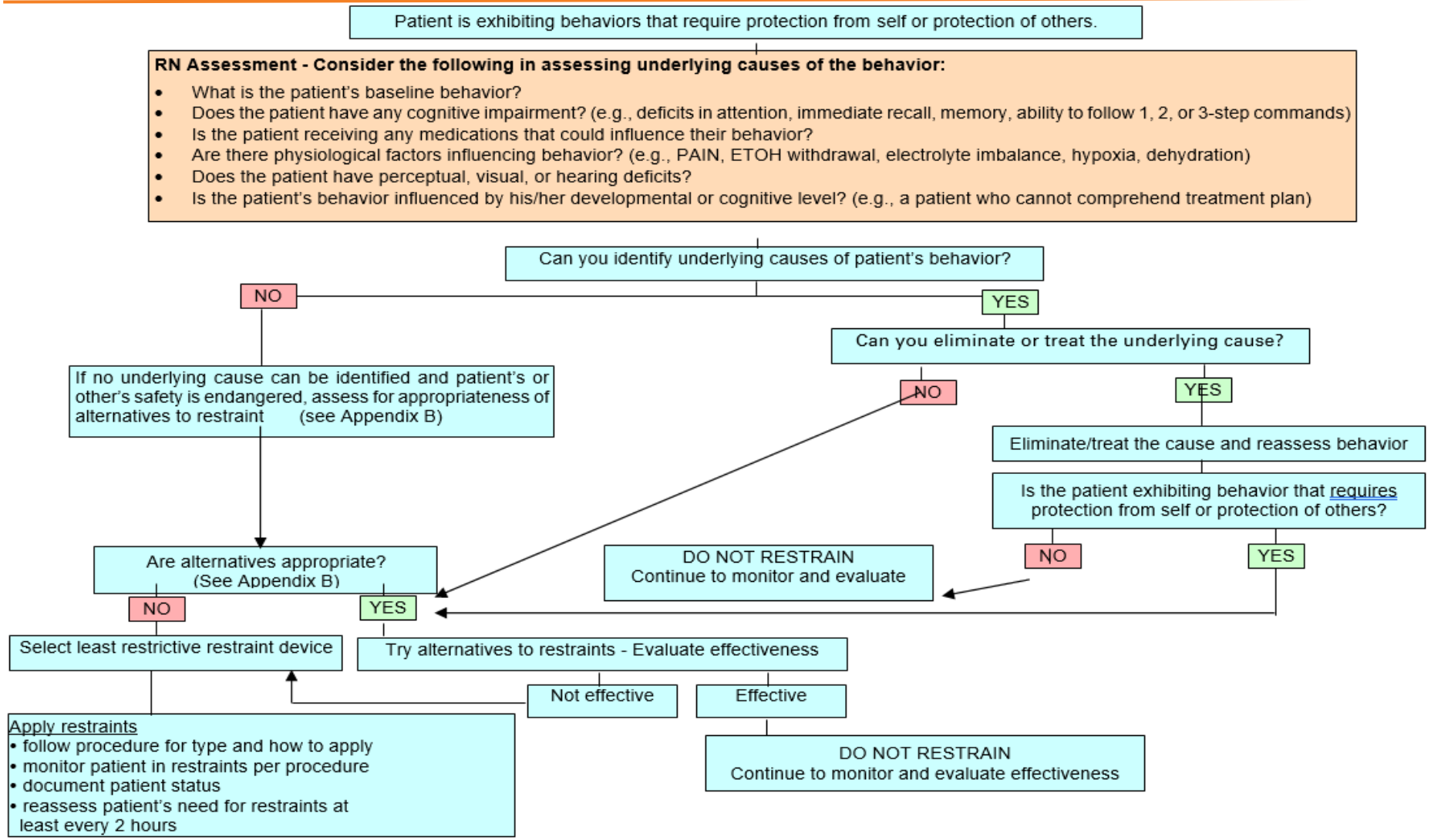
6. **EPISODE of restraint**: period of time from application of restraint to discontinuation. An episode may span more than one day if the device is used continuously for the same purpose and the restraint order has been renewed by the appropriate provider.

