POLICY:

In accordance with the mission of St. Joseph Hospital, restraints will only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

PURPOSE:

The purpose of restraint use is to provide for patient safety in accordance with our mission for compassionate care. The dignity, rights and well being of the patient will be maintained.

DEFINITIONS:

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; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Medical Restraint: Used to directly support the medical healing of the patient and the attainment of medical or psychosocial goals when use of least restrictive means has not proven effective. The use of restraint in these instances is regarded as a safety measure to prevent certain medical decline or injury.

Behavioral Restraint: Is the restriction of movement for the management of violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member or others.

Seclusion: Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior. If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether the door is actually locked or not.

Physical restraint: any manual method, physical or mechanical device, material or equipment involuntarily attached or adjacent to the patient's body that he/she cannot easily remove that its intended use restricts freedom of movement or normal access to one's body.

Chemical restraint: A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Easily remove: The manual method, device, material or equipment that can be removed intentionally by the patient in the same manner as it was applied by the staff (e.g. side rails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied, etc.)

Standard treatment/dosage of a drug/medication:
• The drug/medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters;
• The use of the drug or medication follows national practice standards established or recognized by the medical community; or professional medical associations or organizations; and The use of the drug or medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's or other LIP knowledge of that patient's expected and actual response to the medication.

Emergency situation: when a patient’s violent or aggressive behavior presents immediate and serious danger to the safety of the patient, other patients or staff.

Voluntary: a cognitively intact patient that agrees to the restraint device and is able to give written permission for the use of the restraint. Examples: restraint of the arm of the patient with uncontrollable involuntary movements.

Medical Immobilization: mechanisms usually employed during medical, diagnostic or surgical procedures that are considered routine part of such procedures. These mechanisms unusually include body "restraint" during surgery.

Adaptive support: mechanisms intended to permit a patient to achieve maximum normative bodily functioning. These usually include orthopedic appliances, braces, wheelchairs and other appliances used to posturally support the patient.

Protective device: mechanisms intended to compensate for a specific physical deficit or prevent safety incidents not related to cognitive dysfunction. These include bumper pads, tabletop chairs and protective helmets.

Comprehensive assessment: must include but not limited to cardiovascular, respiratory, and mental status, and the safety of self and others in the treatment area performed by a physician or LIP

Face-to face assessment: includes both a physical and a behavioral assessment of the patient. It must be performed by a physician or LIP.

Immediately: within a few minutes

RN: registered nurse

LIP: licensed independent practitioner. Any practitioner permitted by both law and the hospital to provide care, treatment and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. At SJH, this refers to a physician licensed in the State of Maine who has been credentialed and privileged by SJH.

Shift: every twelve hours

PROCEDURE:

• The safety of the patient, staff, or others is the basis for initiating and discontinuing the use of restraints.

• A comprehensive, individualized physical assessment must be performed to determine whether the use of less restrictive measures poses a greater risk than the risk of using a restraint. The comprehensive assessment should include a physical assessment to identify medical problems that may be causing behavioral patient changes. E.g.) temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions, and drug side effects that may cause confusion, agitation and combative behaviors.

• Restraints are not used as a punitive action or for staff convenience. They are not to be applied in a manner that causes undue physical discomfort or harm.

• The use of restraint for the management of patient behavior should not be considered a routine part of care.

• The use of restraints for the prevention of falls should not be considered a routine part of a falls prevention program.
• The physician’s order will specify the type of restraint, a time duration and reason for use.

**RERAINT DEFINITION:**

All patients placed in Twice as tough restraint system OR Net with fifth point restraint for safety require direct observation for safety. These devices are to be used in the ED or CCU where specialty training has occurred. In the event that a patient condition warrants, these devices may be applied on the inpatient unit ONLY with the assistance from ED, CCU, security or nursing supervisor staff. As soon as the patient is stabilized, patient is to be transferred to the CCU. If the CCU is full capacity and the patient must be maintained on the inpatient unit, nursing staff caring for the training must receive equipment education (from above specified staff) and have a patient assignment that does not exceed an acuity level of 8.

