**Safe Use of Patient Restraints**

**Indications:**
- Restraints are used **ONLY to protect the safety** of the patient or other people in the area. They are applied when there is an **IMMINENT** risk that cannot be managed by any less restrictive method.
- The restraint applied must be the **LEAST RESTRICTIVE** device that will adequately protect the patient/others.
- Early intervention and de-escalation of a situation is often effective in preventing the use of restraint.
- **ALL new or worsening symptoms** (including agitation) are **PRESUMED MEDICAL** until ruled out. This means the patient should have an appropriate medical evaluation by a provider with the required competencies to recognize or rule out a medical cause.
- When a nurse applies restraints the **physician must be immediately notified** and a telephone order obtained, or the physician must enter an order in the medical record immediately.

**Behavioral restraint** (violent or self-destructive):
- Requires at Face to Face evaluation by the physician within 1 hour of application of restraint.
- Requires observation at least every 15 minutes by a trained staff member (may be unlicensed).
- Requires initial and subsequent assessment and documentation by an RN of condition, behavior, environmental considerations at **least hourly** or more frequently if indicated.
- Requires renewal of order based on age. 18 years or older every 4 hours, 9 to 17 years every 2 hours, under 9 years old every 1 hour.
- Suicidal patients in restraint require **1:1 Safety Attendant** (“Sitter”).
- Patients in seclusion and restraint require face to face continual observation by an assigned, trained staff member (Seclusion is used at Arlington Campus ONLY).

**Medical Safety restraint** (Non-Violent, non-self-destructive):
- Renewal of order required every 24 hours. A face to face physician/LIP assessment is not required for renewal.
- Requires initial assessment and subsequent assessment/monitoring and documentation at least q 2 hours by the RN.
- Care may be provided by trained non-licensed staff as needed at least every 2 hours.

**ALL restraints should be applied so that:**
- There is **space for 2 fingers** between the restraint and the patient’s skin
- The restraint is connected or tied **directly to the FRAME** of the bed or gurney.
- Soft restraints that are tied around the patient’s wrist **MUST have a “Safety Knot”** to prevent the restraint tightening from patient movement. This knot must be a complete knot – at **least 2 ties** so that it does not allow the restraint to slip or tighten if pulled against

**Removing Restraints:**
- The restraints MUST be removed when there is no longer a risk of injury or when the patient can be kept safe by less restrictive methods.
- Restraints are removed one at a time with assessments demonstrating that the patient remains safe and controlled between each removal. **NEVER leave a patient restrained by the feet only.** The LAST restraint removed should always be from a wrist.
- If a patient requires restraint after being released from restraint for ANY period of time A **NEW ORDER** is required.
  (Note: a temporary removal during a fully supervised time for the purpose of assessment, range of motion, or other medical treatment is **NOT** a release from restraint). There is no “Trial out of Restraint”. If restraints are removed for reasons other than care, a new order is required.

**KEY:** Any patient restrained by a locked restraint **MUST have a key at the bedside at all times**