7. **Least Restrictive Measures**: permit the maximum amount of freedom of movement consistent with patient safety and protection from injury.

8. **Less Restrictive Measures:** modify the environment, enhance interpersonal interaction, or provide treatment as a strategy to minimize or eliminate the behaviors placing the patient/others at risk. Refer to Appendix D for examples of less restrictive measures.

Restraint Use *(continued)*

Appendix C: Restraint Decision Tree



Appendix D: Alternatives to Restraint

Prior to use of physical restraint, the RN evaluates the patient and situation for appropriate use of less restrictive interventions. The RN will use physical restraint only when the safety of the patient and others can NOT be maintained by less restrictive interventions. Alternative interventions attempted and their efficacy are documented in APeX/EHR. The following is a list of examples of alternative interventions.

Environmental Interventions

1. Move the patient closer to the nurses' station
2. Bed/chair alarm
3. Low bed
4. Adequate lighting (consider night lights, when appropriate)
5. Ensure that the patient can reach and knows how to use the call light
6. Decrease noise and activity
7. Provide age/developmentally appropriate diversions, i.e., TV, repetitive activities to keep hands busy, music, etc.
8. Promptly answer call light
9. Consider use of Velcro belt or activity apron (Velcro closure in the front)
10. **PEDIATRICS**: Consult with Child Life Services for other age and developmentally appropriate modifications to the environment or activities
11. **ADULTS**: Consult Geriatrics for cognitively appropriate modifications to environment or activities.

Physiological Interventions

1. Provide scheduled comfort measures (e.g., massage and ROM) and pain relief; provide toileting, positioning, and fluid intake.
2. If possible, remove tubes and lines that are causing discomfort. If not able to remove, try to cover with camouflage sleeve, clothing or tape out of view to decrease interest in manipulating. Alter treatment regimens. For example, convert indwelling IV catheter to heparin lock.
3. Assess medications for interactions that may be causing underlying behavior. Consult with physician regarding discontinuing these medications, if possible, and/or consider medications that could be administered to alleviate/mitigate the behavior.
4. Ensure that glasses, hearing aids and other sensory aids are utilized to prevent misinterpreting cues from the environment.

Psychosocial Intervention

1. Encourage family and friends to stay with patient or to provide handholding, distraction, reading to patient, and other diversions to lessen need for or decrease length of time patient is in restraints
2. Provide continuity of staff
3. Use touch and comforting measures to calm and reassure
4. Orient and reorient as needed
5. Obtain a safety attendant for the patient
6. **PEDIATRICS:** Obtain Child Life Services consultation as appropriate.
7. **ADULTS:** Obtain Geriatrics consultation as appropriate.

Appendix E: Restraint Devices, Indications, and Application Techniques

Non-Violent Restraint:

- Restrict freedom of movement that puts the patient at risk for injury or interference with medical treatment necessary to promote medical healing.
- Protect a patient from inadvertent dislodgement of catheters, tubes or drains that would impede medical healing or are life-sustaining.

Finger Control Mitts

1. Indications:
    a. Patient is pulling at or dislodging lines or tubes; or picking, pulling, or scratching at wounds or dressings.
    b. When mitts are not secured to the bed or chair, they provide the least restrictive means of restraint.
2. Contraindications:
    a. Fractures or open wounds on the affected limb
    b. Patient is suicidal, aggressive/combative, strikes self and/or others
3. Application:
    a. Refer to Appendix A for PMM for adult or pediatric sizes.
    b. Place patient's hand in mitt. If mitt has finger slots, insert fingers into slots. Wrap cuff firmly around patient's wrist. Completely encircle cuff with webbing strap. Snap plastic buckle together and adjust webbing strap snugly around cuff. When pushing plastic buckle together, make sure it snaps together tight. To ensure mitt is not too tight, one finger should fit between mitt and patient.
    c. If more restriction of movement is required, secure ties to bed or chair with quick-release knots/buckles. Note: when used in this fashion, mitts are more restrictive than soft limb restraints. Place side rails in up position.

