

TITLE: Restraint / Seclusion

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Policy Number: IDPC.427

Dept: Patient Care Services

PURPOSE:

Provide guidelines for the use of restraints in Non-Violent or for emergency use of restraint for psychiatric/mental health care need Violent or Seclusion. This follows after a comprehensive assessment concludes that for the patient the use of alternative measures poses a greater risk than the risk of using restraint/seclusion.

GOALS:

- All patients have the right to be free from restraint/seclusion that is not medically necessary or is used for purposes other than patient benefit and safety.
- Restraint/seclusion is used only when less restrictive measures have been found to be ineffective in protecting the patient or others from injury.
- All patients have an assessment performed to determine the safety and protective needs of the patient prior to the application of restraint/seclusion.
- Restraint/seclusion is applied in accordance with a physician order by trained staff.

SCOPE:

- Includes Acute Care (Emergency Department, inpatient units such as ICU, Medical, Surgical, OB, and Psychiatric Services). Also includes Skilled Nursing and Rehab units.
- Excludes Long Term Care.
- Certain patient populations are vulnerable with regard to restraints. These include patients who are cognitively impaired, developmentally disabled and pediatric patients. The use of restraint should employ patient assessment and intervention methodology standard to providing care to these special groups.

DEFINITIONS:**A. Restraint** (See Addendum I)

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.

- 1) **Restraint for (Non-violent)**: Any method of physically restraining a person’s freedom of movement, physical activity, or normal access to his or her body, material, or equipment attached or adjacent to the patient’s body that he or she cannot freely remove. It is the **intent** by which someone’s freedom of movement is restricted that determines whether the device is a restraint, adaptive/supportive/protective device, or medical procedure requiring temporary immobilization.

Two criteria exist for a restraint to be considered a Non-violent restraint:

1. The patient is unable to cooperate AND
2. The patient is attempting to do something to his/her treatment site.

This may include situations where the patient is unable to maintain balance or ambulate safely AND refuses/is unable to seek assistance.

- 2) **Restraint for a Psychiatric/mental health care need or Violent**: Applies to **emergency** situations where the patient’s behavior is violent, aggressive, assaultive, or results in property damage, and restraint is the least restrictive measure that will assure the patient’s or other’s safety. This is behavior that presents an immediate and serious danger to the safety of the patient, other patients, or staff.

- B. **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. Whether or not an order for a drug or medication is PRN does not determine whether or not the use of that drug or medication is considered a restraint. Criteria used to determine whether the use of a drug or medication, or combination of drugs or medications is a standard treatment or dosage for the patient’s condition includes all of the following:

- 1) The drug or medication is used within the pharmaceutical parameter approved by the FDA and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters;
- 2) The use of the drug or medication follows national practice standards established or recognized by the medical community, or professional medical association or organizations; and,
- 3) 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 licensed independent practitioner’s (LIP) knowledge of that patient’s expected and actual response to the medication.

The standard use of a drug or medication to treat the patient’s condition enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of the drug or medication.

- C. **Seclusion:** 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 that jeopardizes the immediate physical safety of the patient, a staff member, or others.

- D. **Licensed Independent Practitioner (LIP):** A LIP is a physician or any practitioner permitted both by State law and by the hospital as having the authority under his/her license to independently order restraints, seclusion, medications for patients, and to perform both the physiological AND psychological components of the 1-hour face-to-face evaluation.

- E. **Guidelines or Protocol Required for Restraint/Seclusion:** Protocols that allows for restraint/seclusion of a person with a particular clinical condition (i.e. care of the patient on a ventilator) are NOT used at Mercy Medical Center.

- F. **Time Out:** An intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe (30 minutes or less) from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses. Timeout is not considered seclusion.

