

**HUNTINGTON MEMORIAL HOSPITAL
CLINICAL POLICY & PROCEDURE**

SUBJECT: RESTRAINTS AND SECLUSION	POLICY NO.: 8740.142	Page 1 of 18
AUTHORIZED APPROVAL:	EFFECTIVE DATE: 9/12	SUPERCEDES/ REPLACES: 9/10

PURPOSE:

To guide the appropriate and safe management of patients who are restrained and/or in seclusion. To guide on appropriate utilization of alternatives to restraint and/or seclusion, as well as nonphysical interventions.

DEFINITIONS:

I. LICENSED INDEPENDENT PRACTITIONER (LIP)

A MD, DO, Psychologist, Psychiatrist or any other Licensed Independent Practitioner as defined in the Medical Staff Bylaws and State Law.

II. PATIENT POPULATION

Patient population will include any patient who enters the hospital for treatment or services including inpatient or outpatient.

III. RESTRAINT CATEGORY

A. NON-VIOLENT OR NON-SELF DESTRUCTIVE

Used to promote healing and improve the patient's well-being.

B. VIOLENT OR SELF DESTRUCTIVE BEHAVIOR

1. Emergency measure
2. Violent and/or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff or others

IV. RESTRAINT METHOD

A. 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, or prevent the patient from voluntarily exiting the bed.

B. CHEMICAL RESTRAINT

A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

C. SECLUSION

The involuntary confinement of a person alone in a room or an area from which the patient is physically prevented from leaving. May only be used for the management of violent or self-destructive behavior.

V. EXCEPTIONS TO RESTRAINT USAGE

1. Restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests or to protect the patient from sliding out of bed, or to permit the patient to participate in activities without the risk of physical harm.
2. Side Rails are not a restraint
 - When used to prevent the patient from sliding out of bed with beds with certain therapeutic surfaces, and other beds that have slippery surfaces
 - When used for patients on turning beds for respiratory failure or other treatment modes (Sport beds and other rentals for intubated, critically ill patients in the Critical Care Unit or PICU)
 - When used with gurneys to prevent patients from falling off the gurney
 - When used with patients who are experiencing involuntary movements
 - When used with patients who are not physically capable of getting out of bed regardless of whether side rails are raised or not
 - When padded and raised for Seizure Precautions
3. "Freedom" splints, when used as a reminder not to bend the arm on a cognitively intact patient, are not restraints.
4. Therapeutic holding is not a restraint.
5. Cribs, high chairs, strollers with straps and the like are not restraint but commonly accepted baby/infant/child safety devices
6. Patients who are recovering from Anesthesia in the PACU unless the use of restraint extends beyond normal recovery time
7. Patients may not be restrained to perform a test or procedure that the patient has refused.
8. Forensic and correction restrictions used for security purposes, i.e., handcuffs.

POLICY:

Restraint may only be used to ensure the immediate physical safety of the patient, staff or others and must be discontinued at the earliest possible time. Alternative and nonphysical interventions are attempted prior to use of restraints.

A. PATIENT RIGHTS

When restraints are deemed necessary, such activity will be undertaken in a manner that protects the patient's health and safety and preserves his/her dignity, rights, and well being.

Restraints will be used for medical necessity only and not as a means of coercion, discipline, convenience, or retaliation.

- A. Each patient will be respected as an individual
- B. Staff will monitor and meet the patients needs while in restraints
- C. Staff will reassess and encourage release from restraints
- D. The patient and family will be encouraged to participate in care and receive education as appropriate.
- E. Provide for safe application and removal of restraint by qualified staff authorized to do so, and whose competencies have been validated

II. ORGANIZATIONAL OVERSIGHT

Huntington Hospital leadership staff, including the LIP's determine and direct the hospital's approach to the use of restraints in the care of patients by:

- A. Approving the restraint policy/procedure outlining risks, preventive strategies, effective alternatives, criteria for use, education of the patient and family, and the care of the patient in restraints
- B. Providing appropriate staffing for safe and effective use of restraint alternative(s) and restraint(s)
- C. Assuring that staff is trained and competent to minimize the use of restraints and to use restraints safely with consideration of the patient's dignity and well being.
- D. Including the restraint reduction plan as part of the organization's performance improvement plan
- E. Refining patient assessment processes to identify earlier the potential risk of dangerous patient behavior and the prevention, when appropriate , of those behaviors
- F. Assuring restraints are used in conformity with all prevailing laws, regulations, and accreditation standards.