<table>
<thead>
<tr>
<th>Restraint:</th>
<th>NOT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tucking a patient's sheets in so tightly that the patient cannot move</td>
<td>• Devices (e.g. orthopedically prescribed devices; surgical dressings and bandages; protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.</td>
</tr>
<tr>
<td>• If the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access his/her body, the use of the arm board would be considered a restraint.</td>
<td>• Use of an IV arm board to stabilize an IV line.</td>
</tr>
<tr>
<td>• A mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support (E.g. patients requiring leg braces to walk or neck/head/back braces to sit upright).</td>
<td>• A medically necessary positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures.</td>
</tr>
<tr>
<td>• Pinning or otherwise attaching those same mitts to bedding or using a wrist restraint in conjunction with the hand mitts would meet the definition of a restraint. In addition, if the mitts are applied so tightly that the patient's hand or fingers are immobilized or if the mitts are so bulky that the patient's ability to use their hands is significantly reduced; this would be considered a restraint.</td>
<td>• Many types of Hand mitts would not be considered a restraint.</td>
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</table>
| • Age or developmentally appropriate protective safety interventions (E.g. stroller, safety belts, swing safety belts, high

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
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<tbody>
<tr>
<td>• If the patient cannot easily remove or escape the grasp</td>
<td>This would be considered a physical restraint.</td>
</tr>
<tr>
<td>• Physical escort would include a &quot;light&quot; grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered a restraint.</td>
<td></td>
</tr>
<tr>
<td>• Holding a patient in a manner that restricts the patient's movement against the patient's will is considered a restraint. This includes holds that some members of the medical community may term &quot;therapeutic holds&quot;.</td>
<td>Regulation permits the physical holding of a patient for the purpose of conducting routine physical examination or tests.</td>
</tr>
<tr>
<td>• Physical holding of a patient during a forced psychotropic medication procedure or in order to administer a medication against the patient's wishes is considered a restraint.</td>
<td>• In certain circumstances, a patient may consent to an injection/procedure, but may not be able to hold still for an injection, or cooperate with a procedure. In such circumstances, and at the patient's request, staff may &quot;hold&quot; the patient in order to safely administer an injection (or obtain a blood sample, or insert an intravenous line, if applicable) or to conduct a procedure. This is not considered a restraint.</td>
</tr>
<tr>
<td>• The use of side rails to prevent the patient from exiting the bed voluntarily would be considered a restraint.</td>
<td>• A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or certain types of therapeutic beds to prevent the patient from falling out of bed.</td>
</tr>
<tr>
<td>• Physical holding of a patient during a forced psychotropic medication procedure or in order to administer a medication against the patient's wishes is considered a restraint.</td>
<td>• If a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails for this patient would not be considered a restraint because the side rails have no impact on the patient's freedom of movement.</td>
</tr>
<tr>
<td>• Use of a “net bed” that prevents the patient from freely exiting the bed.</td>
<td>• When a patient is on a bed that constantly moves to improve circulation or prevents skin breakdown, raised side rails are a safety intervention to prevent the patient from falling out of bed and are not viewed as restraints.</td>
</tr>
<tr>
<td>• Physical holding of a patient during a forced psychotropic medication procedure or in order to administer a medication against the patient’s wishes is considered a restraint.</td>
<td>• When a patient is placed on seizure precautions and all side rails are raised, the use of side rails would not be considered a restraint. The use of padded side rails in this situation should protect the patient from harm; including falling out of bed should the patient have a seizure.</td>
</tr>
<tr>
<td>• Use of a “net bed” that prevents the patient from freely exiting the bed.</td>
<td>• Placement of a crib with raised rails is an age-appropriate standard safety practice for every infant or toddler. Therefore, placement of an infant or toddler in the crib with raised rails would not be considered a restraint.</td>
</tr>
</tbody>
</table>
• If the patient is on a stretcher (a narrow, elevated, and highly mobile cart used to transport patients and to evaluate or treat patients), there is an increased risk of falling from a stretcher without raised rails due to its narrow width, and mobility. In addition, because stretchers are elevated platforms, the risk of patient injury due to a fall is significant. Therefore, the use of raised side rails on stretchers is not considered a restraint but a prudent safety intervention. Likewise, the use of a seat belt when transporting a patient in a wheelchair is not considered a restraint.

**DOCUMENTATION:**

1. **Identify** patients **at risk for injury** and **document** the behavior observed.
   The patient may be a candidate for restraint if he/she exhibits but not limited to any of the following criteria:
   a. confusion, disorientation or extreme restlessness to the degree that he/she is; agitated, hostile or abusive toward care givers, the patient is at risk for injury to self or others
   b. Interferes with or pulls at treatment lines and/or life support devices (GI or GU tubes, ET tube, etc.)