PROCEDURE: See Addendum II - Decision Tree for Restraint/Seclusion Use

1. Determine when the policy/procedure for restraint/seclusion does **NOT** apply as in the following situations:
 The restraint is associated with medical, dental, diagnostic, or surgical procedures and used as a positioning or securing device to limit mobility or temporarily immobilize (e.g., surgical positioning, I.V. arm boards, radiology procedures, and protection of surgical/treatment sites in pediatric patients);
 - The restraint device is used to meet the assessed needs of the patient requiring adaptive support of protective equipment such as helmets, postural support and orthopedic appliances;

- Side rails when used to protect the patient from falling out of bed (e.g. on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed). When a patient is placed on seizure precautions and all side rails are raised, the use of side rails would not be considered restraint. Placement in a crib with raised rails is an age-appropriate standard safety practice and would not be considered restraint.
 - A staff member(s) physically redirects or holds a child, without the child's permission, for 30 minutes or less. (Note: staff competency and training requirements are still met);
 - A time-out when the patient is restricted for 30 minutes or less from leaving an unlocked room and when its use is consistent with the patient's treatment plan;
 - Instances in which a patient is restricted to an unlocked room or area, consistent with a unit's rule or regulations, and hospital policy(ies) and procedure(s);
 - Forensic and correctional restrictions for security reasons applied to and monitored by law enforcement officials.
2. Once it has been determined that the use of restraint/seclusion falls within the scope of the policy, the next step is to determine the reason for its use since that determination will guide the procedures to be followed. In all instances, restraint/seclusion can be considered only when less restrictive and nonphysical measures/alternatives have been ineffective.

Restraint/seclusion is used for one of two reasons:

- a. The reason for the restraint/seclusion is driven by a psychiatric/mental health problem, if it is an emergency use. (Violent Restraint) The patient’s behavior is aggressive, violent, or assaultive and presents an emergency. This behavior is an immediate and serious danger to the safety of the patient, other patients, or staff as in when the patient:
 - attempts to strike out at others;
 - attempts to hurt self; or
 - attempts to destroy property that result in danger to self or others.
 - b. The reason for the restraint is driven by the need to promote healing when the patient is unable to cooperate in maintaining medical interventions. The goal is to promote physical healing. **(Non-violent restraint)** The patient is unable to cooperate AND is attempting to interfere with a treatment site(s), as in the patient:
 - needs to be protected from injury;
 - medical equipment/tube needs to be maintained; or
 - patient safety needs to be ensured.
3. This determination is made regardless of clinical setting. violent restraint/seclusion procedures apply in psychiatric settings as well as non-psychiatric settings where restraint/seclusion is used for psychiatric/mental health reasons.
 4. If it is determined that the restraint/seclusion use is to promote physical healing and is a Non- violent restraint, then the procedures outlined below in the Non violent Column are followed.
 5. If it is determined that the restraint/seclusion use is an emergency and that the behavior of the patient is an immediate and serious danger, then the procedures identified below in the Violent column are followed.
 6. Where there is only one column the requirements are intended to apply to non-violent restraint use regardless of setting.

Procedures	Restraint Category	
	Medical/Post-Surgical (Non-violent)	Psychiatric/mental health (Violent)
Criteria For Use	a. Patient is unable to cooperate AND is attempting to	The patient’s behavior is aggressive, violent, or assaultive and presents an emergency. This behavior is an immediate and serious danger to the safety of the