Elbow immobilizer

1. Indications for use:
    a. Patient is pulling at or dislodging lines or tubes, especially feeding tubes or endotracheal tubes.
    b. Prevents bending at elbow to reach head and neck area
    c. BCH: Pedi Wraps (elbow immobilizers commonly referred to as "No- No's") are NOT considered restraints for infants 4 months old and younger. These are primarily used for infants/children with midline surgeries to prevent patients from causing damage to surgical incisions. Elbow immobilizers are NOT restraints when used during a time-limited procedure. In all other cases in patients older than 4 months, they ARE considered a restraint. Refer to Appendix I.
2. Application:
    a. One-size fits all
    b. Place immobilizer around mid-portion of arm with elbow in the middle. Secure with Velcro straps.

Restraint Use *(continued)*

Belts: Soft Waist and Velcro

Soft Waist belt

1. Indications for use:
    a. Patients who require reminding not to get up without assistance. Considered less restrictive than a vest. (Note: vest restraint is not used at UCSF).
    b. May be used to secure a patient in bed or chair.
2. Contraindications:
    a. Patients with incisions or tubes that might be compromised by a restrictive product.
3. Application:
    a. Sizes: large and extra-large. Large size will fit small adult or large child.
    b. Place belt over patient's waist with soft, flannel-like side against patient's body.
    c. To provide less restriction of movement, crisscross the ties in back. This allows patient to roll from side to side. When applied so ties cross in front, patient will be unable to roll from side to side.
    d. Allow enough room for four fingers between restraint and patient.
    e. If patient is in bed, ties should come from patient to sides of bed at a 90° angle. Treat ties as one and secure to bed frame with a quick release knot.
    f. Place side rails in up position.
    g. If patient is in chair/wheelchair, ties should always be crossed in front. Pull ties at a 45° angle between arm and seat of chair. Secure to wheelchair kick bar or leg of chair.

Velcro Belt

1. Indications for use:
    a. May be used to secure a patient in chair. Considered less restrictive than a vest (note that vest restraint is not used at UCSF).
    b. Patients who require reminding not to get up without assistance before exiting a chair and are able to follow instructions.
    c. May be used as a "safety support belt" for patients requiring upper torso postural support to help reduce tilting, leaning and falling from chairs or who need a positioning device for added safety while in a chair. If used for this purpose, belt is not considered a restraint and provider order is not required.
2. Contraindications:
    a. Patients with incisions or tubes that might be compromised by a restrictive product.
3. Application:
    a. This product is designed for self-release. If patient is not able to easily demonstrate self-release or if Velcro belt is not being utilized as a "safety support belt", it is considered a restraint and must be accompanied by a provider order. Position patient as far back in the seat of the chair as possible, with the buttocks against the back of the chair.
    b. Wrap foam Velcro belt around patient's waist/lap and chair backrest. Press Velcro fasteners firmly together.

Restraint Use *(continued)*

c. Secure Velcro fastener in front of patient for self-release or behind patient for assisted release. Belt should be snug and must not interfere with breathing. To check for proper fit, slide an open hand (flat) between belt and patient.
d. Place belt over lower lap to hold buttocks against backrest and help prevent sliding.
e. Wrap belt under seat on a part of the frame that will not allow belt to slide forward.

Soft Limb Restraints

1. Indications for use:
   a. Patients who disrupt lines, tubes, etc.; pick, pull, scratch at wounds or dressings; or strike and endanger self or others.
   b. Use when finger control mitts are ineffective or inappropriate.
   c. A 3rd soft limb restraint on a lower extremity may be appropriate for non-violent restraint purposes to protect/prevent dislodgement of devices whose termination would impede medical healing, or that are life-sustaining. Example of 3-point non-violent soft limb restraint use: a confused patient with an intra-aortic balloon pump or femoral catheter access (2 upper extremities and 1 lower extremity soft restraints).
2. Contraindications:
   a. Dislocated joints/bones, fractures, open wounds or lines which could be compromised.
3. Application:
   a. One size fits all
   b. Wrap limb holder around wrist/ankle with padding next to patient's skin and secure Velcro tab.
   c. Fasten quick release buckle and tighten enough to allow one finger between restraint and patient.
   d. Secure ties/buckles to bed frame. Place side rails in the up position.

