Title: Use of Restraints and/or Seclusion
(for patients on the inpatient psychiatry unit refer to the Deaconess 4 policies)

Policy #: CP – 28

Purpose:
This policy serves to describe those situations where a restraining device or seclusion may be used to manage patient safety. This policy outlines the required orders, assessments, and documentation.

This policy applies to restraint or seclusion regardless of where these patients are in the organization, with the exception of patients on Deaconess 4, the inpatient psychiatry unit.

Policy Statement:
Restraint or seclusion may only be imposed to assure the imminent safety of the patient, staff or others and must be discontinued at the earliest possible time. Patients may not be restrained as a means of coercion, discipline, convenience or retaliation. Patients may also not be restrained for purposes of conducting a search unless they meet the standards set forth in this policy.

Restraint or seclusion are used only if, in the clinical judgment of a nurse and/or licensed independent practitioner, the patient is at imminent risk of causing harm to self or others and other less restrictive measures are ineffective or inappropriate. If it is determined that less restrictive interventions are ineffective in protecting the patient or others from harm, the hospital may then consider the use of restraint.

The decision to use restraint or seclusion is driven by a comprehensive individual assessment that concludes that for this patient at this time, the use of less intrusive measures poses a greater risk than the use of using a restraint or seclusion. The comprehensive assessment of patients should include a physical assessment to identify medical problems that may be causing the behavior changes in the patient. For example, temperature elevations, hypoxemia, hypoglycemia, electrolyte imbalances, drug interactions and drug side effects can cause confusion, agitation, and combative behavior. Addressing these medical issues can often eliminate or minimize the need for the use of restraints or seclusion. Documentation must reflect that these assessments have been conducted prior to application of restraint or seclusion.

When used, restraint or seclusion must be the least restrictive intervention that protects the patient's safety if alternatives have failed. Restraint/seclusion must end as soon as possible.

In all instances of restraint and seclusion use, measures will be taken to protect the rights, dignity, and well being of the patient.

Definitions:

Restraint:

- Any manual or physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his arms, legs, body or head freely.
- A drug or medication when it is used as a restrictive means to manage a patient's behavior or to restrict the patient's movement and is not a standard treatment or dosage for the patient's condition.

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.

Licensed Independent Practitioner:

- Any individual permitted by law and by the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges (NP's or MD's).

Exceptions:

Does not include devices such as orthopedically-prescribed devices, surgical dressing or bandages, protective helmets or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examination or tests or to protect the patient from falling out of bed (i.e. cribs, emergency room stretchers, side rails on specialty beds) or to participate in activities without the risk of physical harm (i.e. gait belts).

Implementation:

<u>USE OF RESTRAINT</u>:

Restraint and seclusion are significant interventions which have the potential to produce psychological and physiological consequences for the patient. All efforts should be directed toward using restraint or seclusion only when absolutely necessary to prevent injury to the patient or others or to prevent the destruction of property. Restraint and seclusion shall be used only as an unusual and temporary measure when the independent licensed practitioner and nursing assessment deem it necessary and other available techniques or interventions have failed.

Issues to be considered in determining that restraint or seclusion are clinically appropriate and adequately justified are:

- Identifying and eliminating/correcting when possible, the cause of the patient's behavior, including physiologic, cognitive and/or environmental factors.
- Initiating alternative measures to manage the patient's behavior without restraints or seclusion.

The type of restraints or seclusion should be determined after:

- Assessment of the patient and the situation have been completed,
- Precipitating factors have been identified and eliminated, whenever possible,
- Consultations with other healthcare professionals have occurred, when appropriate,
- Information from the patient's initial assessment is taken into consideration.

It is acceptable and standard practice to raise 4 siderails when a patient is on a stretcher, recovering from anesthesia, suffering from involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. If 4 siderails are raised for other reasons (i.e. to prevent the patient from getting out of bed), this is an episode of restraint.

LICENSED INDEPENDENT PRACTITIONER'S ROLE

1. Determine that restraints and/or seclusion are appropriate and necessary and less restrictive treatment is not feasible.

2. At the time of the in-person evaluation:
   - Works with the patient and staff to identify ways to help the patient regain control
   - Revises the patient's plan for care, treatment and services as needed
   - If necessary, provides a new written order

3. Must document restraint/seclusion episode(s) as required and defined in the *Assessment and Documentation Guidelines* table embedded within this policy.

NURSE'S ROLE

1. Assess the behavior requiring intervention/determine the less-restrictive interventions, and patient response to these interventions.

2. In an emergency situation to protect the patient and/or others from imminent injury, restraint may be initiated by a registered nurse if, in the judgment of that nurse, other less restrictive measures are either not effective or not feasible.

3. Page LIP to request a face-to-face evaluation and a written order within 1 hour of initiation of restraint.

4. Patients/family should be informed regarding the use and reason for restraint and

seclusion within a reasonable period of time, and behavioral expectations for release of restraint or seclusion.

5. Restraint devices are applied in accordance with manufacturer's directions by staff that have been trained to do so.

6. Restraint or seclusion may be discontinued by the RN, (except in the cases where the restraints were at the recommendation of a consulting psychiatrist, in which case the consultant's concurrence must be documented**).**

7. Documentation on the Restraint or Seclusion Flow Sheet must include an assessment using the guidelines defined in the *Assessment and Documentation Guidelines* table embedded within this policy.