Procedures	Restraint Category	
	Medical/Post-Surgical (Non-violent)	Psychiatric/mental health (Violent)
	interfere with a treatment site(s).	patient, other patients, or staff. (Duplicated)
Criteria For Use	<ul style="list-style-type: none"> Less restrictive measures/alternatives are ineffective (see Addendum IV). Restraint/seclusion use will improve the patient's well being. 	
Assessment of Need For Restraint or Seclusion	<ul style="list-style-type: none"> RN assesses the need for restraint/seclusion 	<ul style="list-style-type: none"> The initial admission assessment of the patient in a psychiatric setting assists in obtaining information that could help minimize the use of restraint/seclusion. <p>This assessment identifies:</p> <ol style="list-style-type: none"> Techniques that would help the individual control their behavior. The individual's need for methods or tools to manage their behavior. Pre-existing medical conditions or any physical disabilities that would place the individual at greater risk during restraint/ seclusion. Any history of sexual or physical abuse that would place the individual at greater risk during restraint/seclusion. The patient and significant other (SO) are informed of the hospital's philosophy regarding the use of restraint/seclusion to the extent that such information is not clinically contraindicated.
Physician Order Obtain	<ol style="list-style-type: none"> An order for restraints is obtained prior to or concurrently with application. In a quickly escalating situation, there may not be time to contact the physician/LIP before taking action. The physician/LIP is contacted at the earliest possible time (while the intervention is being initiated or immediately after the patient is restrained or secluded) to obtain an order for the restraint/seclusion. Enter order in the EMR. If restraint <u>type</u> changes, you must get a new order. 	
Face-to-face assessment:		<ul style="list-style-type: none"> The patient must be seen in person within 1 hour after initiation of restraint/seclusion by a physician

Procedures	Restraint Category	
	Medical/Post-Surgical (Non-violent)	Psychiatric/mental health (Violent)
		or other licensed independent practitioner (LIP), or a trained RN.
Order Specifications	<ul style="list-style-type: none"> Orders have a start and stop time for the restraint/seclusion, are specific to type of the restraint, dated, and signed. If the restraint/seclusion order is given by a physician/LIP other than the attending, the attending physician is be consulted as soon as possible. Restraint/seclusion orders are not written as a standing or PRN order. An episode of restraint refers to each time frame requiring a new order and a new restraint initiation form should be completed at the start of each episode. Protocols are not currently allowed 	
Order Time Limitations	<ul style="list-style-type: none"> Orders may be for any time frame, but not to exceed a calendar day. The original order may be renewed for up to a total of 24 hours. The physician/LIP completes a face-to-face evaluation if the patient has been restrained for 24 hours. 	<ul style="list-style-type: none"> The order may not exceed: <ul style="list-style-type: none"> 4 hours for adults age 18 or older, 2 hours for children and adolescents ages 9-17, 1 hour for children under 9. After the first order period expires, a qualified RN or other qualified, authorized staff member re-evaluates the patient’s need for continuation of restraint/seclusion. If restraint/seclusion is still required after re-evaluation, the LIP is notified and an order is given for up to the number of hours allowed for the initial order. After the second episode in restraint/ seclusion, the physician/LIP or trained RN conducts an in-person re-evaluation of continued need for restraint/seclusion and writes an order for up the number of allowable hours. This process is repeated as long as restraint/ seclusion remains clinically necessary. Within 24 hours, a physician/LIP who is responsible for the care of the patient must see and assess the patient.
Discontinuation of Restraint or Seclusion	<ul style="list-style-type: none"> Nursing decides when a restraint can be discontinued based on patient behavior. If restraints or seclusion are discontinued prior to the expiration of the original order, a new order is obtained prior to reinitiating seclusion or reapplying the restraints. 	

Procedures	Restraint Category	
	Medical/Post-Surgical (Non-violent)	Psychiatric/mental health (Violent)
	<ul style="list-style-type: none"> Restraints are discontinued when the patient is able to cooperate and is no longer interfering with the treatment site(s) 	<p>Restraint/seclusion use is discontinued when the individual meets the <u>criteria</u> for their discontinuation:</p> <ul style="list-style-type: none"> Behavior requiring restraints ceased. As early as feasible (within 1 hour of use) the patient is made aware of the reason for restraint/seclusion and the behavior criteria for discontinuation. <p>Document the patient’s behavior when the criteria for discontinuation are met.</p>
Patient Care	<ul style="list-style-type: none"> Use of restraint/seclusion is reflected in written modification to the patient’s plan of care. The RN updates the plan of care as appropriate to reflect the restraint/seclusion intervention. Restraint is used in the least restrictive manner possible. Restraint/seclusion is ended at the earliest possible time. The patient’s dignity (i.e., keeping patient covered, assessing psychological status and comfort) is maintained. The condition of the patient is being continually assessed, monitored, and reevaluated. Staff are responsible for providing monitoring and reassessment that will protect the patient’s safety. The RN re-assesses, monitors, and evaluates the need for the appropriate degree of restraint/seclusion and documents. The restrained extremity or extremities are released from the restraints and the restraints are rotated every 2 hours or more often based on assessed need. Blood pressure, pulse, and respiration are monitored according to individual patient needs and response. 	
Patient Care	<p>The following are monitored and documented every 2 hours unless the RN determines the need for more frequent monitoring:</p> <ul style="list-style-type: none"> Skin color and integrity, temperature, and pulses in the 	<ul style="list-style-type: none"> Every 15 minutes the following items need to be assessed/monitored and documented: <ul style="list-style-type: none"> Signs of injury associated with the application of restraint. Skin and Circulation in the extremities Physical and psychological status and comfort Readiness for discontinuation of restraint/seclusion Clinical judgment and knowledge of the patient