Non-Violent or Violent Restraint (depends on intent):

Durable Soft Limb Restraints (formerly known as Twice-As-Tough Cuffs)

1. Indications for use:
   a. Non-violent restraint use
      i. Patients assessed to be at risk of disrupting life-saving treatments/monitoring (i.e. chronic line/tube pulling).
      ii. Patients whose picking, pulling, scratching, or peeling exacerbates a skin condition, causes self-injury, or compromises wound integrity.
      iii. May be used when standard soft limb restraint is ineffective.
   b. Violent/self-destructive restraint use:
      i. Patients assessed as being in extreme danger of injury to themselves or others. As with all patients in violent/self-destructive behavior restraint, patient must have constant observation, such as provided by a safety attendant/sitter or qualified staff member constantly at bedside, at all times.
      ii. Application of Durable Soft Limb Restraints for management of violent/self- destructive behavior must be supervised by the RN. Assistance of additional staff members in applying Durable Soft Limb Restraints may be needed to prevent injury to patient or staff.

Restraint Use *(continued)*

2. Contraindications:
    a. Dislocated joints/bones, fractures, open wounds and/or lines which could be compromised.
3. Application:
    a. Color of cuff liner designates wrist or ankle application: blue cuffs are wrist and red cuffs are ankle.
    b. Always secure both hands to prevent patient from releasing him/herself.
    c. Attach connecting strap to gurney or bed frame out of patient's reach.
    d. Wrap smooth neoprene piece (blue or red side against skin) around wrist/ankle.
    e. Sandwich neoprene piece with fuzzy material between the two pieces of rough hook (Velcro). Be sure to overlap at least one inch. Press Velcro material together firmly.
    f. When completed, you should be able to pass one finger between device and wrist/ankle.

Violent Restraint:

- Used in an emergency for situations when unanticipated, severely aggressive, violent or self-destructive behavior places patient or others in imminent danger of physical harm, and non-physical interventions would not be effective.
- Preventing the patient from striking a care provider with intent to cause harm (rather than preventing interference with medical treatment) is an example of violent/self-destructive restraint use.

4 or 5 Point Soft Limb Restraints

Patients in 4 or 5 point restraints are at risk for harm from others because they cannot protect themselves. Therefore, for safety and well-being:

- Inpatients: 1:1 RN or qualified staff-to-patient assignment. An RN must be able to provide every 15 minutes assessments and documentation.
- Emergency Department: continuous surveillance

1. Indications for use:
    a. Agitated patients whose movements interfere with medical treatment or who strike and/or endanger self or others.
    b. Patients who require all 4 limbs restrained for non-violent indications.
2. Contraindications:
    a. Dislocated joints/bones, fractures, open wounds and/or lines which could be compromised
3. Application:
    a. One size fits all.
    b. Wrap limb holder around wrist/ankle with padding next to patient's skin and secure Velcro tab.
    c. Fasten quick release buckle and tighten enough to allow one finger between restraint and patient.
    d. Secure ties/buckle or tie with slip knot to bed frame.
    e. Place side rails in up position.

Restraint Use *(continued)*

Locked Restraints

Patients in locked restraints, regardless of how many limbs are restrained, are at risk for harm from others because they cannot protect themselves. Therefore, for safety and well-being:

- Inpatients: 1:1 RN or qualified staff-to-patient assignment. An RN must be able to provide every 15 minutes assessments and documentation.
- Emergency Department: continuous surveillance

1. Indications for use:
    a. Locked restraints should only be used when other, less restrictive and softer restraints have failed or cannot be used without jeopardizing the safety or care of patient or others.
    b. Very agitated or combative patients who strike and/or endanger self or others and 4-point soft restraints are ineffective or their use would jeopardize the patient's safety or patient care or the safety of others.
2. Contraindications:
    a. Patients with dislocations, fractures, open wounds and/or lines which could be compromised.
3. Application:
    a. Place soft padding between patient and strap, e.g., ABD, washcloth, etc.
    b. Fit strap around wrist and ankle to allow for one finger between strap and patient.
    c. Position lock in hole and clamp lock device over lock.
    d. Secure longer strap to bed and lock. Do not secure to bedrails.
    e. Place key to restraints at head of bed in plain view of staff.

