



Restraint and Seclusion -- SAHS

- I. Policy Statement:** At Saint Alphonse, it is our goal to protect and preserve patients' rights, dignity, and well-being when restraint or seclusion is employed. Saint Alphonse recognizes that all patients have the right to be free from any form of restraint or seclusion that is not medically necessary. Saint Alphonse does not permit the use of restraint or seclusion for the purposes of coercion, discipline, convenience, or retaliation. Restraint or seclusion will only be used as detailed in this policy to ensure the immediate physical safety of the patient, a staff member, or others.
- II. Procedure:**
- A. Use of Restraint/Seclusion:** Restraint or seclusion may only be used to ensure the immediate physical safety of the patient, a staff member, or others. In addition, 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.
1. A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint or seclusion is outweighed by the risk of not using the restraint or seclusion. While less restrictive interventions do not always need to be tried, less restrictive interventions need to be determined by staff to be ineffective and the type of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
 2. Seclusion may only be ordered for the management of violent or self-destructive behavior.
 3. Restraints are not to be sent with the patient upon discharge.
- B. Order for Restraint/Seclusion:** Except in an emergency application situation, the use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent provider who is responsible for the care of the patient and authorized to order restraint or seclusion under state law and the Medical Staff's Bylaws, Rules and Regulations. Physicians and other licensed independent providers authorized to evaluate the need for and order restraint or seclusion will have a working knowledge of this policy. In the case of an emergency application by a trained nurse, the order must be obtained either during the emergency application of the restraint or seclusion, or as soon as possible (not to exceed one hour) after application.
1. If the patient's attending physician did not order a patient's restraint or seclusion, the attending physician must be consulted as soon as reasonably possible (not to exceed one hour) and such consult may occur via telephone.
 2. Standing orders or PRN orders for restraint or seclusion are not acceptable. The restraint or seclusion may be reordered as detailed in Table 1.
 3. If a restraint or seclusion order is placed in the chart and restraint/seclusion is not used, or if restraint/seclusion is removed or discontinued, a new order for restraint/seclusion is required if restraint/seclusion is needed later.

4. Licensed nurses or other trained health care staff may temporarily remove restraints for patient care treatment/activities as needed and reapply afterwards. Patient behavior requiring restraint should be evaluated when restraints are removed for cares.
 5. Oregon Only: After 24 hours of continuous violent/self-destructive restraint or seclusion, an examination and second opinion must occur by a second physician prior to further restraint and seclusion.
- C. **Observations and Assessment/Discontinuation of Restraint or Seclusion:** The condition of the patient who is restrained or secluded must be observed and assessed by a physician, other licensed independent provider, or trained nursing staff as detailed in Table 1.
1. Patients who are in violent/self-destructive restraints or seclusion must be seen face-to-face within one hour of initiation of the intervention by a physician, other licensed independent provider, or trained nursing staff.
 - a. The face-to-face evaluation must 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.
 - b. If the face-to-face evaluation is conducted by trained nursing staff, the patient's physician or other licensed independent provider must be consulted as soon as possible.
 2. The restraint or seclusion must be discontinued at the earliest possible time when the patient no longer presents an immediate risk of harm to self or others regardless of the length of time defined in the order.
 3. The risk of harm must be assessed by a physician, other licensed independent provider, or trained nursing staff prior to releasing the patient, and the removal of restraint/seclusion must be documented as detailed in Table 1.
- D. **Documentation:** (See Table 1.)
1. Plan of care should be updated in accordance with the individualized needs of the patient.
 2. Education of patients and family members, including the reason for restraint/seclusion and when the restraint/seclusion can be discontinued, must be documented.
- E. **Law Enforcement Restraint Devices:** The use of law enforcement restraint devices (including, but not limited to, handcuffs, manacles, shackles, other chain-type restraint devices, spit masks and hoods) are not considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients. When a law enforcement officer applies restraint devices to a patient, the law enforcement officer must maintain custody and direct supervision of the prisoner who is the hospital's patient.
1. The law enforcement officer is responsible for the use, application, and monitoring of these restrictive restraint devices in accordance with state law.
 2. The hospital is responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient who is in the custody of a law enforcement officer.
 3. In the event a patient arrives at Saint Alphonsus with a spit hood/mask placed by a third party such as ambulance personnel or law enforcement, colleagues should request removal or remove it immediately. If the third party does not agree to remove it, or attempts to interfere with the removal of the spit hood/mask, colleagues should escalate the concern to the Clinical Coordinator. Colleagues should wear PPE if patient engages in activity attempting to cause contact with any form of bodily fluid.