Procedures	Restraint Category	
	Medical/Post-Surgical (Non-violent)	Psychiatric/mental health (Violent)
	<p>extremity; patient complaints of numbness/tingling.</p> <ul style="list-style-type: none"> • Maintenance of the patient’s physical safety i.e., potential for actual physical injury due to the restraint; • A safe environment; • Patient’s physical and emotional wellbeing • Hygiene, toileting, nutrition, and oral fluids are offered/provided. • Range of motion (ROM) and repositioning every 2 hours unless clinically contraindicated or more frequently as needed. • At a minimum the RN assesses and documents the need for continued restraint at least every 8 hours. • When restraints are discontinued document the patient’s behavior that allowed the restraints to be discontinued. 	<p>and his or her individual needs is used to schedule when and what items need to be evaluated, including whether waking a patient is advisable. Visual checks can be done when and if the patient is too agitated to approach.</p> <ul style="list-style-type: none"> • Every 2 hours the following items need to be assessed/monitored and documented: • ROM and repositioning unless medically contraindicated. • Nutrition/hydration • Hygiene and elimination • Readiness for discontinuation of restraint/seclusion. • <u>For restraints</u>, continuous in person observation is required. • If the patient is in a physical hold, a second staff person is assigned to observe and monitor the patient. • <u>In seclusion</u> patients are monitored face-to-face throughout the entire episode.

Procedures	Restraint Category	
	Medical/Post-Surgical (Non-violent)	Psychiatric/mental health (Violent)
Patient/SO Education and Notification	<p>Patient and, when appropriate the SO are informed about the reason for the restraint and the care of the patient who is restrained. See Addendum IV.</p>	<ul style="list-style-type: none"> • The patient and SO are informed of the hospital’s philosophy on the use of restraint/seclusion to the extent that such information is not clinically contraindicated • Any issues related to an advance directive that may impact the treatment are discussed with the patient/SO. • The role of the SO in being notified of a restraint/seclusion episode is discussed with the patient and, as appropriate, the SO. This is done in conjunction with the patient’s right to confidentiality. • Where the patient has consented and the SO has agreed to be notified, the staff attempts to contact the SO to inform them of the restraint/seclusion episode. • The date, time, and how and who was notified is documented. If the SO was not notified, the date/time of attempt and reason notification did not occur is documented.
Notifications or Reporting	<p>The Hospital Risk Manager must report deaths associated with the use of restraint/seclusion per CMS regulation.</p> <ul style="list-style-type: none"> • Each death that occurs while a patient is in restraint/seclusion. • Each death that occurs within 24-hours after the patient has been removed from restraint/seclusion. • Each death known to the hospital that occurs within 1 week after restraint/seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient’s death. 	
		<ul style="list-style-type: none"> • Clinical leadership is immediately notified if: <ul style="list-style-type: none"> • The patient remains in restraint/ seclusion for more than 12 hours • The patient has experienced two or more separate episodes of restraint/seclusion of any duration within 12 hours. • Leadership is notified every 24 hours if either of the above conditions continues.

