STANDARDIZED PROCEDURE
ORDERING RESTRAINTS FOR MEDICAL-SURGICAL CARE (Adult, Peds)

I. Definition

This procedure applies to the ordering of restraints used on Medical-Surgical patients who are at risk for injuring themselves either by interfering with medical treatment or by removing catheters, tubes or drains that are part of the medical treatment necessary for healing.

II. Background Information

A. Setting:

The setting (inpatient vs outpatient) and population (adults vs pediatrics) for the Advanced Health Practitioner (AHP) is determined by the approval of the privileges requested on the AHP Privilege Request Form. If the procedure is being done on a Pediatric patient, make sure Child Life is involved and use age appropriate language and age appropriate developmental needs with care of children, as appropriate to the situation.

B. Supervision:

The necessity of the procedure will be determined by the AHP in verbal collaboration with the attending physician or his/her designee. Direct supervision will not be necessary once competency is determined, as provided for in the protocol. At that time, general or indirect supervision is acceptable.

Designee is defined as another attending physician who works directly with the supervising physician and is authorized to supervise the NP

The Advanced Health Practitioner will notify the physician immediately upon being involved in any emergency or resuscitative events or under the following circumstances:

1. Patient decompensation or intolerance to the procedure
2. Outcome of the procedure other than expected

C. Indications:

1. When the patient has confusion or short-term memory problems that place the patient at risk of:
   a) Deliberately removing necessary medical devices or
   b) Non-compliance with medical treatment
2. The patient requires frequent reminders that it is not safe to get up without assistance
3. Comfort and environmental measures have not been adequate for reducing the risks to the patient.

D. Contraindications

1. The patient requires behavioral or chemical restraints.
2. Less restrictive alternatives such comforting the patient, removing lines or moving the patient closer to the nurses' desk are effective.

III. Materials

Pre-printed UCSF Medical Center-approved Restraint Orders form.

IV. Procedure

A. Pre-treatment evaluation:

1. Assess the patient and determine the patient's baseline behavior.
2. Determine whether any cognitive impairment exists.
3. Determine whether the patient is receiving any medications that could be influencing his/her behavior.
4. Determine whether any physiological factors such as pain, hypoxia or electrolyte imbalance could be causing the behavior.
5. Determine whether the patient has any perceptual, visual or hearing deficits that could be contributing to the behavior.
6. If no underlying cause for the behavior can be identified, assess for less restrictive options for keeping the patient safe.

B. Set up:

Obtain Restraint order form

C. Patient preparation

1. Take a Time-out to check two patient identifiers.
2. Inform the patient/family of the treatment plan and necessity for maintaining patient safety.

D. Perform the procedure

Complete and sign the medical-center approved Restraint Orders **every 24 hours.**

E. Follow-up treatment

1. Reassess the patient's need for restraints any time the nursing staff reports changes and at least **every 24 hours**.
2. Complete and sign a new Restraint Orders form each 24 hours after repeating the same pre-treatment evaluation.

F. Termination of treatment
At any time that the patient's cognitive or behavioral changes resolve or patient safety can be assured while using less restrictive measures.

V. Documentation

A. Documentation is in the electronic medical record

1. Documentation of the pretreatment evaluation and any abnormal physical findings.
2. Record indications for restraint use on the Restraint Orders form.
3. Daily progress note will include continuation of need for restraint and patient tolerance

B. All abnormal or unexpected findings are reviewed with the supervising physician.

VI. Competency Assessment

A. Initial Competence

1. The Advanced Health Practitioner will be instructed on the efficacy and the indications of this therapy and demonstrate understanding of such.
2. The Advanced Health Practitioner will demonstrate knowledge of the following:
   (1) Medical indication and contraindications of ordering restraints
   (2) Risks and benefits of the procedure
   (3) Consent process (if applicable)
   (4) Steps in performing the procedure
   (5) Documentation of the procedure
   (6) Ability to interpret results and implications in management.
3. Advanced Health Practitioner will observe the supervising physician perform the procedure once and perform the procedure **three** times under supervision.
4. Supervising physician will document Advanced Health Practitioner's competency prior to performing procedure without supervision.
5. The Advanced Health Practitioner will ensure the completion of competency sign-off documents and provide a copy for filing in their personnel file and a copy to the medical staff office for their credentialing file.

B. Continued proficiency

1. The Advanced Health Practitioner will demonstrate competence by successful completion of the initial competency.

2. Each candidate will be initially proctored and signed off by an attending physician. Advanced Health Practitioner must perform this procedure at least **three** times per year. In cases where this minimum is not met, the attending, must again sign off the procedure for the Advanced Health Practitioner. The Advanced Health Practitioner will be signed off after demonstrating 100% accuracy in completing the procedure.
3. Demonstration of continued proficiency shall be monitored through the annual evaluation.
4. A clinical practice outcomes log is to be submitted with each renewal of credentials. It will include the number of procedures performed per year and any adverse outcomes. If an adverse outcome occurred, a copy of the procedure note will be submitted.

VII. RESPONSIBILITY

Questions about this procedure should be directed to the Chief Nursing and Patient Care Services Officer at 353-4380.

VIII. HISTORY OF PROCEDURE

Revised Sept 2012 by Subcommittee of the Committee for Interdisciplinary Practice
Reviewed Sept 2012 by the Committee on Interdisciplinary Practice
Prior revision May 2009
Approved Sept 2012 by the Executive Medical Board and the Governance Advisory Council.

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