CAMBRIDGE HEALTH ALLIANCE

Title: **CAU Physical Hold/ Restraint Policy**

Replaces (supercedes)

Policy Number: D-

Policy Type: Departmental

Effective Date 1/05

Area of Operation(s): CAU

Policy Chronicle:

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Date of Most Recent Review/Revision to the Policy:

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Printed Name of Most Recent Reviewer/Reviser:

Regulatory Agency/Standards:

JCAHO

DMH

CMS

CAU Nursing Standard of Care for Aggression

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Keyword(s): Physical Restraint, CAU Restraint, Physical Hold

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I. **Purpose:** To provide and maintain a safe environment for child psychiatric patients and their families while ensuring that care of all children is humane, non-coercive and trauma-sensitive

II. **Personnel:** All staff of the CAU

III. **Policy:** All physical holds of children to restrict movement shall be considered physical restraints.

1. Physical restraints are not done for destruction of property.

2. Physical holds are done as an emergency measure after all other less restrictive interventions have been tried unsuccessfully and all staff present agree that no other alternative is left to prevent ongoing physical assaults of other patients or staff.

3. Physical holds should be a rare occurrence that is followed by an intensive review process. The leadership of the unit is to be notified immediately following such an event.

4. Physical Holds/Restrains shall be considered incident occurrences and require that an incidence occurrence form be filled out in addition to other Restraint paperwork.

5. Physical holds are done for the least amount of time necessary with the least restrictive interventions tried first (basket hold, one wrist, two wrists, one, ankle, two ankles, etc.) Take down holds resulting in 4 limb holds are considered the most restrictive of interventions in the physical hold category.
6. The Charge nurse is responsible for coordinating that all procedures, steps, notification and documentation of all paperwork and forms are done by the end of the shift. The Charge nurse will make her/himself available within 72 hours for a review of the events leading to the decision to perform a physical restraint. Staff working during that shift and involved in the decision to implement a physical restraint should also be expected to attend a review meeting within 72 hours following the event.

7. Physical restraints should not continue 1 second beyond what is absolutely necessary in an emergency situation. Once restrained, all efforts immediately move to the fastest relief possible. If not already done, attempted Release should occur within a maximum of 30 seconds and continued release attempts every 10 to 30 seconds thereafter.

8. Every child must have an individualized “Safety Plan” that is written up, with one copy in the record, one in the Pass-On Book and one for the child. These plans should be developed within 24 hours of admission and the Parent Assessment sheet as well as input from the child should be used in developing the Safety Plan. The safety plan should identify what events, situations the child perceives as upsetting, what strategies help the child calm, what doesn’t work and the child’s preferences for helping him/her when they are aggressive.

IV. Steps:

1. A priority in the sequence of events as a child is escalating is that efforts are made to support the child (not set limits) to calm the situation down.

2. Every possible alternative must be tried exhaustively. There will need to be clear, specific documentation of each intervention to manage aggressive behavior without resorting to threats to restrain. The patient’s Safety Tool should be consulted and referred to in designing interventions to de-escalate the situation and to prevent re-traumatization.

3. Staff are required to carry out a “huddle” with all teammates on the unit to see if any one has suggestions that have not been tried and all need to agree that the restraint is the only alternative left to remedy the situation.

4. A minimum of 2 people should perform the restraint. Whenever possible another staff should participate as a “witness” to the restraint.

5. A person who has been assaulted should not be the person making the decision to restrain. This is based upon the recognition that it is hard to be objective when you have just been hit, kicked, choked or spit at. And recognizing that, we need to assure that the decision to restrain is make after calm thinking and by someone who is still able to “think out of the box” in considering alternatives.

6. When a restraint is done, it should not be assumed that all 4 limbs need to be held and that the child needs a “takedown”. Although, this may seem the safest and easiest from our point of view, it is the most restrictive hold and there is more likelihood of escalation and injury form a takedown and holding of all limbs. Decisions for types of holds should include prioritizing least restrictive holds before considering more restrictive holds. This would mean that least restrictive holds are those that involve only one-limb such as one wrist or ankle, next would be considering a “baskethold”, then 2-limb holds, next 3-limb holds and more restrictive would be a 4-limb hold. The most restrictive hold is a 4-limb hold that includes a "takedown".

7. If a child is spitting, using a sheet (holding it in front of you) as a protection for the staff is effective. It is dangerous to put anything in a child’s mouth to prevent spitting or biting. Gentle positioning of the head and changing staff position to avoid being bitten is the safest intervention for biting.
8. A physician must be called immediately—at the onset of the hold—and the physician must arrive within 1 hour to review the situation, write the order, evaluate the patient and write a restraint note.

9. Releases should occur as soon as possible, but the maximum time allowed before an attempt at release is 30 seconds. Continued attempts at release should occur rapidly with the maximum interval between release attempts being 30 seconds. After 2 minutes with a child and no sign of calming; then the team holding the child should switch off with other staff. A change of faces may be just what is needed for the child to be able to come around and calm down.

10. A full account of the hold and the handling of the hold must be documented. Holds must be documented on various forms and in notes: 1) on the Physical Hold Assessment sheet; 2) a detailed Nursing Restraint note that reflects all the items covered in this protocol as well as reference to the specifics of the Safety Plan that were attempted. The time of the hold, and the length of time with release attempts times should be clearly designated with observations of the patient; and 3) In addition, all the required state DMH paperwork must be completed and all forms filled in. Of particular interest are all the interventions that were tried as the child was beginning to escalate before a decision was made to initiate a physical hold.

11. Immediately after the hold, the charge nurse is expected to call the Nurse Manager and review the entire process. If the NM is unavailable then the Medical Director should be contacted.

12. The Charge nurse must ensure that all paperwork is completed by the end of the shift. The forms should be placed in the Nurse Manager’s mailbox (upon completion) for initial review.

13. Every hold requires a formal de-briefing of all the milieu staff before the end of the shift.

14. Every hold requires an apology to the child before the end of the shift. We are apologizing because we were unable to find any other way to handle the situation and we regret any harm the hold may have had on the child. We also are expected to promise that the staff will work hard to rebuilt a relationship of trust with the child and acknowledge that trust has been breeched by the physical intervention.

15. All holds will be formally reviewed within 72 hours; and an informal review will be conducted at the next daily Rounds. Data will be compiled to look for trends regarding holds including day of week, shift, staff involved, nurse making formal order for the restraint, etc. for review and for quality improvement purposes.