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	Medical/Post-Surgical (Non-violent)	Psychiatric/mental health (Violent)
Debriefing		<p>Following an episode of restraint/seclusion a debriefing occurs as soon as possible and is documents on the discontinuation assessment form.</p> <p>The patient and, if appropriate, the SO, participate with staff who were involved in the episode.</p> <ul style="list-style-type: none"> The debriefing is used to: <ol style="list-style-type: none"> Identify what led to the restraint/seclusion and what could have been handled differently; Ascertain that the patient’s physical well being, psychological comfort, and right to privacy were addressed; Counsel the individual involved for any trauma that may have resulted from the incident; and; When indicated, modify the patient’s treatment plan.
Staff Education	<ul style="list-style-type: none"> All staff that has direct patient contact has education and training in the proper and safe use of restraint/seclusion. Staff training includes the techniques for minimizing the use of restraint/seclusion, as well as management of patients in restraint/seclusion before application. All staff that has direct patient contact has ongoing education and training in alternative methods for handling behavior, symptoms and situations. 	
Trained RN for Face-to-face		<p>A trained registered nurse is permitted to conduct the 1-hour face-to-face evaluation. These RNs have a documented training that demonstrates they are qualified to conduct a physical and psychiatric assessment of the patient that addresses: the patient’s immediate situation, the patient’s reaction to the intervention, the patient’s medical and psychiatric condition, and the need to continue or terminate the restraint/seclusion.</p> <p>RN training is conducted and competency demonstrated prior to performing face-to-face evaluation and annually thereafter.</p>
Physician/ LIP Role	<ul style="list-style-type: none"> Writes/enter the order. 	<ul style="list-style-type: none"> Discuss with staff the physical and psychological status of the patient;

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	<ul style="list-style-type: none"> Completes a face-to-face evaluation <u>if the patient has been restrained for 24 hours.</u> 	<ul style="list-style-type: none"> Determine whether restraint/seclusion should be continued; Guide staff in identifying ways to help the patient regain control. Write/enter the order Make any necessary revisions to the individual's treatment plan.
Monitoring Restraint Use and Performance Improvement	Restraint and seclusion data are collected and incorporated into performance improvement activities. Restraint/seclusion data are collected to determine why restraint/seclusion is used and how use can be decreased.	
	There is an initial baseline assessment of aggregate data followed by targeted monitoring.	Restraint and seclusion data are collected in 100% of cases to ascertain that restraint and seclusion are used only as emergency interventions and to identify opportunities for improving the rate and safety of restraint and seclusion use.

Addendum I

Definitions

Types of Restraint:

All Side Rails Up		Enclosure Bed/Net Bed
	Geri Chair	
Leathers x 2: opposite wrist and ankle (add waist also)		
Leathers x 4: bilateral wrists and ankles (add waist also)		
Lap Belt Mitt x1, Mitt x2		
Side Rail Wedge		Seclusion
		Tray Chair
Vest		Waist Belt
Soft Limb x1, Soft Limb x2, Soft Limb x3, Soft Limb x 4		

Note: The use of side rails up x 4 (or 2 sides up for non-split rails) should be used ONLY when based on assessed needs of the patient. Exception: Crib rails for pediatric patients should be in the “up” position at all times. When a patient is placed on seizure precautions and all side rails are raised, the use of side rails would not be considered restraint.

Note: A net bed enclosure can be a form of restraint, as determined needs of the patient, its intended use, and if it is voluntary.

Protective/Adaptive/Supportive Devices:

Protective devices compensate for physical deficits and prevent injury related to cognitive impairment. Adaptive/Supportive devices permit the patient to achieve maximum body functioning. The care of the patient and specific use of the device follows defined policy and procedure. The **intent** of the device determines if it is a protective device or a restraint. E.g. A Geri-Chair used to maintain posture for an alert stroke patient is considered a supportive/adaptive device. A vest restraint used to confine movement of a disoriented elderly patient is considered a restraint. If a patient can easily remove a device, the device would not be considered a restraint. Easily remove means the device can be removed intentionally by the patient in the same manner as it was applied by the staff.