- F. **Colleague Education:** Restraint and seclusion education will be provided upon new hire orientation and periodically thereafter. Colleagues in Oregon will be provided annual education.
1. Licensed Nurses having direct contact with patients who may require restraint and/or seclusion will have initial orientation and ongoing education/competency assessment completed by qualified trainers covering:
 - a. Techniques to identify staff and patient behaviors, events, and environmental factors which may trigger circumstances requiring restraint or seclusion.
 - b. The use of non-physical intervention skills (redirecting, diversion, etc.).
 - c. Choosing the least restrictive intervention based on an individualized assessment of the patient's condition.
 - d. Safe application and use of restraints and seclusion, including return demonstration and how to recognize and respond to signs of physical and psychological distress.
 - e. Identification of behavior changes indicating 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 as indicated.
 2. Registered Nurses authorized to complete face-to-face evaluations for patients in violent restraints or seclusion will have initial orientation and annual training in the evaluation of a patient's immediate situation, reaction to the intervention, medical and behavioral condition, and continued need for restraint or seclusion.
 3. Other colleagues who may provide direct patient care for patients in restraint or seclusion (e.g., physical therapists, respiratory therapists) will have initial orientation and ongoing training covering:
 - a. Techniques to identify behaviors, events, and environmental factors that may trigger a need for restraint.
 - b. Potential hazards of restraints.
 - c. Techniques for safe application of various types of restraint.
 - d. Safety precautions for working with patients in restraint.
- G. **Injury:** A VOICE report will be completed as soon as possible for any injury to a patient that occurs during the application or use of restraint or seclusion so that the situation may be investigated and addressed, as needed. Additionally, depending upon the nature of the injury, the situation may need to be escalated as set forth in Saint Alphonsus' Administrative Delegation of Authority and Administrator On Call Responsibilities Policy.
- H. **Death Reporting:** Any death that occurs while a patient is in restraint or seclusion, any death that occurs within 24 hours after the patient has been removed from restraint or seclusion, or any death where it is reasonable to assume the use of restraint or seclusion contributed directly, or indirectly, to the patient's death, must be promptly reported to the Clinical Coordinator.
1. The Clinical Coordinator must promptly report these deaths to the Quality Department and Administrator On-Call.
 2. The Quality Department will make any required reports to CMS and the State, as well as maintain any needed log of patient deaths, as required under 42 CFR 482.13.(g) and applicable state law.
 3. Oregon Only: In addition to the requirements outlined above, any death that occurs while a psychiatric patient is in seclusion or restraint must be reported

to the Addictions and Mental Health Division within 24 hours of death.

III. Definitions:

- A. Restraint– A restraint is any (1) 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, including the use of an enclosure bed; or (2) 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 (i.e. chemical restraint). Please see Appendix 1 for a list of items that do not constitute a restraint.
- B. Non-Violent Restraint and Non-Self-Destructive Restraint: Restraint used for acute medical or surgical care which supports the physical health and safety of the patient who is non-violent/non-self-destructive, allowing medical treatment to continue without interruption.
- C. Violent or Self-Destructive Restraint: Restraints used to establish control in order to manage the patient’s violent or self-destructive behavior jeopardizing the immediate physical safety of the patient, staff or others. Restraints used to manage the patient’s violent or self-destructive behavior may occur in any area of the organization. This includes the manual restraint (Physical holding) of a patient for any reason, including medication administration.
- D. Seclusion: The involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving. Physically prevented from leaving includes threats by staff if the patient attempts to leave, including the threat of restraint or seclusion. Confinement on a locked unit or ward does not constitute seclusion. Seclusion may only be used to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.
- E. Physical Hold (Therapeutic hold in Power chart):
 - 1. Restraint Physical Holding: Patients have the right to refuse treatment and, therefore, holding a patient in a manner that restricts the patient's movement against the patient's will is considered restraint. These include holds that some members of the medical community may term "therapeutic holds". Physically holding a patient in order to administer a medication against a patient's wishes is also considered a restraint (these include forced psychotropic medication procedures).
 - 2. Non-Restraint Physical Holding: Methods involving the physical holding of a patient for the purpose of conducting routine physical examinations or tests. Picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient.
- F. Licensed Independent Provider: A person who is licensed as a physician, physician assistant, or advance practice registered nurse under state law for the state in which he/she is practicing.

