Restraints: Use of Four Point Locking Restraints in the ED (Richmond Hospital)

Site Applicability

VCH – Richmond Hospital Emergency Department

Practice Level

Registered Nurse (RN)

Policy Statements

Four point locking restraints are used as a temporary measure where imminent or potential danger to self or others may occur.

Under the direction of a health care provider, such as the Registered Nurse (RN), Most Responsible Provider (MRP), or Psychiatric Liaison RN, security will apply lockable restraints on a patient.

Obtain an order for four point locked restraints from the MRP within 15 minutes of/ or immediately after security applied restraints.

A locked restraint order cannot exceed 24 hours, and generally should not exceed eight (8) hours (or lesser period as clinically indicated).

Need to Know

There are significant risks associated with physical restraint including: asphyxia, aspiration, falls, neurovascular damage, injuries and rhabdomyolysis. Therefore, physical restraint should only be considered when other methods fail.

Attempts at de-escalation should be considered before the use of four point restraints, including:

- Provide time and space: step back, reassess and resume care if patient escalates.
- Recognize the patient's personal space, by keeping a distance of about three feet.
- Introduce self and ask for permission to approach patient's care area.
- Maintain eye contact that remains at eye-level with the patient. If patient is uncomfortable with the eye contact, consider an activity with the patient to break up the eye contact.
- Respectfully converse and talk to the patient in a steady, neutral pitch and tone
- Actively listen, validate, paraphrase and clarify patient's concerns.
- Using a two-person planned approach
- Having a coworker or a security guard close by and out of sight of patient

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- Redirecting and/or distracting patient's emotions
- Providing patient with options that fit with the patient's treatment goals, are realistic and achievable, and stated in simple terms
- Separating the patient from others
- Offering appropriate medications

Equipment and Supplies

1 set of extremity restraints (1 set locking wrist and 1 set locking ankle)

1 restraint key

Guideline

Assessment

Indications for use**:**

- Less restrictive alternatives/interventions have been attempted with no success
- Patient is physically combative
- Imminent danger to self and/or others
- When delay in restraint would subject the patient/others to risk of serious harm
- Code White standard activated

Important: Consider the need for constant care when there is evidence of increased risk of harm to self or others, or if ordered by the MRP

Contraindications:

- When the patient is not a danger to self and/or others
- When less restrictive alternatives have not been considered or attempted

Procedure

Initiation

- Initiate Code White
- Inform Most Responsible Provider (MRP)
- Obtain a provider's order
- Don personal protective equipment
- Security is responsible for bringing and applying restraints under the direction of a clinical care giver/provider, such as the RN, MRP and Psychiatric Liaison RN.
- Ensure patient is placed in the safest position (supine, one arm up, one arm down, head of bed raised 30 degrees)
- Ensure restraint key is kept at patient bedside at all times, as well as at PCC desk
- Provide a safe environment for the patient and staff:
    - Remove objects from area that could be used as weapons
    - Keep equipment such as suction tubing out of reach of patient
    - Place patient in an area that allows for frequent, easy observation

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Ongoing Care/Management

- The patient should be assessed and findings documented:
    - Every 15 minutes until behaviour stabilizes and then
    - Every 30 minutes for one hour and then
    - Every 60 minutes until the restraints are discontinued.
    - Every 24 hours for ongoing need for restraints.

  Assessment includes behaviour observation to determine if the behavior necessitating restraint is escalating, decreasing, or has resolved.
- RN to ensure restraint key is present at the bedside at the start/end of shift
- A health care provider must be available within sight or sound at all times
- Orientate the patient to time, person, place PRN
- Assess Vital Signs and GCS Q2H and PRN
- Monitor CWMS to limbs Q30 min
- Remove and reposition one limb at a time to check skin and provide range of motion Q4H or PRN. Security must be present when removing or repositioning patient in restraints
- Communicate with patient/family the reason for the restraint and the behaviors expected to change for restraint removal
- Assess patient's level of consciousness and alertness prior to considering the patient's ability to eat and drink. Assess for safety to release only one arm to do so. Security must be present when removing or repositioning patient in restrains.
- Toilet check Q4H and PRN
- Administer medication as ordered by the provider
- Orders for restraints must be limited to four 24 hours and use re-evaluated
- Patients are not to be transferred to inpatient units in four point locking restraints
- Security must accompany all patients who are restrained when transferring within and out of the department

Discontinuation

- Four point restraints should be discontinued as soon as possible once it is safe to do so
- Upon the completion of a Nursing assessment, RNs can determine when to discontinue the restraints. Assess discontinuation when patient regains control of behaviour.
    - Rationale for removal to be included in documentation
- Security must be present to remove restraints
- Remove one limb restraint at a time while carefully monitoring the patient to ensure safety
- Debrief with the patient/family and staff members after restraint removal

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Documentation

A Restraint Initiation Record is completed when mechanical restraint is initiated, and includes the following:

- Decision-making for initiation of restraint
- Reason for restraint application (patient behaviour)
- Alternatives to restraint (eg. de-escalation)
- Restraint type
- Notification of provider, time of provider assessment and written order for restraints

The Restraint Documentation Record is used to document patient assessment, including the following ongoing monitoring and management while restraints in place:

- Position of patient
- restraint key is present at the bedside
- vital signs/GCS Q2H and PRN
- CWMS to limbs Q30 min
- skin check and range of motion provided Q4H or PRN
- fluid and nutrition intake
- elimination

Additional plan of care documentation using the Emergency Nurses Assessment Record should also include:

- Patient's response to restraint
- Information given to the patient /family re: the need for restraints
- Medications given
- Time the restraint removed and rationale for removal

Update Violence and Aggression Tracking and Review Tool (VCH.0021)

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Related Documents

- Elsevier/Mosby Clinical Skills: Restraint Application and Monitoring – CE (To best view this document, copy and paste link into Google Chrome) http://mns.elsevierperformancemanager.com/SkillsConnect/Default.aspx?Token=549253&SkillID=585
- Observation Levels: Close or Constant Care (Acute) SOP - (D-00-16-30227)
- Observation Levels: Provision of Close or Constant Care (Acute) - (D-00-07-30305)
- Code White Standard (Sept. 2018)
- Restraints: Care of the Patient at Risk for or Requiring Restraint (D-00-07-30281)

References

- Booth, James Stuart. (2018, December). **Four - Point Restraint.** Retrieved from https://emedicine.m*edscape*.com/article/1841454-print.

- Child Health BC Provincial Least Restraint Guideline. Initial Management of Least Restraint in Emergent/Urgent Care Settings. Background and Evidence. April 2018

- Child Health BC Provincial Least Restraint Guideline. Initial Management of Least Restraint in Emergent/Urgent Care Settings. Practical Summary and Tools. April 2018.

- Springer, Gale. When and how to use restraints. *American Nurse Today.* January 2015. Volume 10, Number 1. Page 26-32.

- Application of Locking 4 Point Restraints (D-00-07-30278) (Old VA No- PCG R-031).

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