Protective Devices

- Helmets
- Protective nets

Adaptive Devices

- Orthopedic appliances
- Braces
- Ultimate Walker (with easy release)

Postural Support Devices

- Wedge cushion
- Rolls
- Geri-Chairs
- Lap Buddy
- Side rails for positioning
- Lap tray
- Lap belt (with easy release)

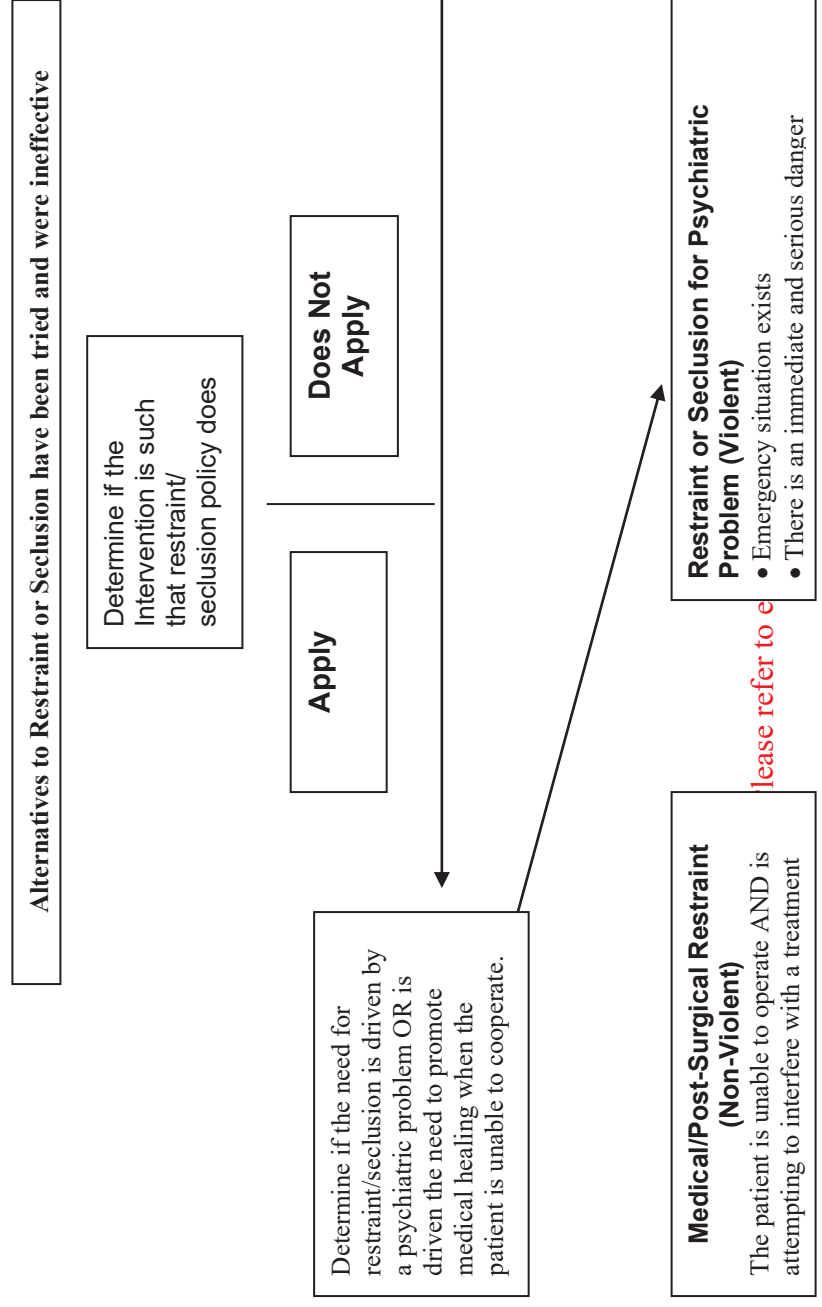
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Immobilization during Medical/Post-Surgical Procedures:

When restraint is associated with medical, dental, diagnostic, or surgical procedures and used as a positioning or securing device to limit mobility or temporarily immobilize (e.g., surgical positioning, I.V. braces/arm boards, radiology procedures, and protection of surgical/treatment sites in pediatric patients) it is not a restraint.