2. **Utilize the least restrictive means.** Restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. Less restrictive interventions do not always need to be tried, but less restrictive interventions **must be determined by staff to be ineffective** to protect the patient or others from harm **prior to the introduction of more restrictive measures.** Alternatives attempted or the rationale for not using alternatives must be **documented.**

3. **Care Plan:** The use of restraints (including drugs or medications used as restraint as well as physical restraint) must be **documented** in the patient's **plan of care.**

4. **Type and Location of the restraint device(s)** shall be **documented** at least **once per shift and when changed.**

5. **Rationale for restraint (observed condition or behavior)** shall be **assessed** on an **ongoing** basis and **documented** at least **once per shift.**

6. The following needs should be assessed and attended to (as necessary) by the nursing staff per these minimal time frames specified:
   a. An **assessment** will be **performed and documented** by the RN **every hour.** It will include:
      ◦ Continued need for restraint
      ◦ Nutrition/Hydration
      ◦ Toilet, hygiene, comfort needs
      ◦ Respiratory status
      ◦ Mental status

7. **Every two hours** the RN will **document:**
   • Release all extremities (one at a time) to perform exercises and provide skin care. If this release puts the patient or others at risk due to continued unsafe behavior additional staff should be present at the time of release.
   • Readiness for discontinuation every two hours or sooner

8. The **reason and time for removal** must be **documented** on the restraint plan of care.
   E.g. When the initial behavior is no longer evident or alternatives are effective (decreased agitation, demonstrates understanding of instructions and is able to comply, alert and oriented, etc.) results of attempts made to discontinue restraint use **prior to expiration of the physician’s order require an RN documented assessment and physician notification.**
9. **Ongoing documentation** including a **narrative** for all patients must include the criteria **supporting the use of the medical restraint every shift**.

10. Patient will be checked every 15 minutes if in physical restraints and not under direct observation with the exception of medical restraint use in the CCU.

**PATIENT MONITORING:**

- The patient's modesty, circulation and comfortable body temperature will be maintained.
- The patient will be monitored visually every hour by an RN, CNA or ED technician.
- Vital signs will be monitored every 4 hours and as needed by the RN, CNA, or ED tech.
- **Discontinuation**: A restraint must be removed at the earliest possible time. Staff is expected to continually assess and monitor the patient to ensure that the patient is released from restraints at the earliest possible time.
- If a patient was recently released from the restraint, and exhibits behavior that can only be handled through the reapplication of restraint, a new order would be required. Staff cannot discontinue a restraint intervention and then re-start under the same order.
- Orders for the use of restraints must never be written as a standing order or on an as needed basis (PRN). A "trial release" constitutes a PRN use of restraint, and, therefore, is not permitted. **EXCEPTIONS include**:
  - **Raised side rails**. If a patient's status requires that all bedrails be raised (restraint) while the patient is in bed, a standing or PRN order is permitted. It is not necessary to obtain a new order each time the patient is returned to bed after being out of bed.
  - **Repetitive self-mutilating behavior**. If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyhan Syndrome, and the patient engages in repetitive self-mutilating behavior, a standing or PRN order for restraint to be applied in accordance with specific parameters established in the treatment plan would be permitted. Since the use of restraints to prevent self-injury is needed for these types of rare, severe, medical and psychiatric conditions, the specific requirements (1-hour face-to-face evaluation, time-limited orders, and evaluation every 24 hours before renewal of the order) for the management of violent or self-destructive behavior do not apply.
- **Seclusion**: Patients who meet criteria for seclusion will have direct observation. Seclusion may be initiated by an R.N. Within one hour of initiation, the patient will have a face to face evaluation by an LIP. The order for seclusion must be signed by an LIP within one hour of initiation and is valid for twenty four hours. The order and need for seclusion must be re-evaluated and re-ordered by the RN caring for the patient and at regular intervals as the patient's behavior indicates.
- **Time Intervals**:
  - Adults (Age 18 or greater): every 4 hours
  - Adolescents (Ages 9-17): every 2 hours
  - Children (Ages 8 and younger): every hour
- A temporary, directly-supervised release, however, that occurs for the purpose of caring for a patient's needs (e.g. toileting, feeding, or range of motion exercises) is **not** considered a discontinuation of the restraint intervention. As long as the patient remains under the direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint.

**TEACHING:**

- Notify and instruct the patient, family or significant other as soon as possible regarding:
  - a. Reason for restraint
  - b. Need to call for assistance when getting out of bed and ambulating
c. Family participation which could reduce the need for restraints

d. If restraints are released during family visits, the family is required to notify nurse prior to the family leaving

e. Family teaching will be documented.

