

Children's Community Health Plan Member Rights Policy and Procedure

TITLE: Use of Restraints
NUMBER: MR 004

EFFECTIVE: June 1, 2007
REVISION DATE:
REVIEWED WITH NO CHANGES:
APPROVED BY STATE:
RETIRED:

PURPOSE:

Children's Community Health Plan (CCHP) recognizes that members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. The purpose of the restraint policy is to provide a guide for use of restraints to network providers to create an environment that minimizes the use of restraint or seclusion and maximizes the member's health and safety when a restraint is used.

POLICY:

The use of restraints requires consideration of alternative methods and clear indications, as well as safe application, monitoring and reassessment guidelines. Restraint is used in emergencies for violent/self-destructive behavior, when there is an imminent risk of an individual physically harming self or others (including staff), and for medical/surgical necessity to avoid the risk of injury or re-injury to oneself.

DEFINITIONS:

De-escalation: a reduction in the intensity of a conflict.

Drug Used as a Restraint: any medication used as a restriction to manage the member's behavior or restrict the member's freedom of movement and is not a standard treatment or dosage for the member's condition.

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. (See restraint exclusions below for any exceptions.)

Seclusion: the involuntary confinement of a patient alone or in a room or area from which he or she is physically prevented from leaving. It may be used only for the management of violent or self-destructive behavior.

Time Out Used for Behavioral Modification: the imposed restriction of a patient for a period of time to a designated area from which the patient is not physically prevented from leaving for the purpose of providing the patient an opportunity to regain self control.

Violent / Self-Destructive restraint use: used when there is violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others and requires management.

Restraint Exclusions:

This policy and procedure does not apply to:

A. Physical restraint, position or securing devices used to maintain position, limit mobility or temporarily immobilize during routine physical examinations, tests, procedures, or treatments (ex. IV therapy).

Examples include but are not limited to:

- Armboards used for standard IV therapy. (However, armboards used for other purposes may be considered a restraint.)
- Using side rails on a gurney while transporting patients
- Papoose boards
- Hand mitts

B. Mechanical support used to achieve proper body position, balance or alignment so as to allow greater freedom of mobility or to permit participation in activities without the risk of physical harm (does not include a physical escort), than would be possible without the use of such support including:

- Postural support
- Orthopedic appliances

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- Protective helmets
- D. Cribs, enclosure beds, side rails, and safety belts for general patient safety (e.g., to protect the patient from falling out of bed versus preventing the patient from getting out of bed).
- E. Time-out for 30 minutes or less in an unlocked room consistent with member's treatment plan.
- F. Staff picking up, redirecting, or holding an infant or child for the purpose of conducting routine physical exams/tests.

General Principles for Restraints:

1. Protect the member's rights, dignity, safety and well-being.
2. Implement the least restrictive methods for restraint.
3. Assess and reassess the member's need for the use of restraint.
4. Involve the member's family in the decisions and activities that relate to the use of restraints. (Unless the family participation could have a deleterious effect on the patient and his/her rights).
5. Ensure appropriate ordering of restraints.
6. Monitor the patient during the use of restraints and for meeting his/her personal needs.
7. Incorporate restraint use in the written plan of care.
8. Ensure the safe application and removal of restraints by qualified staff.
9. Discontinue use at the earliest time possible.
10. Outline the documentation requirements during the use of restraints.

PROCEDURE:

A. Criteria for Restraint Use

- Based on the initial assessment findings or by qualified staff in emergent situations that pose the risk of injury to self or others.
- Based on the member's needs in the immediate care environment and the interaction of the patient and staff with other patients in the environment.
- Not based solely on prior history or dangerous behavior (current clinical justification must exist).
- Nursing assesses the patient for at least one of the following criteria:
 - Removing invasive lines, surgical bandages, etc.
 - Developmentally unable to remember and/or follow simple instructions
 - Disoriented to person, time and place
 - Agitated
 - Other related criteria

B. Patient Rights

Each patient has the right to respectful care that maintains one's dignity and well-being. Since a restraint has the potential to restrict these rights, each episode of use considers the following:

- Application or initiation of a restraint respects the patient as an individual.
- Environment is safe and clean.
- Patient is able to continue care and participate in care processes.
- Member's modesty, visibility to staff and comfortable body temperature are maintained.

C. Least Restrictive Method

The least restrictive and effective method that maintains the member's safety and safety of others is utilized. It is determined by the member's needs and the effectiveness of methods previously used.

Examples include:

- Revising the clinical plan of care (using comfort measures – e.g. pain management, food, oral fluids, toileting, repositioning, massage, back rub).
- Changing the dose or type of prescribed medication.
- Using different behavioral interventions (redirecting the patient focus – e.g. play, reading material, television).
- Using a sitter or family member
- Implementing environmental modifications (e.g., appropriate lighting, decrease noise level, cover visually offensive equipment).
- Locating patient closer to the nurses' station.

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D. Patient/Family Involvement & Education

Whenever appropriate and/or possible the family will be:

- Involved in the initial assessment of the patient, including identification of successful behavioral techniques, methods or alternative strategies.
- Involved in the decision to utilize restraints.
- Notified in the event of a restraint episode.

The provider educates and informs the patient/family for the following and documents the education given:

- Reason for the restraint
- Alternatives attempted
- Assessment frequency (including comfort measures)
- Changes in behavior, or clinical condition in order to initiate the removal of restraints

Note: If parent/guardian refuses restraints, the refusal of the intervention will be documented.

RELATED POLICIES:

REFERENCES:

Federal Protocol: 438.100 (b) (2)

WRITTEN BY:

Teri Frederickson, Director Clinical Services

REVIEWED BY:

Laura Kerecman, HMO Advocate

REVIEW PERIOD:

Per plan policy.

APPROVED:

Medical Director

Date