Chemical Restraint:

Administration of a medication with the intent to control behavior or restrict freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition (see below for description of "standard treatment").

The medications that comprise the patient's regular medical regimen (including PRN medications) are not considered chemical restraints but are used to enable the patient to participate in their plan of care more effectively and appropriately.

In the rare instance that chemical restraint is necessary to control unexpected physically violent behavior, the patient is monitored per violent/self-destructive restraint standards.

"Standard treatment" includes:

- Psychotropic medication for the clinical treatment of patients with mental illness
- Sleeping medications at an appropriate dose for insomnia
- Anxiolytics prescribed to manage a patient's anxiety
- Psychotherapeutic medication to treat a patient's condition that enables the patient to more effectively or appropriately function.
- Medications used to facilitate mechanical ventilation are not be considered chemical restraint

Example 1: A patient detoxifying from alcohol begins to display aggressive behaviors. Staff administers PRN medication ordered by the physician to manage the withdrawal related behaviors. This is NOT a chemical restraint since the PRN

Restraint Use *(continued)*

medication is used to treat the withdrawal related aggressive behavior and allow the patient to engage in place of care and not with the intent to control behavior or restrict freedom of movement.

Example 2: A patient admitted with abdominal pain is initially calm and interactive. An hour after admission, they become violent and aggressive, attempting to throw a chair through the window. They are screaming and grabbed a pair of scissors and is threatening to "cut" the staff. Security is able to manually secure the patient while the RN administers haloperidol (Haldol) followed by lorazepam (Ativan) as ordered by the MD. This is an example of chemical restraint since the medications are used to control the patient's behavior and maintain the safety of the patient/staff and is not part of the routine care for a patient with abdominal pain. However, if the patient had a separate diagnosis, like delirium or a mental health condition, administration of haloperidol or lorazepam used for the management of those conditions would NOT be considered chemical restraint.

SOMA Bed Enclosure:

1. May be used in place of other physical restraints. See Appendix F for indications and use.
2. Obtain MD/NP/PA order.

Appendix F: Use of the SOMA Bed Enclosure

PURPOSE

The SOMA BED ENCLOSURE is a passive restraint system for the patient who requires a protective environment and/or is at risk for injury to self or others. In certain situations, the enclosure may be used in place of physical restraints, e.g., soft belt, or limb restraints.

CRITICAL POINTS

1. The SOMA BED ENCLOSURE is considered a restraint and this Restraint Use (General) Nursing Procedure must be followed.
2. For children/adolescents the SOMA bed may not be considered a restraint if use of the bed is to protect a child with a physical disability that limits motor skills or a condition that causes uncontrolled movement (e.g., cerebral palsy) from accidentally falling out of bed.
3. Do not allow patients to retain sharp objects, such as serrated plastic knives, inside the enclosure. It is possible to cut through the netting with these objects.
4. If a low bed is needed, it must be rented in conjunction with the SOMA enclosure (Soma Safe Enclosure low bed model). When using the low bed functionality for patient safety and leaving the patient unrestrained and unattended, the bed must be in the lowest possible position with the side rails removed or in the fully up position.
5. Side and end flaps must be left either fully and completely open or fully and completely closed. Leaving the side flaps open and end flaps closed, or vice versa, may encourage the patient to climb out of bed and cause injury.

EQUIPMENT

1. SOMA BED ENCLOSURE – Obtain a provider order and order through Material Services. Beds are available 24 hours a day, 7 days a week and can usually be delivered within a two-hour window.

PATIENT SELECTION

1. Assess the patient for appropriateness for placing in a SOMA BED ENCLOSURE. Patients exhibiting the following behaviors may be candidates for the enclosure:
    a. Confusion/disorientation
    b. Altered thought process
    c. Agitation
    d. History of falls
    e. **PEDIATRICS:** Physical disability or uncontrolled movement with potential to cause patient to accidentally fall out of bed
2. The SOMA BED ENCLOSURE may not be appropriate for use on patients with:
    a. Multiple invasive lines where the patient is trying to pull or remove the lines inappropriately. The SOMA bed has 8 ports that can accommodate a urinary catheter, and additional venous access lines and oxygen tubing.
    b. Mechanical ventilation, excessively violent or suicidal behavior, seizures, excessive PICA eating disorders, or burrowing behaviors.

   c. Cumbersome appliances such as traction.
3. The SOMA bed must not be used with patients who weigh less than 46 pounds or more than 300 pounds or with patients whose height is shorter than 45 inches or taller than 6 feet 4 inches.