ADDENDUM II

Decision Tree for Restraint or Seclusion Use



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Follow procedures for Medical/Post-Surgical restraint

Follow procedures for Psychiatric restraint.

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Addendum III**Alternatives to Restraint/Seclusion****Non-Violent**

Bed Alarm
Chair Alarm
Decreased Environmental Stimuli
 Approaching patient in a calm, unhurried manner
Diversional Activities
 Providing a safe object to handle
 Television
 Listening to favorite music
Environmental Modification
 Increasing frequency of nursing rounds
 Moving patient closer to nurses' station
 Covering IV sites or tubes
 Having the SO stay with the patient
Frequent Toileting
Limit Distractions
Medication****
Pads/pillows
Pain relief/comfort measures
Promote normal sleep pattern
Promote physical activity as tolerated
Refocusing Attention
Re-Orientation
Verbal Reminders
Visual Supervision

Violent

1:1 Intervention
Counseling
Decreased Environmental Stimuli
Diversional Activities
Environmental Modification
Limit Setting
Medication****
Pain relief/comfort measures
Reality Orientation
 Redirection
Refocusing Attention
Reorientation
Room Time
Therapeutic Holding
Time Out
Verbal Reminders
Visual Supervision

****See definition of chemical restraint

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Addendum IV**Understanding the Use of Restraints: Information for Patients & Families**

Our goal is to protect the rights, dignity and safety of our patients. It is our desire to create an environment limiting the use of restraints. Family members can help us achieve our goal. At times it is your presence that calms the patient and allows us to avoid the use of restraints.

What are restraints?

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. Restraints are used to protect the patient from injuring themselves or others.

Why are restraints used?

Restraints are only used to prevent harm to our patients or others. Some behaviors that might require restraint include:

- Trying to get out of bed and/or chair when the patient is not able to do so safely and does not ask for help.
- Pulling at essential lines or tubes.
- Physically aggressive behavior towards another individual, family and/or staff, property.

When are restraints used?

Restraints are used only after many other methods to prevent their use have been tried. These may include:

- Talking with the patient
- Involving family
- Taking the patient to the bathroom
- Changing the patient's position
- Moving closer to the nurse's station
- Providing for fluid/food needs
- Using medications

How can you help?

- Spend time with your family member
- Talk calmly and provide reassurance
- Help caregivers understand the patient's needs and gestures
- Help communicate information to the patient

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- Bring personal reminders/items from home

Are there risks when using a restraint?

- Yes, however, in order to minimize any risks such as skin irritation, poor circulation or even more serious problems, the patient is monitored frequently and the restraint is removed just as soon as it is safe to do so. Restraints are generally removed when the patient demonstrates that this protection is no longer needed.

If you have other questions regarding the use of restraint, please feel free to ask the patient's nurse or physician.

RESOURCES:

1. **Cerner Model Restraint Documentation Workgroup (2015)**
2. CMS Interpretive Guide lines for Hospital CoP for Patient's Rights
3. Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS). CMS Manual System, Pub. 100-07, Revised Interpretive Guidelines for Restraint and Seclusion.
3. JC, CAMH Refreshed Core. Provision of Care, Treatment, and Services (PC), Update July 2, 2014.
4. Journal of Psychosocial Nursing (2009). Clinical Practice Guideline: 1-Hour Face-to-Face Assessment of a Patient in a Mechanical Restraint. 47 (6), 37-43.
5. Trinity Health Behavioral Medicine Team and Restraint Redesign Team (2012).