Assessment and Monitoring During Restraint and Seclusion

Keeping our patients safe during a high risk procedure.....
Any time a patient must be physically restrained, the patient and the staff involved are put at risk for serious injury.
The RN has the responsibility to monitor behavioral management incidents to prevent injury to the patient and to assure that patients are restrained as safely as possible.
Restraint Prevention

It is also the RN’s responsibility to monitor the unit milieu so that nursing staff can intervene early, when possible, to prevent the need for behavioral management.
Restraint Prevention

All Nursing personnel must be alert for:

- An increase in tension or stress level on the unit.
- Indications from individual patients or groups of patients that anxiety or agitation is increasing.
- Signs and symptoms in patients of increased psychotic symptoms that might lead to aggression.
When physical management of a patient is necessary...

The RN has the responsibility to assure that the patient is monitored in order to prevent or minimize injury and discomfort during a restraint procedure.
Preventing a restraint or seclusion is the BEST way to avoid patient or staff injury due to restraint or seclusion.

Staff on the unit should enlist the help of the RN immediately whenever a patient is in danger of losing self-control and restraint might become necessary.
Whenever it becomes necessary to restrain a patient, proper physical management techniques taught in Bridge Building training should be utilized. Unless the patient is already attacking you or someone else, you should yell for, or call for, assistance before physically laying hands on the patient…you should not attempt to restrain a patient without the necessary assistance from other staff.

It is the responsibility of the Nursing Staff to take precautions to assure that physical management of a patient is done as safely as possible.
When a restraint or seclusion is initiated....

It is the responsibility of every staff member, nursing or non-nursing, who must implement, or who witnesses, a restraint or seclusion with a patient to tell the Unit RN immediately if the RN did not directly witness the incident.

When reporting the incident, the staff member should specifically label the incident to the nurse as a “hold” restraint or a seclusion so there is no misunderstanding of what happened.
When a restraint is initiated, the RN must assess:

- The patient, to justify the need to proceed to seclusion or mechanical restraint, or to continue a manual restraint.

- Reason/behavior necessitating restraint or seclusion (include a description of current behavior).
When a restraint is initiated, the RN must monitor:

- The patient’s physical status, paying particular attention to maintaining chest expansion, air exchange and consciousness.

Someone should be assigned to specifically monitor that the patient’s respiratory and circulatory status are not compromised.
RN Assessment Responsibilities at initiation of a restraint

- De-escalation strategies considered or attempted (what was tried to prevent the restraint that did not work).

- Less restrictive alternatives not attempted and why they were not attempted.
Identify the least restrictive type and location of restraining devices to prevent injury to self or others.

The type of restraint selected should be based on information learned assessing the patient’s condition, behavior and situation.
Patients restrained or secluded are assessed at the beginning of a restraint or seclusion episode by the RN, and regularly throughout the duration of the episode.

The RN assures that the patient is searched for possession of unsafe items that may include belts, shoestrings, and other clothing, jewelry, sharps and other contraband.
Assess for signs of injury associated with the application of restraints or seclusion.

Look for any swelling, bruising, marks, abrasions, discoloration and other signs of injury.
RN Assessment During Restraint or Seclusion

- Assess circulation and range of motion in the extremities.
  - Restraints should be snug enough to prevent removal, but not tight enough to limit circulation.
  - Restraints should not position the patient in an awkward, uncomfortable position.
  - Skin color distal to the restraint applied to a limb should be pink, and not blanched or show pallor.
  - Range of Motion should be attempted every hour unless patient is uncooperative.
Vital Signs

- Vital signs are to be monitored every 15 minutes throughout the restraint/seclusion episode.
RN Assessment During Restraint or Seclusion

- RN assures that the environment is safe, clean, well-lighted, and that the temperature of the room is comfortable.

- RN assures that the patient is *continuously* monitored by nursing staff to assure that the patient remains safe and as comfortable as possible.
Monitoring and Assessment During Restraint or Seclusion

- Nursing Staff monitors that the patient receives adequate nutrition and hydration.

- Fluids must be offered at least every hour during a restraint/seclusion episode.
Monitoring and Assessment During Restraint or Seclusion

- Nursing Staff monitors hygiene and elimination.

- Staff cleanse the patient if soiled with blood or body fluids as soon as it is safe to do so.
- The patient is given the opportunity to toilet at least every hour and as often as needed during the restraint/seclusion episode.
Monitoring and Assessment During Restraint or Seclusion

- Physical and psychological status and comfort should be continuously monitored.

- If the patient is fearful or anxious, offer reassurance (if helpful), and possibly a PRN medication (if available).
The RN should monitor the patient’s clinical condition for readiness to discontinue the restraint or seclusion.

- The patient should be released from restraint or seclusion *as soon as the release criteria have been met.*

- The release criteria should be established at the beginning of the restraint/seclusion episode, and should be related to the behavior that necessitated the restraint or seclusion.
The release criteria should be communicated to the patient as soon as possible after the patient is placed in restraints or seclusion.
Release Criteria may include:

- Patient is free from threatening behavior towards self and others.
- Patient is able to maintain physical and/or verbal control.
- Patient is able to verbally contract with staff to ensure safety of self and others.
- Patient is calm, quiet, directable, and receptive.
- Patient demonstrates the ability to follow directions necessary for safety.
Nursing staff monitoring the patient must document at least every 15 minutes on the “Seclusion/Restraint Observation/Intervention Flow Sheet.”

<table>
<thead>
<tr>
<th>Time</th>
<th>Every 15 Minutes</th>
<th>Every 1 Hour</th>
<th>Assessment every 1 Hour by RN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Circulation Check</td>
<td>BP, Temp, Pulse, Respiration, Injury, Behavior</td>
<td>Bathroom, Fluids Offered, ROM</td>
</tr>
</tbody>
</table>

RN Assessment of clinical condition (i.e., physical & psychological status & comfort and any injury)
The RN must initial the Observation Flow Sheet every 15 minutes, and must also document an assessment every hour in the space provided.
Documentation of monitoring and assessment

- Additional documentation of the patient’s behavior, condition, circumstances surrounding the restraint/seclusion episode, the patient’s reaction to the event and other pertinent information should be documented in the progress notes in the patient record.
Restraint and seclusion are risky procedures that should only be initiated to maintain or establish safety for the patient and for others in the environment.

Patients who need to be restrained or secluded must be continuously monitored to decrease the risk for injury and to maintain optimal comfort and support for the patient.
You have completed the inservice on
ASSESSMENT AND MONITORING DURING
RERAINT AND SECLUSION

Name (printed): _____________________________

Signature:  __________________________________

Date:  _________________

Print and complete this slide and send it to the Nursing Administration Office by August 10th. RNs must also complete a test obtained on the intranet in the Nursing Link within the “Nursing Department Inservices 2013.”