

Title: **RESTRAINT AND/OR SECLUSION**

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 Approved By: **Garren Colvin, EVP/COO**

 Policy No.: **ACLIN-R-03**

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 Interdisciplinary Review: **Restraint PI Committee; Clinical Coordination Committee; Patient Care Committee**
POLICY:

All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint and/or seclusion may 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.

 1. **PHILOSOPHY:**

The St Elizabeth organization is committed to preventing, reducing, and working to eliminate the use of restraints and seclusion. Hospital Leadership supports the philosophy to use non-physical interventions and to use guidelines to promote, safety, dignity and wellbeing when physically restrictive measures become necessary to promote healing. Restraint or seclusion 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. These requirements are specific to the patient behavior that the restraint or seclusion intervention is being used to address.

 2. **DEFINITIONS:**

A. **A restraint** is 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 and cannot be easily removed by the patient.

B. **Restraints for Non-Violent / Non-Self-Destructive Behaviors** may be considered appropriate when the patient displays potentially harmful behaviors toward self or jeopardizes their health and safety, interfering with required treatment/life support measures, and when alternatives / other methods are ineffective to protect the patient from harm. Examples of appropriate uses of non-violent/ non-self-destructive restraints would include pulling IV lines and tubes or attempts to compromise airways

C. **Restraints used for Violent / Self-Destructive Behaviors** are used to protect the patient against injury to self or others. These types of restraint or seclusion are used when the patient's violent or self-destructive behavior jeopardizes the immediate physical safety of the patient, staff, or others and when others methods are ineffective to protect the patient, staff or others from injury or harm.

1. Violent/ self-destructive - restraints are intended to be a brief intervention, to allow time for calming the patient and advancing them toward less restrictive alternatives and preventive strategies.

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- D. **A chemical restraint** – is 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. The St. Elizabeth organization does not support the use of a drug or medication used as restraint.
- E. **Seclusion** – is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.
1. Seclusion is used only in the behavioral health units or the emergency departments.
 2. Restraints and seclusion are used only when less restrictive interventions are ineffective.
 3. If a patient becomes violent and is an immediate danger to self and staff, the use of the restraint or seclusion is outweighed by the risk of not using the restraint or seclusion.
 4. Less restrictive interventions do not always need to be tried, but less restrictive interventions shall first be determined by staff to be ineffective to protect the patient or others from harm prior to the introduction of more restrictive measures.
3. **ALTERNATIVES AND PREVENTIVE STRATEGIES TO USE OF RESTRAINT:**
- A. Alternatives are considered before using restraint on any patient and particularly on potentially vulnerable patients, such as emergency, pediatric or cognitively and/or physically limited patients.
- B. Alternatives may include but are not limited to the following methods:
1. Moving the patient closer to the nursing station
 2. Using bed device alarms
 3. Toileting more frequently
 4. Encouraging family/visitor visits and/or participation
 5. Engaging the patient in diversion activities
 6. Using pharmacologic interventions as appropriate
 7. Evaluating for potential medication interactions
 8. Evaluating current lab values
 9. Assessing sleep deprivation.
 10. Repositioning the patient for comfort
 11. Assessing for substance abuse
4. **TYPES OF RESTRAINTS**
- St. Elizabeth Healthcare has approved the use of the following restraints in accordance with manufacturer instructions:
- A. Side rails up X 4
 - B. Mitts
 - C. Joint Immobilizer
 - D. Soft Limb
 - E. Body Holder
 - F. Twice as Tough (unlocked)
 - G. Physical Hold during force administration of psychotropic medication (violent)
 - H. 3 or 4 -point (unlocked, used for violent/self-destructive behavior only)

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- I. 3 or 4- point (locked, BH only)
- J. Swedish belt (locked, BH only)
- K. Twice as Tough (locked, BH only)

