I. Scope:

This policy and procedure applies to healthcare professionals with direct responsibility in the ordering, assessment, care planning, and application and/or implementation of restraints and seclusion, monitoring and care of the restrained patient. This policy is applicable to all age groups of patients, from the neonate to the geriatric population.

II. Purpose:

To provide guidance for the use and management of restraint and seclusion.

III. 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. (See Attachment A for examples of restraint).

Full Side Rails are considered a restraint if the intent is to restrict the patient's freedom to exit the bed. Methods that protect the patient from falling out of bed that are NOT considered a restraint are raised side rails on a stretcher, when patient is recovering from anesthesia, sedated, experiencing involuntary movement, seizure precautions, or on certain types of therapeutic beds.

Chemical Restraint: The use of any chemical, including pharmaceuticals, through topical application, oral administration, injection, or other means, for purposes of restraining an individual which is not a standard treatment for the individual's medical or psychiatric condition.

Seclusion: The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. 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. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member, or others.

Trained Registered Nurse or Physician Assistant: A registered nurse or physician assistant who has been trained to complete the 1 hour face to face evaluation. Training includes content to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion. An evaluation of the patient's medical condition would include a complete review of systems, behavioral assessment, as well as review

This policy and any related procedures or guidelines were developed based on available evidence, regulatory standards, and accreditation requirements. Caregivers are accountable for following policies, procedural steps, and/or guidelines as they carry out their responsibilities. However, no clinical policy, procedure, or guideline can account every situation, so caregivers remain responsible for exercising their clinical judgment within their scope of practice and varying from a policy, procedure, or guideline in the event where the patient's circumstances fall outside the scope of the policy.

and assessment of the patient's history, medications, most recent lab results, etc. The purpose of the 1-hour face-to-face evaluation is to complete a comprehensive review of the patient's condition and determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior.

Violent behavior is violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member or other.

IV. Policy:

A. It is hospital policy to support each patient's right to be free from restraint or seclusion and therefore limit the use of these interventions to emergencies in which there is an imminent risk of a patient physically harming him/her or others. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. The patient has a right to be free from restraint or seclusion imposed as a means of coercion, punishment, discipline, or retaliation by staff. Restraint or seclusion use will not be based on history of past use or dangerous behavior, as a convenience for staff, or a substitute for adequate staffing.

B. The patient's rights, dignity, privacy, safety, and well-being will be supported and maintained. Restraint or seclusion will be discontinued when the patient no longer meets criteria for the use of restraints or seclusion. Patients in restraints or seclusion will be closely monitored and evaluated and immediately assisted if a potentially dangerous situation exists, e.g. choking, seizure, etc.

C. PRN orders may not be used to authorize the use of restraint or seclusion.

D. Assessment of the patient must determine that the benefits associated with the use of restraints outweigh the risk of not restraining the patient. The assessment is documented in the patient's medical record.

E. The restrained or secluded patient's written plan of care shall be modified to address appropriate interventions implemented to assure the patient's safety and encourage the least restrictive means of protecting the patient.

F. The use of restraint must be in accordance with the order of a physician or licensed independent practitioner (LIP) who is responsible for the care of the patient and is authorized to order restraints by hospital policy and medical staff by-laws. If the attending physician is not the physician that wrote the order, he/she must be informed as soon as the patient's care provider can safely do so. The attending physician(s) is (are) the physician of record with primary responsibility for the patient's medical care during the day restraint was initiated and the following day post initiation. Documentation by the attending physician, whether or not it addresses restraint, shall constitute evidence that the physician was notified of the restraint episode.

G. When restraint or seclusion is initiated without an order by a licensed independent practitioner: An RN initiates the restraints based on an assessment that justifies the use of restraints. In these emergency application situations, the order must be obtained either during the emergency application of restraints, or when the RN/PA can safely do so.

H. Antipsychotic medications shall be used in doses consistent with the community standard, to protect the patient or others and to allow the patient to more effectively interact with the environment. (Refer to Attachment A for ordering and monitoring requirements).

I. Applicable State laws are reviewed and followed as indicated.

J. Orders

1. Violent/Self Destructive:

a. Each order for restraint or seclusion for violent or self-destructive behavior may only be renewed in accordance with the following time limits for up to a total of 24 hours:

(1) 4 hours for adults 18 years of age or older

(2) 2 hours for children and adolescents 9-17 years of age; or

(3) 1 hour for children under 9 years of age.

b. After 24 hours, before writing a new order for the use of restraint or seclusion, a physician or other licensed independent practitioner who is responsible for the care of the patient must see and assess the patient. The re-evaluation supporting the continued use of restraint or seclusion must be documented in the patient's record.