**RERAINT TYPES:**

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<tr>
<th>For acute medical/post surgical restraints orders:</th>
<th>For behavioral (chemical restraint orders):</th>
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<tbody>
<tr>
<td>• Time that the order was initiated and an end time not to exceed <strong>24 hours</strong> for medical surgical reasons.</td>
<td>• Drugs or medications that are used as part of a patient's standard medical or psychiatric treatment, and are administered within the standard dosage for the patient's condition; appropriate doses of sleeping medication prescribed for patients with insomnia, anti-anxiety medication prescribed to calm a patient who is anxious, or analgesics prescribed for pain are <strong>not</strong> considered a restraint.</td>
</tr>
<tr>
<td>• The physician must assess and document the patient status within <strong>1</strong> hour of initiating acute medical restraints. The physician has the option to make arrangements for the patient to be evaluated by another LIP. If physical holding for forced medication is necessary with a violent patient, the 1-hour face-to-face evaluation requirement would also apply.</td>
<td><em>E.g. A patient on an alcohol withdrawal protocol becomes violent and aggressive. Staff administers a PRN medication ordered by the physician/LIP to address these types of outbursts. The use of the medication enables the patient to better interact with others or function more effectively. In this case, the medication used for this patient is NOT considered a restraint. The availability of a PRN medication to manage specific behaviors, such as aggressive, violent behavior is standard for this patient's medical condition.</em></td>
</tr>
<tr>
<td>• A new order must be obtained with the expiration of the existing order including a re-evaluation of the patient's continued need for restraint and the physician or LIP must conduct a face-to-face assessment to renew the order. There must be <strong>documentation</strong> in the physician's or LIP's finding to warrant the ongoing application of restraint.</td>
<td><em>E.g. A patient who has been assessed and is undergoing treatment for delirium</em></td>
</tr>
<tr>
<td>• For <strong>Emergency application situations:</strong> In emergency application situations, the order must be obtained either during the emergency application of the restraint, or immediately (within a few minutes) after the restraint has been applied. The failure to immediately obtain an order is viewed as the application of restraint without an order.</td>
<td>• If the overall effect of a drug/medication, or combination of drugs/medications, is to reduce the patient's ability to effectively or appropriately interact with the world around the patient, then the drug or medication is <strong>not</strong> being used as a standard treatment or dosage for the patient's condition and is considered a restraint.</td>
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<tr>
<td>• Any patient placed in 4-point restraints should have <strong>continuous observation</strong>. Patients in non-4 point restraints for behavior management should be observed every hour.</td>
<td>• A drug/medication that is not being used as a standard treatment for the patient's medical or psychiatric condition, and that results in restricting the patient's freedom of movement would be a drug used as a restraint (i.e. patient is a harm to self and/or others)</td>
</tr>
<tr>
<td>For <strong>behavioral restraint orders:</strong></td>
<td>E.g. of chemical restraints:</td>
</tr>
<tr>
<td>• The time limit cannot exceed <strong>4 hours</strong> with adults.</td>
<td>1. Haldol for agitation</td>
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<tr>
<td></td>
<td>2. Lorazepam for agitation</td>
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<td></td>
<td>3. Thorazine</td>
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</tbody>
</table>

• The time limit for behavioral restraints orders cannot exceed 2 hours with children ages 9-17.
• The time limit for behavioral restraint orders cannot exceed 1 hour children under 9.
• Behavioral restraint orders must be renewed within the outlined time period. An onsite assessment is not required by the physician or LIP unless a 24 hour period of restraint has been reached.
• A physician must assess, evaluate and document the need for restraint within one hour of the initiation of behavioral restraints including violent behavior.
• A new order must be obtained with the expiration of the existing order including a reevaluation of the patient’s continued need for restraint and the physician or LIP must conduct a face-face assessment to renew the order. There must be documentation in the physician’s or LIP’s finding to warrant the ongoing application of restraint.
• If a restraint is ordered by a consulting physician, the attending physician must be notified as soon as possible.
• Procedures for care of the patient requiring chemical restraints includes the requirements in behavioral management plus the additional following requirements: Chemical restraints may only be administered after a physician/LIP has conducted a face-to-face assessment of the patient. The order must state:
  1. Reason for the medication
  2. Dose of the medication
  3. Route of the medication
  4. Frequency of monitoring
  5. Is NEVER expressed as a PRN or standing order*New order required for each dose

Ativan IV/IM MONITOR for 24 hours (Gahart, B.L., Nazareno, A.R., 2014, 30th ed., Intravenous Medications, p. 748):
- Bed Rest for a minimum of 3 hours after IV/IM injection and assistance required for up to 8 hours
- Monitor and maintain patent airway
- Respiratory assistance and flumazenil (Romazicon) must be available
- Monitor vital signs: 1 hour post administration and then per floor routine

Haldol IV/IM MONITOR for 24 hours:
- Bed Rest for a minimum of 3 hours after IV/IM injection and assistance required for up to 8 hours
- Monitor and maintain patent airway
- Monitor vital signs: 1 hour post administration and then per floor routine (orthostatic vital signs required-may cause orthostatic hypotension. Use with caution with patients who are at risk of hypotensive episodes (i.e. cerebrovascular disease, cardiovascular disease, hypovolemia, etc.)
- ECG monitoring: may alter cardiac conduction and prolong QT interval; life-threatening arrhythmias have occurred with therapeutic doses of antipsychotics, but risk may be increased with doses exceeding recommendations and/or IV administration. *Use with caution or avoid use in patients with: electrolyte abnormalities (i.e. hypokalemia, hypomagnesemia), hypothyroidism, familial long QT syndrome, use with other medications that might prolong QT interval.
- Place on Aspiration precautions: may cause esophageal dysmotility and aspiration (use with caution in patients at risk for pneumonia-i.e. Alzheimer’s disease)
- Monitor for mental status changes-may cause sedation, muscle rigidity

Staff Education/Training:

Staff members who have direct patient care contact will have training in the following subjects as it relates to duties performed under this policy regarding the use of restraints during the orientation process and annually. Such training shall take place before the new staff member is asked to implement the provisions of this policy and shall be repeated periodically as indicated in the hospitals training plan, which shall be based on the results of quality monitoring activities.

1. Physicians/LIPs who order restraints will have annual training in the requirements of this policy and shall demonstrate a working knowledge of this policy through ongoing compliance.
2. Hospital staff members who assess patients for restraints or who apply restraints shall receive training in the following:
   - Techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of restraints.
◦ The use of non-physical intervention skills.
◦ Choosing the least restrictive intervention based on individualized assessment of the patient's medical or behavioral status or condition.
◦ The safe application and use of all types of restraints by the staff member, including training in how to recognize and respond to physical and psychological distress (e.g. positional asphyxia).
◦ Clinical identification of specific behavior changes that indicate that a restraint is no longer necessary.
◦ Monitoring the physical and psychological well-being of the patient who is restrained, including, but not limited to: respiratory and circulatory status, skin integrity, vital signs and any special requirements specified by hospital policy associated with the 1-hour signs and face-to-face evaluation.

If a death should occur to a patient caused by a restraint or while in seclusion:

1. The charge nurse will notify the risk manager, nursing supervisor and the AOD.
2. Document the date, time and persons notified on the physician’s progress notes in the patient’s record.
3. Complete a variance report.
   The risk manager will notify the CMS regional office of a death associated with restraint or seclusion prior to the close of business on the day following the patient death. Documentation of the date and time CMS was notified shall be recorded in the patient's medical record.
4. If a patient expires within one week of restraints being removed, the risk manager must be notified to investigate the case and facilitate a report to CMS if the death is believed to be caused by the restraint application.

Performance Improvement:

1. A restraint log will be kept on each unit to track patients who are in restraints. The log will contain:
   Patient’s name
   Date and time of order
   Shift restraint present
   Type of restraint
2. Performance improvement data will be collected per the nursing PI process and reported at least on a quarterly basis to identify trends, deficiencies and educational opportunities.

REFERENCES:

TJC Standard PC.03.05.01; PC.03.05.03; PC.03.05.05; PC.03.5.07; PC.03.05.09; PC.03.05.11; PC.03.05.13; PC.03.05.15; PC.03.05.17; PC.03.05.19
CMS: §482.13 (Standard: Restraint or Seclusion) A-0154 through A-0214

ATTACHMENTS:

Posey Application Instruction Sheets
Restraint Log – NS 602
SI/HI/Restraint flowsheet NS 730
Restraint Order – Behavior Management – PO 242
Restraint Order – Medical Management – PO241
Restraint algorithm
Restraints Behavioral Chemical Careplan
Restraints Behavioral Physical Adult Careplan
Restraints Medical Adult Careplan
### PHYSICAL RESTRAINTS APPLICATION PROCEDURE