PROCEDURE:**I. ALTERNATIVES TO RESTRAINT USE**

Alternatives and nonphysical interventions are less restrictive interventions and must be attempted and determined to be ineffective to protect the patient and/or others from harm prior to the application of restraints. (See Addendum A)

II. ASSESSMENT AND THE DECISION TO USE RESTRAINTS

A. A patient assessment is completed by the LIP or qualified Registered Nurse (RN) prior to restraint application to determine the justification for the restraint and to select the appropriate restraint.

B. Restraint(s) is/are applied when alternative strategies or less restrictive interventions have been determined to be ineffective to protect the patient or others from harm.

C. Assessment of the patient is required prior to administering a chemical restraint. The assessment must be documented in the medical record and contain:

1. Rationale for use
2. What alternative, less restrictive interventions were attempted.

III. SELECTING THE LEAST RESTRICTIVE TYPE

The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

A. "Freedom" Splints are considered a restraint when applied to a patient who cannot readily remove them. They are a restraint when applied on both limbs. They are a restraint when applied to the functioning arm of someone who does not have use of the other arm (for instance someone with hemiplegia from a stroke).

B. Roll belt

C. Side Rails

Side rails are considered a restraint

- When used to prevent a patient from getting out of bed.
- When used to create a barrier with other furniture to prevent a patient from voluntarily exiting the bed

D. Soft limb holder-wrist and/or ankle (1-4 points)

E. Seclusion Only (DMC and/or ED only)

F. Chemical

G. Locking restraints (CCU, PICU, DMC, ED ONLY)

IV. SAFE APPLICATION OF RESTRAINTS

A. Restraints will be applied correctly and appropriately according to the manufacturer's recommendation by competent, trained staff.

B. Soft restraint straps will be secured to the bed frame (not to side rails, in a bow or knot that can be released quickly and easily in an emergency).

C. Sharp objects will be kept away from the patient.

D. Locking restraint keys will be readily available so that restraints may be released immediately in emergency situations.

V. RESTRAINT ORDERS

A. Restraint(s) is/are used in accordance with the order the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and is authorized to order restraint or seclusion in accordance with state law.

1. If the attending physician did not order the restraint, the attending physician (or treating physician) must be consulted as soon as possible.

B. Orders for restraints are documented on the Restraint Order Set in the patient's medical record.

C. All orders are time limited and restraints must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

D. Orders will not be accepted as a standing order or on an as-needed (PRN) basis.

E. Chemical intervention orders include the following:

1. Patient Name, Medication name, dose, route and that it is a STAT or NOW order.

VI. NON- VIOLENT/ NON SELF-DESTRUCTIVE

A. ORDERS:

1. INITIATION

a. The RN may initiate non-violent/non-self destructive restraints based on appropriate assessment of the patient when the LIP is not available.

b. The RN will notify the patient's LIP of restraint initiation and obtain a written/telephone order within 12 hours.

- The telephone order will be authenticated within 24 hours.

3. If the initiation of the restraint is based on a **significant change in the patient's condition**, the RN will **immediately** notify the LIP.

4. A written order, based on an examination of the patient by the LIP is entered on the Restraint Order Set in the patient's medical record within 24 hours of initiation of the restraint.

2. CONTINUATION

a. A new Restraint Order Set must be completed at least once each calendar day AND is based upon an examination of the patient by the LIP.

B. Reassessment and Monitoring

1. Monitoring is accomplished by observation, interaction with the patient, or related direct examination of the patient by qualified staff.

2. The RN is responsible for reassessing and monitoring the patient in restraints.

a. The RN may delegate components of monitoring to other competent staff members within the scope of their practice or licensure.

b. The RN is responsible for supervising all delegated monitoring components.