8. A constant observer should be employed for patients in restraint or seclusion for reasons of violent or self destructive behavior. The required 15-minute assessment by the observer or RN must be documented using the Observer Section of the Restraints or Seclusion Flow Sheet.

9. Document a patient's response to trial/early release and less restrictive alternatives. Consider requesting support from security personnel when releasing a potentially violent patient. In suicidal patients, consult with a psychiatrist or licensed independent practitioner prior to attempting early release.

10. If a patient was released from restraint or seclusion and suddenly exhibits the behavior that can only be handled by the reapplication of restraint or seclusion, a new order is required. *Staff cannot discontinue and restart under the same order.* **Reapplication of restraint requires a new order.** However- a temporary release for the purpose of caring for a patient's needs – for example toileting, feeding, range of motion is not considered a discontinuation of the intervention.)

Assessment and Documentation Guidelines:

Assessment and Documentation Guidelines for Restraint/Seclusion Interventions

	Non-violent Behavior: Restraint	Violent and/or Self-destructive Behavior: Restraint	Violent and/or Self-destructive Behavior: Seclusion
Restraint Ordering Timeframe	MD must complete order within 1 hour of initiation		
Restraint Order/Reorder Time Limitation	• 4 hours for adults • 2 hours for patients age 17 and under • PRN orders are not permitted.		

MD Face-to-Face Evaluation	Must occur within 1 hour of restraint/seclusion initiation		
Assessment and Documentation Guidelines for Restraint/Seclusion Interventions (cont).			
	Non-violent Behavior: Restraint	**Violent and/or Self-destructive Behavior: Restraint**	**Violent and/or Self-destructive Behavior: Seclusion**
MD Face-to-Face Re-evaluation	4-hour renewal of orders may take place by a verbal order EXCEPT in the case of patients restrained for violent or self-destructive behavior. If a patient has been in restraint/seclusion for 24 hours *(a total of 6 consecutive orders,* the MD must return for a face to face evaluation of the patient prior to a written renewal of the order. The evaluation must be documented in the progress notes.	Must occur every 4 hours with each new restraint/seclusion order issued. For patients age 17 and under, this is not to exceed 2 hours.	
Components of Required MD Documentation	• Restraint Order in POE or ED Restraints/Seclusion Flow sheet must be completed with every application/ reapplication of restraint/seclusion OR renewal of order for continuation of restraint/seclusion. Each order must be time-limited and written for a specific behavior which puts the patient at risk. Examples of such behaviors include: pulling at lines/tubes, risk of assault or self-harm, extreme aggression and impulsivity. • Documentation of Initial Face-to-Face Evaluation must be made in the progress notes, including time. Restraint/ seclusion intervention must be incorporated into plan of care.		
Components of Required 15-minute RN or Observer Documentation	None required	• Circulation (a finger check beneath restraint only) • Body Alignment • Patient's Behavior	• Patient's Behavior
Components of Required 1-hour RN Documentation on Flow sheet	None required	• Basic needs (food, fluids, elimination) • Skin condition • Exercise of restrained extremities (when awake) • Consideration of less restrictive interventions • Signs of Injury associated with application of restraint	• Basic needs (food, fluids, elimination) • Consideration of less restrictive interventions • Signs of injury associated with seclusion intervention • Vital Signs • Patient's response to restraint

		• Vital Signs • Patient's response to restraint • Behavior indicating reason for continuation of restraint/ seclusion	• Behavior indicating reason for continuation of seclusion
Assessment and Documentation Guidelines for Restraint/Seclusion Interventions (cont).			
	Non-violent Behavior: Restraint	**Violent and/or Self-destructive Behavior: Restraint**	**Violent and/or Self-destructive Behavior: Seclusion**
Components of Required 2-hour RN Documentation on Flow sheet	• Basic needs (food, fluids, elimination) • Skin condition • Patient's response to restraint • Exercise of restrained extremities (when awake) • Consideration of less restrictive interventions • Signs of Injury associated with application of restraint • Vital Signs • Less restrictive interventions attempted/ considered • Behavior indicating reason for continuation of restraint	Maintain hourly documentation of above	Maintain hourly documentation of above

Training Requirements:
Staff must be trained and able to demonstrate competency in the application of restraints and seclusion, the assessment, monitoring and care for patients in restraint and/or seclusion at orientation and through an annual competency review.

CMS Mandates Reporting of::
Each death that occurs while a patient is in restraint or seclusion
Each death that occurs within 24 hours of restraint or seclusion episode
Each death known within 1 week after removal of restraint/seclusion when it is reasonable to assume death was due to restraint/seclusion
* A notation must be made in patient medical record if their death is reported to CMS

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Approved By:

☒ **Medical Executive Committee: 5/16/07** **Mary Anne Badaracco, MD**
Chair

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Revisions: 6/05 (CP-04 divided into 2 policies)
3/07 (in response to New CMS guidelines)
8/08 (in reponse to new CMS guidelines) Has been approved by the Code Purple/Restraint Committee and is awaiting MEC approval

Next Review Date: 5/10

Eliminated: (Date)