5. CRITERIA FOR USE OF RESTRAINT:

- A. A restraint is used only if needed to improve the patient's well-being and less restrictive interventions have been found to be ineffective to protect the patient or others from harm.
- B. Restraints are implemented in the least restrictive manner possible and are ended at the earliest possible time.
- C. When practical, restraint use is discussed with the patient and, when appropriate, with the patient's family around the time of restraint application.
- D. A restraint **does not include** orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physically 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 (this does not include a physical escort).
- E. A restraint does not include methods that promote and/or protect the patient from harm.
Examples:
 - 1. The use of side rails on therapeutic beds to improve circulation or prevent skin breakdown.
 - 2. The use of padded side rails for seizure precautions.
 - 3. The use of raised side rails for a patient on a stretcher.
 - 4. Use of restraints during recovery from anesthesia that occurs when the patient is in critical care or PACU. However, if restraints continue after transfer to another unit or after the patient recovers from the effects of anesthesia, a restraint order is necessary.
- F. The use of handcuffs, manacles, shackles or other chain type restraint devices applied by non-hospital employed or contracted law enforcement officials for custody, detention and public safety reasons are not governed by this policy. See policy: Legally Restricted Patients SEC-L-01.
- G. Restraints may be used if indicated for patients with nasal Bi-Pap; restraints are not used on patients with Bi-Pap where a full-face mask is indicated.
- H. Physically holding a patient during forced psychotropic medication procedures is considered a restraint, and requires an order and documentation consistent with violent/self-destructive restraints.
- I. Restraints are not a routine part of a fall prevention program.
- J. **Restraints used for Non-Violent / Non-Self-Destructive Behaviors**
 - 1. Restraints for non-violent/non-self-destructive behavior are used when the patient is unable to follow directions and is exhibiting unsafe behaviors such as: pulling IV lines, tubes, or airways or displaying potentially harmful behaviors toward self.
 - 2. In all cases, the least restrictive form of restraint that protects the physical safety of the patient, staff or others is used.
 - 3. Restraints are discontinued at the earliest possible time, regardless of the scheduled expiration of the order.

K. Restraints or seclusion used for Violent / Self-Destructive Behaviors

1. Restraints or seclusion for violent or self-destructive behavior are used to protect the patient against injury to self or others. These types of restraints are used when the patient's violent or self-destructive behavior jeopardizes the immediate physical safety of the patient, staff, or others, and when other methods are ineffective to protect the patient or others from injury or harm.
2. Restraints and/or seclusion are discontinued at the earliest possible time, regardless of the scheduled expiration of the order.
3. In all cases, the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff or others is used.
4. Seclusion may only be used for the management Violent / Self-Destructive behavior that jeopardize the immediate physical safety of the patient, the staff member or others on the Behavioral Health Units or in the Emergency Departments.

6. ORDERS:

- A. A physician or APRN, who is responsible for the care of the patient and authorized to order the application of restraints, must order the use of restraints or seclusion.
- B. Each order must include the justification for the use of restraint and/or seclusion and type of restraint.
- C. The expectation is that a physician or APRN responsible for the care of the patient, places the order for the restraint or seclusion immediately prior to the application of the device.
- D. In some situations, however, the need for a restraint or seclusion intervention may occur so quickly that an order cannot be obtained prior to the application of restraint or seclusion. In these emergency situations, the RN may make the decision to utilize the restraints, but the order must be obtained either during the emergency application of the restraint or seclusion, or immediately (not to exceed 30 minutes) after the restraint or seclusion has been applied. The failure to immediately obtain an order is viewed as the application of restraint or seclusion without an order.
- E. If the attending physician did not order the restraint, he or she must be consulted as soon as possible but not to exceed two hours. If the attending physician is unavailable, responsibility for the patient must be delegated to another physician, who is then considered to be the attending physician.
- F. If more than one intervention or multiple types of restraints are needed all must be included in the order. (example: soft limbs and a body holder – both must be selected)
- G. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).
- H. A "Trial Release" constitutes a PRN use of restraints or seclusion and therefore is not permitted. A temporary, directly supervised release that occurs for the purpose of providing care for a patient's needs or to observe for early release, is not considered a discontinuation of restraints or seclusion intervention.
- I. If a patient was recently released from restraint or seclusion, and exhibits behavior that can only be handled through the reapplication of restraint or seclusion, a new order is required.
- J. If continued use of the restraint is indicated, each order for restraint used to ensure the physical safety of the Non-Violent / Non-Self-Destructive patient is renewed each calendar day.