- c. When the LVN and/or PCA notices a change from the previous data collected, the RN will be notified immediately.
3. Monitoring Frequency and Parameters:
 - a. The following must be documented at least every shift and prn:
 - (a) Restraint Type and site
 - (b) Reason for restraint
 - (c) Alternative interventions and other actions to prevent restraint
 - (d) D/C criteria for restraint release
 - (e) Patient/Family education
 - b. Monitor and document the following at least every 2 hours as appropriate.
 - ii. The LVN may assist with the data collection of these components:
 - (a) Restraint Status/ Evaluation of continued need
 - (b) Restraint site assessment
 - (c) Orientation/LOC
 - (d) Behavioral Status
 - iii. The LVN or PCA may assist with the data collection of these components
 - (a) Vital signs
 - (b) Respiratory rate
 - (c) Nutrition/hydration
 - (d) Activity/position
 - (e) Toileting
 - (f) ROM (to restrained limbs)
4. Any patient in restraints being transported off the nursing unit for testing must have the RN accompany the patient

VII. VIOLENT AND/OR SELF DESTRUCTIVE BEHAVIOR THAT jeopardizes the immediate physical safety of the patient, staff or others (Previously behavioral restraints)

• **ORDERS:**

1. Physical & Seclusion-INITIATION

IN AN EMERGENCY where the patient can reasonably be expected to immediately bring harm upon him/herself or others:

- A qualified RN may apply the restraints then call the LIP or the DMC RN supervisor or appropriately trained designee to request a face-to-face patient evaluation.
- The face-to-face evaluation must occur within one (1) hour of restraint application.
- If a DMC RN supervisor or designee performs the 1 hour patient eval, the attending must be consulted as soon as possible and an order obtained.

If the ED physician orders the restraint, the attending LIP must be consulted as soon as possible.

The initial LIP evaluation includes

- The patient's immediate situation
- The patient's reaction to the intervention
- The patient's medical and behavioral condition and the need to continue or terminate the restraint or seclusion.
- Documentation that DMC RN supervisor or designee or the physician worked with the patient and staff to identify ways to help the patient regain control
- Revises the patients plan of care for treatment and services as needed

d. The initial Violent/Self Destructive Restraint Order will be signed by the LIP by

- i. Eight hours for 18 years of age and older.
- ii. Four hours for 17 and younger
- iii. Two hours for 9 year and younger

2. Physical Restraint & Seclusion- CONTINUATION

Restraint usage beyond time limit may be renewed by alternating LIP face to face evaluation with a written renewal order and DMC RN supervisor or designee patient assessment and LIP notification for telephone order.

Orders are time limited as follows:

- a. Four (4) hours for adults 18 years of age and older with face to face patient re-evaluation and written order renewal every eight (8) hours.
- b. Two (2) hours for children and adolescents age 9 to 17 with face to face patient re-evaluation and written order renewal every four (4) hours.
- c. One (1) hour for children under 9 years of age with face to face patient re-evaluation and written order renewal four (4) hours.

3. Any patient in restraints who must be transported off the unit for testing is accompanied by an RN

4. Chemical Restraint Initiation- Initial Assessment and ordering parameters are the same as for physical restraint and seclusion. It is not the intent of this standard to interfere with the clinical treatment of patients who are suffering from serious mental illness who need therapeutic doses to improve their ability to function in the world around them.

- a) A chemical restraint is a medication or a dose of a medication that is NOT a standard treatment or dose for the patient's condition.

b) If the medications used are a standard part of treatment for the patient's medical or psychiatric condition they are not considered a chemical restraint.

5. For example if the patient is admitted with a history of outbursts, agitation, and/or assaultive behaviors and this is incorporated in his or her plan of care, and is a focus of the treatment, the medication the patient is receiving, even on an "as needed" basis

6. Chemical –CONTINUATION

a. If the patient needs additional medication, and the patient has been assessed by a physician and the behavior has been addressed on the care plan, it is no longer a chemical restraint.

B. Reassessment and Monitoring

1. Monitoring is accomplished by observation, interaction with the patient, or related direct examination of the patient by qualified staff.

2. The RN is responsible for reassessing and monitoring the patient in restraints.

a) The RN may delegate components of monitoring to other competent staff members within the scope of their practice or licensure.

b) The RN is responsible for supervising all delegated monitoring components.

c) When the LVN and/or PCA notices a change from the previous data collected, the RN will be notified immediately.

3. Monitoring Frequency and Parameters:

- Simultaneous use of **restraint and seclusion** are monitored through continuous in-person (face to face) observation, by a competent staff member, for the duration of the restraint and seclusion episode.