PROCEDURE

1. Obtain a provider (physician/NP/PA) order for restraint.
2. Explain to patient and family the reason for applying the enclosure.
3. Follow documentation and monitoring requirements as outlined in this procedure.
4. Once the enclosure is in place, check to ensure the following upon initiation and every shift thereafter:
   a. No objects are left in the enclosure bed that the patient could use to hurt themselves or use to damage the enclosure bed.
   b. All zippers are completely closed and secured.
   c. All tubing and lines are unobstructed. Zippered openings may be found at the base of the enclosure for a urinary catheter. All unused IV catheter ports are zipped closed. Any that are used should be zipped as close as possible without interfering with tubing.
   d. All 4 side rails are raised at all times. If indicated, side rails should be padded.
   e. Bed should be in lowest position with bed frame supporting the mattress. Head and knees flat unless alternate position is medically necessary. Netting should be taut.
   f. Complete a visual inspection of the enclosure bed to ensure the netting or vinyl has no tears or holes.
5. Assess for earliest possible discontinuation or removal of restraint/enclosure. If the zippers are down and mobility is not hindered, the restraint/enclosure should be documented as discontinued. If a patient recently discontinued from restraint/enclosure exhibits behavior that can only be managed by the reapplication of restraint (enclosure fully and completely zipped), then a new order is required.
6. Call Material Services to remove the enclosure when discontinued.

IMPORTANT SAFETY CONSIDERATIONS WHEN USING THE SOMA BED ENCLOSURE

1. Always keep the bed Hi-Low function in the lowest possible position without suspending the canopy except when attending to the patient.
2. Put the head and foot sections in the down or flat position before raising the bed with the Hi-Low function. Raising the head or foot sections while the bed is in the Hi position could damage and breach the canopy, allowing the patient to get out.
3. Any mattress used with this product must be at least 80 inches long by 35 inches wide and no more than 6 inches thick and be hospital grade or is a mattress provided by Vivax Medical (makers of the Soma bed enclosure). Air therapy or water mattresses should only be used for medical purposes and with a provider order.
4. When using a bedframe other than a Soma bedframe with the Soma bed enclosure, it must specifically be a medical/hospital bed with head and foot boards installed and equipped with side rails raised when the patient is unattended.
5. Always keep the bed and frame casters locked except when the Soma bed enclosure needs to be moved.
6. Mechanical suffocation and suffocation by ingested objects such as IV lines, small objects, plastic films and even sheets and blankets, may pose a patient risk. The RN should assess if patients can be safely left unattended with any objects or articles inside the enclosure that could cause patient suffocation.

Restraint Use *(continued)*

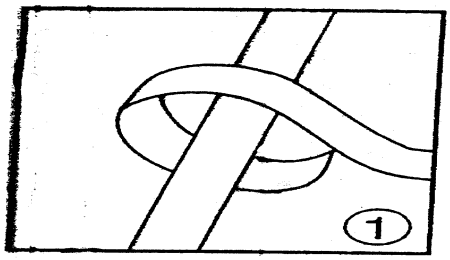
SOMA BED ENCLOSURE EVACUATION PROCEDURE

1. Go to the Left or Right of the Soma bed enclosure.
2. Locate the zipper pull-tabs on the Side Access Panel.
3. Unzip the zipper by pulling each zipper pull-tab to the left or right uppermost corner of the Side Access Panel.
4. Place the Side Access Panel on the top of the Soma bed enclosure.
5. Remove the patient through the side just opened.