IV. Related Policies/Forms:

- A. [Administrative Delegation of Authority and Administrator On Call Responsibilities - SAHS](#)
- B. [Interprofessional Plan of Care -- SAHS](#)
- C. [Patient Safety Monitoring -- SAHS](#)
- D. [Non-Violent Restraint Checklist - SAHS](#)
- E. [Violent Restraint and/or Seclusion Checklist - SAHS](#)

F. [Patient Education and Information Sheet - Restraints -- SAHS](#)

V. References:

- A. Centers for Medicare and Medicaid Services (Retrieved: May 1, 2019). Medicare and Medicaid Programs: Hospital Conditions of Participation: Patients; Rights: State Operations Manual, Appendix A. 42 CFR Part 482.13(e)(f)(g).
- B. Nadler-Moodie, M. (2009). Clinical Practice Guideline: 1-Hour Face-to-Face Assessment of a Patient in a Mechanical Restraint. *Journal of Psychosocial Nursing*, 47(6), 37-43.

VI. Approval Committee(s):

- A. Nampa Medical Executive Committee – July 9, 2019
- B. Boise Medical Executive Committee – July 29, 2019
- C. Ontario Medical Executive Committee – August 13, 2019
- D. Baker City Medical Executive Committee – July 18, 2019

TABLE 1	Non-Violent Restraints	Violent Restraints/Seclusion
Definition	Restraint used for acute medical or surgical care, which supports the physical health and safety of the patient who is non-violent/non-self-destructive this includes enclosure beds. A restraint <i>does not</i> include devices, such as orthopedically prescribed devices, surgical dressings or 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 (this does not include a physical escort). See definition section of policy	Restraints used to manage the patient's violent or self-destructive behavior jeopardizing the immediate physical safety of the patient, staff or others. Restraints used to manage the patient's violent or self-destructive behavior may occur in any area of the organization. This includes the manual restraint (Physical holding) of a patient for any reason, including medication administration.
Alternatives	Alternatives to restraint or seclusion will be considered and/or attempted prior to the application of restraints or seclusion. Must be documented in the medical record.	
Provider Order- must include type of restraint * NOTE: NO PRN/ Standing Orders	<ul style="list-style-type: none"> Prior to initiation <i>OR</i> During the emergency application or immediately after initiation Reordered every calendar day 	<ul style="list-style-type: none"> Prior to initiation <i>OR</i> During the emergency application or immediately after initiation Reordered at maximum intervals defined below: *Ages 18 or older, every 4 hrs *Ages 9-17, every 2 hrs *Ages 8 and under, every 1 hr New order: After 24 hrs, provider must see and assess patient prior to initiating new order. Oregon only: after 24 hrs of continuous violent restraint or seclusion, an exam and 2nd opinion must occur by a second physician before a new order is placed.
Documentation at Initiation (Initiate form)	<ul style="list-style-type: none"> Face-to-face evaluation: <ul style="list-style-type: none"> Within 1 hour of initiation Done by provider or trained RN *If done by RN, must consult & document that the findings were discussed with provider as soon as possible Date and time each restraint or seclusion was applied. Type and location of restraint(s) applied/ordered. Reason for restraint or seclusion use (patient's specific behavior). Alternative measures attempted prior to initiation including what was tried, for how long and why each measure was ineffective Plan of care- initiate either violent or non-violent IPOC Education of patient and family 	
Ongoing Documentation of Assessment	Assessments at minimum every 2 hrs, or as needed: <ul style="list-style-type: none"> Skin/Circulation Nutrition/Hydration ROM/Positioning Hygiene/Elimination Cognitive/Emotional Response Continued need for restraint Describe specific behavior observed 	Observations every 15 minutes: <u>and</u> <ul style="list-style-type: none"> Skin/Circulation Respiratory Cognitive/Emotional Response Nutrition/Hydration, if applicable Positioning, if applicable Call Light, if applicable Hygiene/Elimination Safety Assessments at minimum every 1 hr, or as needed: <ul style="list-style-type: none"> Skin/Circulation Respiratory Cognitive/Emotional Nutrition/Hydration ROM/Positioning Hygiene/Elimination Safety Vital Signs Type of restraint and location Continued need for restraint <p>***All violent restraint/seclusion patients must be continuously observed and staff must be physically close enough to protect the patient in an emergency.</p>
Removal	<ul style="list-style-type: none"> Restraint and seclusion are to be discontinued at the earliest possible time, regardless of the expiration time of the written order. Restraints released temporarily for patient care (e.g., toileting, feeding, and range of motion) are not considered a discontinuation of the intervention. Upon removal of restraints or seclusion, nursing must document discontinuation, complete the order, and update the IPOC. 	