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- K. Within one hour of initiating violent/self-destructive restraints, a **Face-to-Face** physical and behavioral assessment is completed by a physician or APRN. If the restraint or seclusion is discontinued before the face-to-face assessment is conducted, the one hour face-to-face evaluation is still required to be completed.
- L. Orders for violent/self-destructive restraints may be renewed according to the times limits listed below for a maximum of 24 consecutive hours. A face to face evaluation must be conducted within every 24 hours. Restraints and/or seclusion may only be employed while the unsafe situation continues. Once the unsafe situation ends, the restraint or seclusion is discontinued.
- M. Orders for violent / self-destructive restraints are time limited not to exceed 4 hours for patients 18 years of age or older, 2 hours for children 9 – 17 years of age, 1 hour for children younger than 9 years old. If the need for restraints continues beyond the above time frames, a new order is required. The need for continued use of restraints or discontinuation is determined by the assessment of the RN.
- N. All orders will be acknowledged by the RN responsible for the care of the patient.
1. Acknowledgment of an order consists of the following:
 - a. The order was obtained at the correct time, immediately (not to exceed 30 minutes) of application.
 - b. The device(s) and location of device(s) were ordered correctly.
 - c. Any modification of the order must occur at the time of acknowledgment.
7. ASSESMENT – MONITORING – DOCUMENTATION:
- A. **NON-VIOLENT/NON-SELF-DESTRUCTIVE RESTRAINTS:**
1. The presence of a restraint order is verified on the restraint flowsheet every shift.
 2. Document that the attending physician was notified with the initial order.
 3. Direct visual observation of patient behavior while in non- violent restraints is individualized based on patient needs, but at a minimum occurs once every 2 hours.
 4. Perform range of motion exercises every 2 hours while patient is awake.
 5. Perform circulation and skin assessments of restrained extremities every 2 hours.
 6. Vital Signs (BP, P and R) every 4 hours
 7. Offer fluids/bathroom/bedpan every 2 hours while patient is awake.
 8. Assess if a less restrictive intervention may be appropriate.
 9. Provide documentation for justification of continued use every 2 hours.
 10. Provide personal hygiene needs as patient requires but not less than every 24 hours.
 11. Provide patient and family (if present) education indicating the reason for restraints and the type of restraint used as appropriate initially and as needed.
- B. **VIOLENT/SELF-DESTRUCTIVE RESTRAINTS:**
1. The Restraint Order for violent /self-destructive restraints should be renewed every four hours for patients 18 years of age and older, every 2 hours for 9-17 years old, and every 1 hour for children younger than 9 years of age.
 2. Document that the attending physician was notified with the initial order.

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3. Direct observation of the patient behavior while in **restraints or seclusion** is determined on an individual basis but occurs at least every hour. Observation may be by video surveillance or in person.
4. For patients in **simultaneous restraints and seclusion**, direct visual observation is continual in 1:1 patient care, and is recorded every 15 minutes.
5. Assess if a least restrictive intervention may be appropriate.
6. Reassessment for the continued use of restraints or seclusion occurs in person every 2 hours or more frequently if indicated. Reassessment for the continued use of simultaneous restraints **and seclusion is done in person and at a minimum every 1 hour.**
7. **Use or restraints and/or seclusion** is only employed while the unsafe situation continues.
8. Perform circulation and skin assessments of restrained extremities every 2 hours.
9. Vital signs: (BP, P and R) every 2 hours
10. Perform range of motion exercises every 2 hours while patient is awake. It may be necessary to remove each restraint one at a time and re-apply before removing the next.
11. Offer fluids/bathroom/bedpan every 2 hours while patient is awake.
12. Provide personal hygiene needs as patient requires but not less than every 24 hours.
13. Provide patient and family (if present) education indicating the reason for restraints and the type of restraint used as appropriate initially and as needed.