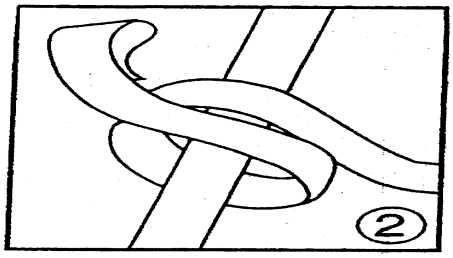
Restraint Use *(continued)*

Appendix G: Quick Release Knot

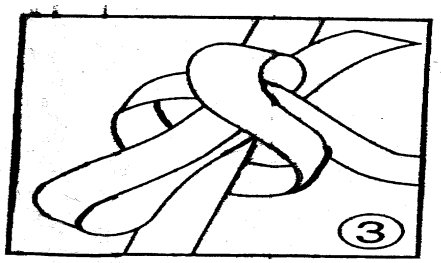
1. Loop tie around bed frame or chair post. Tie coming from patient must be taut.



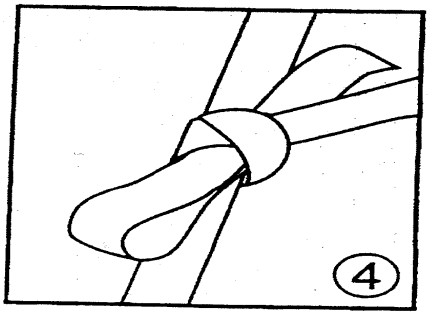
2. Fold end of tie (8” or more) and insert inside where the ties cross each other.



3. Pull on folded part of tie to tighten.



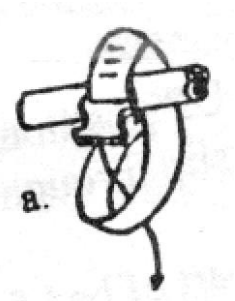
4. Completed quick release



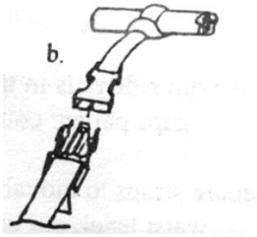
Restraint Use *(continued)*

Appendix H: Quick Release Buckle

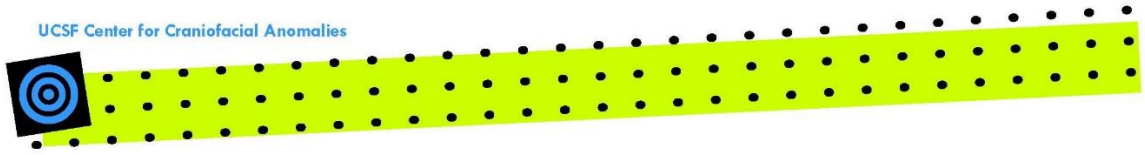
1. Take webbing strap, wrap around frame slip buckle through loop and pull tight to secure to immoveable part of bed frame.



2. Snap two parts of the Quick Release Buckle together. Verify buckle is securely snapped.



Appendix I: Instructions for Pedi-Wraps



Instructions for using Pedi-wraps

Pedi-wraps are designed to keep your baby's hands from injuring the repair after cleft lip or palate surgery

• Putting on the Pedi-wrap

- While holding the baby's left arm straight, find the Pedi-wrap labeled **left**. Open it up and fit it snuggly under the left armpit.
- Make sure the stiff portion of the wrap is over the inside of the elbow and attach the Velcro strips.
- The plastic ring should then be by the shoulder.
- Repeat for the right side.
- Attach the over the shoulder strap to one ring and pass it over the shoulders to the other ring. The strap can then be Velcro closed so that it is loose enough for the child to bring the hands together but not loose enough let the Pedi-wrap slip off the arm.

• What else should you know?

- Your doctor recommends the Pedi-wraps stay on day and night for two weeks or until the wound is completely healed.
- They should come off at least four times a day, for instance, when you are holding your baby, changing their clothes or giving a bath. The wraps stay on better with a long sleeve tee shirt on underneath or a larger long sleeve shirt on top.
- It is difficult to put the Pedi-wrap on too tight but just in case, check your baby's hands to make sure they are warm and pink every two hours.
- The Pedi-wraps are machine washable and dryer safe. Overlap Velcro and wash with towels.
- Return the Pedi-wraps to the clinic following the second post op check.