#### APPLICATION OF SOFT EXTREMITY CUFF(S) AND TWICE AS TOUGH CUFF(S):

<table>
<thead>
<tr>
<th>Steps:</th>
<th>Key Points:</th>
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</thead>
<tbody>
<tr>
<td>1. Place soft side of device next to skin.</td>
<td>Allow for one finger to move easily under cuffs.</td>
</tr>
<tr>
<td>2. May be applied unilaterally, bilaterally (both wrists), in opposite sequence (i.e. right wrist –left leg), bilateral wrists, one leg or all four extremities.</td>
<td>If patient has an IV at restraint site, apply Kerlix over site to prevent injury.</td>
</tr>
<tr>
<td>3. If a patient is in bed, secure ties to bed frame using the <strong>clip</strong>. If the patient is sitting in chair, secure straps in a safe position behind chair using the <strong>clip</strong>.</td>
<td><strong>NEVER</strong> secure ties to any part of the bed/chair that moves (i.e. side rails, mattress or hinges) so that effectiveness of restraint is maintained. Place side rails in up position. Side rail covers may be needed to prevent patient's body or head from going under, around, through or between side rails which could result in injury.</td>
</tr>
<tr>
<td>4. If a patient is in bed, secure ties to bed frame using the <strong>clip</strong>. If the patient is sitting in chair, secure strap in a safe position behind chair using the <strong>clip</strong>.</td>
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#### APPLICATION OF POSEY VEST:

<table>
<thead>
<tr>
<th>Steps:</th>
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<tbody>
<tr>
<td>1. Determine the correct size based on the patient's weight. X-small (up to 110 lbs.) Small (110 – 130 lbs.) Medium (120 – 160 lbs.) Large (150 – 185 lbs.) X-large (175 – 200 lbs.) XX-large (200 lbs. or more)</td>
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<tr>
<td>2. Place a clean hospital gown on the patient.</td>
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<tr>
<td>3. Place vest on patient's upper body with the opening in front.</td>
<td>3. Allow for 1 finger to move easily around strap areas.</td>
</tr>
<tr>
<td>4. Fasten shoulder ties behind the head at one side to secure vest and ensure comfortable fit.</td>
<td>4. Make sure that skin beneath the vest straps in intact or protected.</td>
</tr>
<tr>
<td>5. Tie waist straps to a part of the bed frame, chair/ wheelchair that can move with the patient if applicable. Use square knot to secure the straps to the bed frame or chair.</td>
<td>5. Never attach to the bed rails or to the head of the bed.</td>
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#### CARDIAC –CHAIR/WHEELCHAIR:

<table>
<thead>
<tr>
<th>Steps:</th>
<th>Key Points:</th>
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</thead>
<tbody>
<tr>
<td>1. Assist patient into chair.</td>
<td>1. Provide appropriate amount of staff to assist patient without injury to staff or patient.</td>
</tr>
<tr>
<td>2. If chair is equipped with Velcro belt, secure around patient's waist.</td>
<td>2. Make sure chair is in locked position prior to moving patient into chair.</td>
</tr>
<tr>
<td>3. For Geri-chair: place tray over arm of chair.</td>
<td>3. Slide into locked position while ensuring patient's arms are above tray (to protect patient from injury).</td>
</tr>
</tbody>
</table>

#### APPLICATION OF HANDMITTS (Tied Down):

<table>
<thead>
<tr>
<th>Steps:</th>
<th>Key Points:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fit mitts onto hand(s) and secure.</td>
<td>1. Allow for 1 finger to move easily around wrists.</td>
</tr>
</tbody>
</table>
2. Side rail covers may be needed to prevent patient's body or head from going under, around through or between the side rails, which could result in injury.

### SIDE RAILS:

<table>
<thead>
<tr>
<th>Steps</th>
<th>Key Points:</th>
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</thead>
<tbody>
<tr>
<td>1. Move side rails up to the locked position.</td>
<td>Side rails are considered a restraint if they inhibit a patient's ability to get out of bed when they want to, and if they are involuntary (against patient's wishes). Side rails may be used alone. Side rails must always be used when any type of vest restraint, waist belt, or extremity restraint is being used.</td>
</tr>
<tr>
<td>2. Apply side rails covers, if necessary.</td>
<td>Side rail covers may be needed to prevent patient's body or head from going under, around, through or between the side rails, which could result in injury.</td>
</tr>
</tbody>
</table>

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**Attachments:**

- Application Instruction Sheets - Posey® Restraint Net