Appendix 1. List of Non-Restraints

The definition of a "restraint" does not include the following:

- a) Orthopedically prescribed devices, surgical dressings or 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.
- b) IV arm boards to stabilize an IV line if the arm board is not tied down, not attached to the bed, and the entire limb is not immobilized such that the patient cannot access his or her body.
- c) Mechanical supports (braces) used to achieve proper body position, balance, or alignment to allow greater freedom of mobility.
- d) Medically necessary positioning or securing devices used to maintain position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures (e.g., securing of affected leg following a procedure requiring leg immobilization: post-angiogram, cardiac cath, etc.).
- e) Medically necessary restraint use during recovery from anesthesia that occurs when the patient is in a critical care area or post anesthesia unit is considered part of the surgical procedure and not a restraint. If the intervention is maintained when the patient is transferred to another unit or recovers from the effects of the anesthesia (whichever comes first) a restraint order would be necessary.
- f) Any device that can easily be removed by a patient. In this context, "easily removed" means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by staff (e.g., side rails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the patient's physical condition and ability to accomplish objective (e.g., transfer to a chair, get to the bathroom in time).
- g) Age or developmentally appropriate protective safety interventions such as cribs with raised side rails, crib covers, stroller safety belts, swing safety belts, or high chair lap belts that would normally be used outside the healthcare setting.
- h) Picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient.
- i) Physical escort including a "light" grasp. The patient should be able to easily remove or escape the grasp to not be considered a restraint.
- j) Side rails in the following situations:
 - a. When side rails are used to prevent the patient from falling out of bed, and side rails have no impact on the patient's freedom of movement. For example, when a patient is on a gurney, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain specialty beds.
 - b. When a patient is on seizure precautions with seizure pads on the side rails.
 - c. When a patient is not physically able to get out of bed regardless of whether or not side rails are used.
- k) Seat belts necessary for safely transporting a patient in a wheelchair or to prevent a patient from unintentionally sliding out of a Geri chair.
- l) Medications to control behavior (including PRN medications) when used as a part of the patient's regular medical regimen or are a standard treatment for the patient's condition. However, a medication constitutes a restraint and is not considered "standard treatment" if the overall effect of a medication is to reduce the patient's ability to effectively or appropriately interact with the world around the patient.
- m) Mitts, if not applied so tightly that the hands or fingers are immobilized, and/or are not so bulky that the patient's ability to use hands is significantly reduced, i.e. secured to bed.
- n) Geri chair safety: If a patient requires the use of a Geri chair with the tray locked in place for the patient to be safe out of bed, a standing or PRN order is permitted. When the patient may be out of bed in a chair several times a day, it is not necessary to obtain a new order each time.