8. TRAINING / EDUCATION:

A. Physicians/Advance Practice Nurses (APRNs)

1. Physicians and APRNs authorized to order restraint or seclusion must have a working knowledge of hospital policy regarding the use of restraints or seclusion.
2. Education regarding use of restraints is documented in their initial and re-appointment applications to the medical staff.

B. Staff

1. Staff members receive training for their assigned duties performed under this policy.
2. Training on restraint use occurs while in orientation and periodically thereafter. If a staff member has not received the restraint education, that staff member does not care for a patient independently until the training is completed. RNs are provided education on determining the initial and continued need for restraint or seclusion.

C. Training requirements include the following components:

1. Patient behaviors, events and environmental factors that may trigger behaviors that require the use of restraints and/or seclusion;
2. Appropriate alternative and preventive interventions to restraints;
3. The use of nonphysical intervention skills;
4. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition;
5. The safe application and use of restraints, including training on how to recognize and respond to signs of physical and psychological distress;
6. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary;

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7. Monitoring the physical and psychological well-being of the patient who is restrained, including respiratory, circulatory status, skin integrity and vital signs.
8. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation.

9. CRITERIA FOR THE DISCONTINUATION OF RESTRAINTS:

- A. Restraints for **Non-Violent / Non-Self-Destructive** Behaviors are discontinued when the patient's behavior ceases and he/she no longer displays potentially harmful behaviors toward self which jeopardizes their health and safety, interfering with required treatment/life support measures.
- B. Restraints used for **Violent / Self-Destructive Behaviors** are discontinued when the patient's behavior ceases and he/she no longer exhibits violent/self-destructive behavior which jeopardizes the immediate physical safety of the patient, staff, or others.

10. PLAN OF CARE:

- A. The treatment plan is reflective of an assessment and evaluation of the patient indicating an identified problem, the need for a restraint or seclusion, and what restraints are implemented.
- B. The patient's plan of care is based upon the patient's individual condition and needs.
- C. The plan of care is reviewed and updated by the RN every shift and more often as needed.
- D. The patient and the family is updated of changes in the plan of care when appropriate.

11. DEATH REPORTING:

- A. The Quality Management department is responsible for reports of deaths associated with restraint and or seclusion use according to CMS requirements.

12. PERFORMANCE IMPROVEMENT

Performance improvement processes are used to appropriately evaluate the use of restraint and / or seclusion with a focus on prevention, reduction and improved patient outcomes.

ATTACHMENTS:

- **References**
- **Restraint Required Documentation**
- **Face to Face Evaluation Form**

REFERENCES:

CMS, Interpretive Guidelines 482.13

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Pierce, L. (2006). *Management of the Mechanically Ventilated Patient, 2nd ed.* St Louis, MO: Saunders Elsevier.

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RESTRAINT REQUIRED DOCUMENTATION