2. Non-Violent/Non-self-destructive:

a. Physician orders for restraint that is not used for the management of violent behavior shall remain in effect until:

(1) The patient's behavior or situation no longer requires restraint, or

(2) If the order includes discontinuation criteria, when such criteria are met.

(3) If the order does not include discontinuation criteria, at the end of the calendar day following the order.

K. Ongoing Monitoring:

1. Violent/Self Destructive:

a. Within one hour of the initiation of restraint or seclusion, the patient shall be evaluated in person by a physician / LIP or by a trained registered nurse or physician assistant. The ordering physician will complete the evaluation if present. A telephone call or telemedicine methodology is not allowed for these evaluations. The evaluation will be documented in the medical record. Registered nurses or physician assistants who perform such assessment shall be trained and have demonstrated competence in the management of violent behavior as specified in Attachment B of this policy.

b. When the face-to-face evaluation is conducted by a trained registered nurse or physician assistant, the attending physician or other licensed independent practitioner who is responsible for the care of the patient is notified ASAP (when it is safe to do so) after the completion of the 1 hour face-to-face evaluation. The discussion will include the results of the face-to-face evaluation, the need for other interventions or treatments, and the need to continue or discontinue the use of restraint or seclusion.

c. If a patient's violent or self-destructive behavior resolves and the restraint or seclusion intervention is discontinued before the Physician or other licensed independent practitioner arrives to perform the 1-hour face-to-face evaluation, the physician or

licensed independent practitioner is still required to see the patient face-to-face and conduct the evaluation within 1 hour after the initiation of this intervention.

d. Ongoing assessment: Assessments by a registered nurse or physician assistant or evaluations completed by a responsible Licensed Independent Practitioner shall occur as often as indicated by the patient's condition, behavior, and environmental considerations and documented at a minimum of every one (1) hour.

(1) On-going assessments include a determination that restraint or seclusion continues to be needed and that the intervention (s) remains the least restrictive to protect the patient's safety.

(2) Assessment includes documentation of a description of the patient's condition while in restraints, a description of the patient's behavior and intervention used; alternatives or less restrictive interventions attempted; patient's response to the interventions, and a review and revision of the plan of care as needed.

e. Ongoing monitoring: Restrained or secluded patients shall be subject to monitoring by individuals trained to do so. Patients who are restrained/secluded for violent/self-destructive behavior shall be continuously monitored through:

(1) Face-to-face observation by staff members or

(2) Remote observation by staff members located near the patient who are viewing a simultaneous video image and audio signal of the patient.

(3) Monitoring may include VS, respiratory and cardiac status, skin integrity checks, I&O, hygiene, and injury. The patient's fluid, nutritional and toileting needs are addressed on an ongoing basis according to the individual needs of the patient.

(4) Documentation of monitoring shall occur at a minimum of every 15 minutes.

2. <u>Non-Violent/Non-Self Destructive:</u>

a. Restraint not used for the management of violent behavior shall be subject to ongoing monitoring and assessment as specified in the patient's plan of care. Monitoring is expected to occur a minimum of every 2 hours.

b. The RN is responsible for monitoring the patient but may be assisted by non-licensed personnel to obtain vital signs and perform comfort measures.

c. Documentation of Monitoring: Episodes of restraint shall be documented as indicated on currently approved assessments, monitoring and ordering forms and computer screens and may include skin integrity, hygiene, nutrition, elimination, circulation, vital signs, and reaction to restraints, Concurrent documentation of monitoring is not required, however, a statement that monitoring occurred, with variances in care noted (if any) must be annotated by the end of the nurse's shift.

L. Discontinuance/release of restraint:

1. An RN competent in the use of restraints may remove the restraints or discontinue seclusion

a. when behaviors or situations that prompted the use of restraint are no longer evident; or

b. it is determined that less restrictive measures will be effective in protecting the patient/other.

M. Documentation related to restraint or seclusion includes:

1. The initial assessment of the patient related to restraint or seclusion use;
2. Documentation of each episode of restraint or seclusion includes:
   a. The circumstances that led to the use of restraint or seclusion
      (1) Specific behaviors
      (2) Detailed description of events leading up to the incident and other pertinent information
   b. Consideration or failure of non-physical interventions
   c. The rationale for use and continued use of restraint or seclusion
   d. Notification of the patient’s family when appropriate
   e. Orders for use – including each order for continuation
   f. Any injuries sustained and treatment received for these injuries
   g. Time of initiation and termination of restraint or seclusion
   h. Treatment plan (Interdisciplinary Plan of Care) review/revision

N. The hospital adheres to State and Federal requirements regarding reportable events regarding restraint use.

3. With the exception of the deaths described below in section 2: The organization reports the following information to the Centers for Medicare & Medicaid Services (CMS) by close of business of the following day after the event is discovered:
   a. Each death that occurs while a patient is in restraints or seclusion;
   b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion;
   c. Each death known to the hospital that occurs within one week after restraint or seclusion were used when it is reasonable to assume that the use of the restraint or placement in seclusion contributed directly or indirectly to the patient’s death; regardless of the type(s) of restraint used on the patient during this time. “Reasonable to assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.
   d. The report sent to CMS will become part of the patient’s medical record. The report will include the date and time that the death was reported to CMS.

4. When the only restraint used is soft wrist restraints and no seclusion has been used, the

hospital staff must record the following information in an internal log:

a. Any death that occurs while a patient is in soft wrist restraints;
b. Any death that occurs within 24 hours after a patient has been removed from soft wrist restraints;
c. Each entry in the internal log must be made no later than seven (7) days after the death of the patient. The staff must document in the medical record the date and time the death was recorded in the internal log;
d. Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care of the patient;
e. The information must be made available in either written or electronic form to CMS immediately upon request.

V. <u>References:</u>

1. Centers for Medicare and Medicaid Programs. State Operations Manual: Conditions of Participation.
2. Hospital Accreditation Standards. Joint Commission Resources, Oakbrook, IL.

Attachment A

Examples of Physical Restraint

Device	Not Restraint	Restraint
Devices to protect the patient during a procedure or anesthesia	During a procedure or anesthesia.	Once the patient has recovered from anesthesia.
Side Rails	Used to keep the patient from **falling out of bed.**	Used to keep the patient from **getting out of bed.** (Order may be PRN)
Mittens	Not tied down. Allows use of hand / fingers.	Patient cannot flex fingers or does not have access to his / her body.
Arm Boards	To protect site of intravenous access.	If used to prevent the patient from having access to his or her body.
Adaptive Devices: Seat belts, waist belts, Geri chairs, etc.	The patient can remove the device (or remove themselves from the device) in the same manner in which it was applied (e.g. unlatching a seat belt, untying a knot, letting the side rail down)	The patient cannot easily remove the device. (Order for Geri-chair may be PRN)
Covered bed	Covered bassinet for infants or toddlers.	For adults to keep them from getting out of bed.
Protective interventions for infants, toddlers and pre-school children	Stroller safety belts; seat belts for high chairs; etc.	
Holding the patient	Light touching during escort	Therapeutic hold
Holding to give medications or treatments	Voluntary	Forced
Forensic Devices (handcuffs, shackles)	Used for patients in custody	May not be used as a device for restraint

Examples of Seclusion

Not Seclusion	Seclusion

Confinement on a locked unit or ward where the patient is with others.	Confinement in a locked room apart from other patients
Having the patient agree to confine their movements to a room with an open door.	Physically preventing a patient from leaving an unlocked room
A “time out” in a quiet (unlocked) location.	Preventing a patient from leaving an unlocked room through intimidation.

Antipsychotic Medications Used to Manage Violent Behavior

Not Chemical Restraint	Chemical Restraint
FDA-approved use of an antipsychotic medication to manage violent behavior.	Off-label use of an antipsychotic medication to manage violent behavior.
Ativan for the management of violent behavior of unknown etiology. Geodon used for the management of violent behavior in patients suffering from schizophrenia or bipolar disorder.	Geodon for the management of violent behavior of unknown etiology.
Order may be PRN	Orders may **not** be PRN
Order renewed as required in medication management policy.	Order renewed at least every 4 hours for adults, every 2 hours for adolescents, and every 1 hours for children.
Medication and dose are consistent with professional standards of practice.	
Used for the safety of patients or others and to help the patient more effectively interact with their environment	
May NOT be used for staff convenience.	
Documentation describes the behavior supporting the use of the medication.	
Monitoring of vital signs appropriate for the potential sedating effects of the medication and dose.	

Attachment B
Restraint and Seclusion Training Plan

The restraint and seclusion training plan shall be based on the results of quality monitoring activities. Minimum training shall include:

1. The policy requirements and education for physicians who order restraint or seclusion.
2. The instruction and competency requirements of hospital staff who assess patients for restraint, determine that restraint is indicated, or who apply restraint including:
   a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
   b. The use of nonphysical intervention skills.
   c. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
   d. The safe application and use of all types of restraint or seclusion used by the staff member, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);
   e. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
   f. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, and vital signs.
   g. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic re-certification.
   h. Recognition of signs of physical and psychological distress for hospital staff that monitor restrained patients.
3. Trained Registered Nurses and physicians assistants who perform face-to-face assessments shall have demonstrated competence in the management of violent or self-destructive behavior.