- All episodes of Restraint and Seclusion (separately or combined) have the following documented by the RN on initiation

- Date and time of initiation
- Restraint Position
- Restraint location
- Restraint type
- Alternative interventions
- Reason for restraint
- Seclusion only
- Actions taken
- PRN med given
- D/C criteria for restraint release
- Patient or family education as appropriate

- Monitor and document the following at least every 15 minutes unless otherwise indicated by patient condition (e.g., the patient is too agitated to release restraint, or perform ROM). Constant observation may be selected as indicated by the patient's condition.
 - LOC/Orientation (RN, LVN or PCA)
 - Behavioral Status (RN, LVN or PCA)
 - Restraint site observation of any restrained limbs (RN, LVN or PCA)
 - Pulses
 - Temperature
 - Color
 - Edema
 - Skin Integrity
- e. Monitor and document the following every two hours
 - Vital Signs (RN, LVN or PCA)
 - Respiratory rate
 - ROM to restrained limbs (RN, LVN or PCA)
 - Fluid/nourishment(RN, LVN or PCA)
 - Explanation for withholding fluid/nourishment(RN, LVN or PCA)
 - Toileting (RN, LVN or PCA)
- f. Monitoring Chemical Restraints
 - Describe the specific behaviors necessitating chemical restraint.
 - Monitoring of vital signs, sedation and behavior each time a chemical restraint is administered

VIII. Patient/Family Education

A. To the extent feasible, depending on the emergent nature of the use of a restraint, the reasons for such use will be explained to the patient and/or to an appropriate family member acting on behalf of the patient.

1. If unable to notify family prior to initiation of restraints, the family will be notified as soon as possible of the initiation of restraints, as appropriate.
2. Education will be documented in the medical record.

IX. Discontinuation

- A. Patients will be removed from medical restraints when the reason for the use of restraint is no longer present or when alternative strategies have become successful.
- B. If the reassessment by the qualified registered nurse indicates that the reason for the use of restraint(s) no longer applies, the patient may be removed from restraint.

- C. If the restraints are removed and the alternatives tried are ineffective, the restraint may be reapplied. If the restraint is discontinued prior to the expiration of the original order, and reinitiating of restraint is indicated, a new order must be obtained and a face-to-face assessment completed by the ordering LIP.

X. Documentation

- A. Documentation will be completed for every patient restraint episode upon initiation, and as defined in policy/procedure, and will be maintained in the medical record.
- B. Documentation should provide clinical justification for use and document clinical oversight, including documentation of alternatives/nonphysical interventions that were attempted.
- C. The following elements will be included:
1. Relevant orders for restraint use
 2. Results of patient monitoring
 3. Reassessment
 4. Significant changes in the patient's condition

XI. BEHAVIORAL HEALTH PATIENTS

- A. Additional requirements for patients in the behavioral health unit (Della Martin Services)
1. The initial assessment of each patient at admission or intake assists in obtaining information about the patient that could help minimize the use of restraint or seclusion.
 2. The initial assessment includes
 - a. Techniques methods or tools that would help the patient control his or her behavior.
 - b. Pre existing medical conditions or any physical disabilities and limitations that would place the patient at greater risk during restraint or seclusion.
 - c. Any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint or seclusion.
 - d. as appropriate the patient and or family helps in identifying such techniques.
 - e. the patient and or family are educated about the hospital's philosophy on restraint and seclusion to the extent that such information is not clinically contraindicated.
 - f. the family's role, including their notification of a restraint or seclusion episode is discussed with the patient and as appropriate the patient's family
 - g. this is done in conjunction with the patient's right to confidentiality
 3. Non physical techniques are the preferred intervention in behavior management.

4. The type of physical intervention selected considers information learned from the patient's initial assessment.

B. Debriefing

1. The patient and staff participate in a debriefing about the restraint or seclusion episode.
2. The patient and if appropriate the patient's family participate with staff members who were involved in the episode and who are available in a debriefing about each episode of restraint or seclusion
3. The debriefing occurs as soon as possible and appropriate but no longer than 24 hours after the episode.
4. The debriefing is used to do the following
 - a. identify what led to the incident and what could have been handled differently
 - b. ascertain that the patients physical well being, psychological comfort and right to privacy were addressed
 - c. counsel the patient for any trauma that may have resulted from the incident
 - d. when indicated, modify the patients plan for care, treatment and services
 - e. information obtained and documented from debriefings is used in performance improvement activities

XI. COMPLICATIONS

A. Any complications of restraint or seclusion is communicated to the treating physician. If indicated, will be managed as outlined in Administrative Policy and Procedure #138 "Communication of Unanticipated Outcomes."

B. Complications include but are not limited to:

1. Patient injury
2. Deaths associated with the use of restraint and/or seclusion;
3. Each death that occurs within 24 hours after a patient has been removed from restraint or seclusion;
4. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to a patient's death
5. Significant changes in the patient's condition

XII. EDUCATION

A. Training Documentation

1. The hospital will document in the staff record that the training and demonstration of competency were successfully completed.

B. Trainer requirements

1. Individuals providing staff training must be qualified as evidenced by education, training and experience in techniques used to address patients behavior.

C. Staff Training Requirements

1. Huntington Hospital provides education for staff that have direct patient care responsibility prior to the application of any restraint, as part of orientation and at least annually.
2. Staff are trained and demonstrate competency in the application of restraints, implementation of seclusion (as appropriate), monitoring, assessment, and providing care for a patient in restraint or seclusion.
3. Staff providing direct patient care are required to have education, training and demonstrated knowledge based on the specific needs of the patient population in at least the following:
 - a. Techniques to identify staff and patient behaviors events and environmental factors that may trigger circumstances that require restraint or seclusion.
 - b. The use of nonphysical intervention skills
 - c. Choosing the least restrictive intervention based on an individualized assessment of the patients medical or behavioral status or condition.
 - d. The safe application and use of all types of restraint or seclusion used in the hospital including training in how to recognize and respond to signs of physical and psychological distress. (for example positional asphyxia)
 - e. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
 - f. Monitoring the physical and psychological well being of the patient who is restrained or secluded.
 - g. Emergency response system (Code Blue & Code Rapid Response team)
 - i. The inherent risk of physical safety and psychological well-being of the patient and staff.
 - j. Potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of a patient's rights and even death.

D. The assessments of competencies listed in section C (above) are provided through a computer based learning module. Additionally, skills validation may be utilized as a method of competency validation as needed and as determined for new products, introduction of evidence based practice or changes in regulations.

E. Medical Staff and allied health professionals are trained appropriate to their patient population, regarding the safe and effective use of restraints including:

The restraint policy

Assessment and reassessment of the patient in restraint

Ordering of restraints.

XIII. Death reporting requirements:

The following will be reported to the Department Manager or Nursing Supervisor and the hospital's Risk Management department immediately. During off hours, Risk Management is contacted through the page operator. Risk Management will report to CMS no later than the close of the next business day following the day in which the hospital knows of the patient's death. Risk Management will add a note to the patient's chart stating date and time of CMS notification.

- All deaths that occur while a patient is in restraints or seclusion
- All deaths that occur within 24 hours of being in restraints or seclusion
 - Deaths that occur within 24 hours of use of soft wrist restraints are recorded in a log by Risk Management
- If known to the hospital, within one week after the use of restraints or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death.

XIV. PERFORMANCE IMPROVEMENT MONITORING

A. Huntington Hospital collects, analyzes, and evaluates aggregate restraint data on all restraint episodes classified for all settings, units and locations to identify improvement opportunities including:

1. Patient care outcomes
2. Risk reduction
3. Alternatives to restraint use
4. Restraint use reduction

B. Data on all restraint and seclusion episodes are collected from and classified for all settings/units/locations by the following:

1. Shift
2. Staff who initiated the process
3. The length of each episode
4. Date and time each episode was initiated
5. Day of the week each episode was initiated
6. The type of restraint used
7. Whether injuries were sustained by the patient or staff
8. Age of the patient
9. Gender of the patient

C. The findings are reported periodically (at least annually) to the Quality Management Committee.

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REFERENCE:

Barclay's Official California Code of Regulations (Accessed 9/2012) Title 22. Social Security, Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies.

California Department of Mental Health. (May 7, 2002) California Code of Regulations; Division 1. Department of Mental Health;

Federal Register (5/14/12). Part IV; Department of Health and Human Services. 42 CFR Part 482 Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights; Final Rule.

The Joint Commission (2012). , PC.03.05.01, PC.03.05.03, PC.03.05.05, PC.03.05.09, PC.03.05.11, PC.03.05.15, PC.03.05.17, PC.03.05.19

Reviewed by: Jenny McFarlane

APPROVALS:

P&P Council	9/12
Medical Executive Committee	9/12

Addendum A

ALTERNATIVES TO RESTRAINT

SAFETY CONCERN	BEHAVIOR EXHIBITED	ALTERNATIVES AND INTERVENTIONS	
Discontinuing or removing a medical or therapeutic device	General-All Devices	Medicate for agitation	Have tubes and devices d/c'd as soon as possible
		Hide or camouflage tubing	
		Guide the patient's hand in gentle exploration of device and explain where devices come from and go to	Elbow splint to remind patient not to bend arm (cognitively intact patients only)
			Give clean similar tubing to hold and investigate
			Activity apron or similar to provide tactile stimulation
	Intravenous Therapy	Convert to SL	Skin Sleeve
		Check site condition	Rotate site
		Use stockinet, cast socking, wrap, kling or dressings over IV site	Hide tubing Move tubing and bags out of visual field behind the bed
	Foley Catheter	Smaller size foley	Have patient wear briefs or diapers over Foley catheter or secure catheter to abdomen (Do not use diapers if patient is incontinent of stool- this will result in skin breakdown)
		Check for rubbing, tugging	
		Stat Lock Securement Device	
		Place between legs and drainage bag toward end of bed	Check placement Check for breakdown
		Consider use of leg bag	Check foreskin
	NGT	D/C	Check nares for breakdown
		Change to smaller tube	Medicate for comfort and/or agitation
		Explore GT option with MD	Try cotton/garden glove with ball
		Hand control mittens	Elbow splint to remind patient not to bend arm (cognitively intact patients only)
	GT	Abdominal binder over g-tube	Check for breakdown
		Stat Lock Securement Device	Bolus Feedings
		Disposable panties	
	Oxygen tubing	Humidify oxygen	Lubricate nares
		Tape cannula in place	Use nasal tube stabilizer Check o2 sat-discuss with LIP
	Infants	place a rolled towel as a barrier to the device	Swaddle the infant
Children	place a stuffed animal as a barrier to the device	Divert children with videos, TV music	
	Involve the parents in helping to divert children		

SAFETY CONCERN	BEHAVIOR EXHIBITED	ALTERNATIVES AND INTERVENTIONS	
Unsteady or potential for falls	General	Modify the environment by: <ul style="list-style-type: none"> ◆ Providing optimal lighting ◆ Removing unnecessary furniture and equipment ◆ Keeping the bed at the lowest position 	Provide that the patient's glasses, hearing aid, dentures, purse or telephone are within the patient's reach
		Use bedside commode	Request evaluation by PT/OT to address mobility deficits
		Provide soothing music	Decrease sedative and tranquilizer use
		Offer food and drink	Encourage family supervision
		Eliminate hazards, create a path	Have patient wear non slip grip socks or shoes
		Unsteady Getting out of bed/chair without assistance	Rolled towel or blanket under mattress creates a lip at edge of bed.
	Have the patient sit in a reclining chair		Have the patient sit near the nurses' station
	Pin the call light to gown		Get the patient out of bed and ambulate – even at night. Toileting Rounds-schedule regular toileting to coincide with meds (diuretics) and voiding habits at least q 2 while awake, after meals and bedtime
	Use bed alarms		
	Frequently reorient the patient		
	Wandering	Determine where the patient is going and why	They may be emotionally overwhelmed and distressed by facility environment – may be looking for home
		Decrease stimuli	
		Consider that wanderers tend to be extroverts and want to be in charge	Distract the patient by allowing him to observe unit activities
		Have family bring familiar objects	Set pacing routine to wander facility with supervision
		Anticipate and redirect actions	Close unit doors and allow structured wandering
		Reorient patient and involve in constructive activities such as folding linen or filling pitchers of water	Avoid half doors and restrictive barriers
	Positioning Problems	Modify the chair/bed to conform to the patient's disabilities with foot rests, pillows, cushions, recliner	Place a wedge in the chair or wheelchair
			Non skid pad in chair to keep from slipping out

SAFETY CONCERN	BEHAVIOR EXHIBITED	ALTERNATIVES AND INTERVENTIONS	
Agitation or combative	General	Consider: ♦ Hypoxia ♦ Infection ♦ medication toxicity ♦ Electrolyte imbalance ♦ Depression ♦ Pain ♦ Constipation ♦ Dehydration	Review lab work and discuss imbalances with patient's LIP
			Review medication list
			Assess and treat cause
			Arrange for consistent personnel
			Encourage family involvement
			Explain procedures before touching the patient
			Relaxation music in calming the agitated or confused patient
			Agitation
	Move the patient to quieter area	Provide something warm and soft to hold	
	Have the patient change chairs if they sit for long periods	Keep patient warm, dry and comfortable	
	Remove stressful stimuli		
	Combative (cognitively impaired)	Approach calmly and establish eye contact	Time out and rest periods
		Listen to their comments and respond	Structured routine
Explain interventions before touching		Contracting when appropriate	
Music/television		Medication when appropriate	

NON-PHYSICAL INTERVENTIONS (rev 9/12)

Verbal De-escalation	
<ul style="list-style-type: none"> • Verbal De-escalation is what we use during a potentially dangerous, or threatening, situation in an attempt to prevent a person from causing harm to us, themselves or others. • Verbal De-escalation enhances patient-clinician relationship, decreases likelihood of restraints, seclusion, and hospital admissions, and prevents longer hospitalizations. 	
Risk Factors of Disruptive Behaviors	Warning Signs
<ul style="list-style-type: none"> • History of violence • Substance and alcohol abuse • Diagnosis: Schizophrenia, major depression, bipolar disorder, hypoxia, confusion, disorientation • Wait times: A wait of >45 min increases the likelihood for aggressive behavior • Time of day: Outside normal working hours, evening shifts • Cultural issues: Cultural insensitivities or racial tension, low socio-economic status • Nurse's attitudes: Nurses' personal characteristics or attitudes 	<ul style="list-style-type: none"> • STAMP <ul style="list-style-type: none"> – Staring and eye contact – Tone and volume of voice – Anxiety – Mumbling – Pacing • Other signs <ul style="list-style-type: none"> – Foot tapping, hand wringing, hair pulling, fiddling with clothes and other objects
Things to AVOID	
<ol style="list-style-type: none"> 1. Do not become emotionally involved. Control your emotions at all times. Do not take the situation personally. 2. Do not engage in power struggles. 3. Do not tell the patient/family that you "know how they feel". 4. Do not raise your voice and give ultimatums or demands. 5. Do not pose in challenging stances such as standing directly opposite someone, hands on hips, or crossing your arms. 6. Do not attempt to intimidate a hostile person. 7. Never belittle the patient/family or make them feel foolish. 	
Ten Domains of De-escalation	
<ol style="list-style-type: none"> 1. Respect personal space. Give the patient/family space they need. Maintain at least 2 arm's length of distance. 2. Do not be aggressive. Demonstrate appropriate body language. 3. Establish verbal contact by having 1 person verbally interact with the patient/family. <ul style="list-style-type: none"> • Speak slowly, listen carefully, and talk with calm, firm and confident voice. 4. Be concise and keep it simple using short sentences and simple vocabulary. 5. Identify wants and feelings by asking the patient/family what their request is. 6. Listen closely. You should be able to repeat back to patient/family what they said to their satisfaction. <ul style="list-style-type: none"> • Give your full attention; make sure you are engaged using eye contact; and paraphrase and reflect (empathize). 7. Agree or agree to disagree. <ul style="list-style-type: none"> • Example: If the patient is agitated after 3 attempts to draw his blood, one might say, "Yes, she has stuck you 3 times. Do you mind if I try?" 8. Set clear limits. Inform the patient/family acceptable behaviors and use gentle confrontation with clear instructions. 9. Offer choices and optimism. Let patients know that things are going to improve and that they will be safe and regain control. Never deceive a patient by promising something that cannot be provided. 10. Debrief the patient and staff. Set guidelines with the patient on how to appropriately express their feelings. Get patient/family's feedback on whether their concerns have been addressed. 	