Physician / APRN (Advanced Practice Nurse) Order		All Orders for Restraint or Seclusion should be obtained prior to the initiation of restraints or seclusion. In emergency situations, the RN may make the decision to utilize the restraints, but the order must be obtained either during the emergency application of the restraint or seclusion, or immediately (not to exceed 30 minutes) after the restraint or seclusion has been applied.		
Elements of Documentation		<u>Non-Violent</u> <u>Non-Self-destructive</u> <u>Behavior</u>	<u>Violent /</u> <u>Self-Destructive</u> <u>Behavior</u> <u>Restraint or Seclusion</u>	<u>Violent /</u> <u>Self-Destructive</u> <u>Simultaneous use of Restraint</u> <u>and Seclusion</u>
Face to Face Evaluation		Not required	For Violent / Self-Destructive behaviors, a face-to-face evaluation will occur <u>within 1 hour</u> of initial application. A face-to-face evaluation is not required with each order renewal. The physician or APRN must re-evaluate the patient within 24 hours and within every 24 hours.	
Frequency of physician/APRN order renewal		Every calendar day	<ul style="list-style-type: none"> • Every 4 hrs. – Adults 18 and older • Every 2 hrs. – Children 9-17 • Every 1 hr. – Children under 9 	<ul style="list-style-type: none"> • Every 4 hours - Adults 18 and older • Not appropriate for patients under 18
Attending Physician Notified		As soon as possible within 2 hours	As soon as possible within 2 hours	As soon as possible within 2 hours
Education		Initially and as needed	Initially and as needed	Initially and as needed
Least Restrictive	Assess for the least restrictive intervention	Every 2 hours	Every 2 hours except for children under 9 every 1hour	Every 1 hour
Justification of continued use	Observe Behavior	Every 2 hours	Every 2 hours	Every 1 hour
Observation	Direct visual observation	Individualized based on patient needs, at minimum, once every 2 hours	Individualized based on patient needs, at minimum, once every 1 hours	1:1 Care, Document Every 15 minutes.
Assessment/ Monitoring	Level of distress / agitation	Every 2 hours	Every 2 hours	Every 2 hours
	Cognitive function / mental status	Every 2 hours while awake	Every 2 hours while awake	Every 2 hours while awake
	Circulation / Skin	Every 2 hours	Every 2 hours	Every 2 hours
	Vital Signs	Every 4 hours	Every 2 hours	Every 2 hours
	Range Of Motion	Every 2 hours while awake	Every 2 hours while awake	Every 2 hours while awake
	Hydration / Nutrition	Every 2 hours while awake	Every 2 hours while awake	Every 2 hours while awake
	Elimination	Every 2 hours while awake	Every 2 hours while awake	Every 2 hours while awake

PROGRESS NOTES
FACE TO FACE EVALUATION FORM
 VIOLENT/SELF- DESTRUCTIVE RESTRAINTS
 ONE HOUR OR 24 HOUR
PHYSICIAN/APRN EVALUATION FORM

Originated: Revised: 12/09, 04/12, 08/14
 Medical Record File No.: BH R-07 Form No. 8339 - SEH

DATE/TIME	
	Date and Time Restraint/Seclusion Applied:
	Admission Diagnosis:
	Behavior Necessitating Restraint/Seclusion:
	Current situation/behavior:
	Patient History: rule out other causes of behavior such as electrolyte imbalance, sepsis, hypoxia, dementia, drug/alcohol abuse, drug interactions
	Physical Assessment:
	<ul style="list-style-type: none"> • Vital Signs In The Last Hour: BP: P: R: T: • NAD, Acynotic: • Chest: CL to A, Easy Resp: • Heart: RRR: • Abd: Soft, NT, BS+: • Vasc: Cap Refill – Normal: • Neuro: LOC, Change in Speech, Seizure:
	Review recent lab/tests:
	<input type="checkbox"/> Electrolytes <input type="checkbox"/> O ₂ Sat <input type="checkbox"/> Other <input type="checkbox"/> CBC <input type="checkbox"/> Urine
	Review medications:
	<ul style="list-style-type: none"> • Current medications • Medication PTA
	Behavioral Assessment:
	<ul style="list-style-type: none"> • Level of Distress/Agitation: • Cognitive Function/Mental Status: • Behavior:
	Reaction to restraint/seclusion or medications given:
	Recommendation: <input type="checkbox"/> Continue restraints/seclusion <input type="checkbox"/> Terminate restraint/seclusion <input type="checkbox"/> Change Invention (order)
	Physician/APRN Signature:

