SUBJECT: RESTRAINTS/ SECLUSION

ORIGINATING DEPT: Nursing Administration/ Medical Staff **DISTRIBUTION DEPTS:** All

ACCREDITATION/REGULATORY STANDARDS:

Original Date: 9/91 **Revision Dates:** 1/94, 2/96, 1/97, 8/98, 4/99, 9/99 4/01, 11/01, 7/02, 7/04, 8/05, 6/06, 10/06, 3/08, 10/09, 7/10, 9/12, 1/13, 4/17, 5/17, 8/17 **Reviewed Dates:** 1/16	**APPROVAL:** Administration: _____ Chief of Staff: _____ Safety Dir: _____

PURPOSE

To provide guidelines for the use of restraints throughout the hospital, in accordance with applicable Federal and State regulations, to ensure patient safety, rights and dignity and well being.

DEFINITIONS

Restraint: Any manual method, physical, mechanical or chemical that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely; any drug or medication when used as a restriction to manage the patient's behavior or restrict patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Seclusion - Involuntary confinement of a person alone in a room or area where the person is physically prevented from leaving. Seclusion can 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.

Violent or self destructive behaviors- behaviors that place the patient at risk for injuring self or others.

Prolonged restraint - Non-violent restraints: > 48 hours
Violent restraints: > 24 hours is considered prolonged.

POLICY

1. Patients have the right to the delivery of safe care and to be free from restraints or seclusion.
2. All direct care staff restraint education will focus on the RMC philosophy of preservation of patient dignity, respect for patient rights, practices for restraint alternatives, and employment of least restrictive measures for the least possible time.
3. The use of restraints is not specific to any geographic location and is not diagnosis specific.
4. The use of physical restraints or seclusion will:
   - will be driven by a comprehensive individual assessment that concludes that this patient will be at greater risk if restraint is not used.
   - be used in such a manner as to not cause any undue physical discomfort, harm or pain.
   - not be used as punishment, for convenience, in place of appropriate staffing, or because of a history of dangerous behavior, or history of previous restraint/seclusion use.
   - not be applied to a patient in a prone position.
   - be least restrictive, removed as soon as possible

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5. PRN restraint or seclusion orders are not allowed. If a restraint was removed or seclusion is stopped for any reason other than patient care needs or diagnostic testing; a new order is required.
6. It is expected that staff:
    - will develop and promote preventive strategies
    - will attempt alternative measures to modify behavior prior to utilizing restraints
    - will strive to eliminate use of restraints; use least restrictive restraint when necessary and remove restraint as soon as possible.
    - will monitor the following during a restraint episode: physical and emotional well-being; that the patient's rights, dignity and safety are maintained; whether less restrictive methods are possible; changes in behavior or clinical condition necessitating the removal of restraints.
    - Will educate patient and family to the reason for the restraint, alternatives used and the release criteria as appropriate
7. For violent and self destructive patients, direct caregivers are authorized to initiate and physically apply the restraint if there is imminent risk of harm/danger to a patient or others. The Rapid Response Team is called for complete patient evaluation and determination of restraint needs on units without this advanced training.
8. The use of restraint or seclusion must be in accordance with a written modification to the patient's plan of care and implemented in accordance with safe and appropriate techniques as determined by hospital policy and state law.
9. Seclusion is permitted in the Emergency Department only.
10. Rigid restraints are permitted in ED and CICU only.

PROCEDURE

I. <u>Restraints for non-violent and non-self destructive patient</u>

1. **Assess Patient**

   Assess the physical needs of the patient that may be causing behavior such as current medication management and physiological changes such as hypoxia prior to restraint application. Alternatives interventions are attempted and documented prior to the use of restraints.

2. **MD notification**

   Physician is to be notified when the restraints have been applied.

3. **Obtain Order**
    - The restraint may be initiated by a trained RN or other LIP responsible for the care of the patient.
    - The initial order for non-violent restraints is entered in CPOE or written on OPTIO Form # 17457 within 2 hours of restraint application.
    - An order for non-violent restraints must be entered into CPOE or written on OPTIO Form #17457 daily.

4. **Provider Assessment**

   A face-to-face evaluation by a Physician or other LIP and written order will be documented in the medical record within 24 hours of restraint initiation.

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5. **Patient Monitoring:** (RN/LPN)

   - Monitor and reassess patient a minimum of every 4 hours
   - Assess need for continued restraints according to restraint termination criteria.
   - Patients in non-violent restraints for more than 48 hours need to have an interdisciplinary team evaluation for alternatives or better options to minimize restraint use.

6. **Documentation: (**RN/LPN)

   - Document assessment, alternatives attempted, ongoing monitoring, and patient response on the Restraint Care Flow Sheet. (OPTIO form # 09943 or in CCS)
   - Plan of care will reflect rationale for restraint application.

7**. Termination of Restraint:** (RN/Physician)

   - Terminate the use of restraint at the earliest possible time when the patient exhibits ability to maintain a safe environment for themselves and others and /or can participate in plan of care.

II. <u>Restraints for violent or self-destructive behavior</u>

Restraints and or seclusion for these patients include all the requirements for non-violent in addition to the requirements below.

1. **Assess patient**
2. **MD notification**
3. **Obtain order**

The attending physician must be consulted as soon as possible if restraint or seclusion is not ordered by the patient's attending physician.

Orders must be renewed within the following time limits:

- Every 4 hours for adults 18 years of age and older.
- Every 2 hours for children and adolescents 9 to 17 years of age, and
- Every 1 hour for children under 9 years of age.

After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other LIP who is responsible for the care of the patient must see and assess the patient.

4. **Provide Assessment**

A physician or other LIP or a registered nurse (RN) must see the patient face-to-face within 1 hour after the initiation of the restraint and perform an evaluation.

5. **Patient Monitoring**
   Monitor and reassessment every 15 min
   Patients in restraints for violent or self-destructive behaviors for more than 24 hours need to have an interdisciplinary team evaluation for alternatives or better options to minimize restraint use

6. **Documentation**
   Documentation of assessment every 15 minutes on Restraint/Seclusion Flow sheet (OPTIO Form # 09943 or CCS)

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7. **Termination of Restraint**

III. Use of seclusion in the Emergency Department

1. All patients placed in the Seclusion Room will be searched for weapons and disrobed. Documentation of search will be noted in the ED medical record. The patient's belongings will not be allowed in the locked seclusion room.

2. Patients will be informed of the following:
   - Observation will be occurring by video and audio
   - Door may be locked

3. The family/significant others are notified of restraint/seclusion episode if patient consents to notification. Family members/friends will not be allowed to bring belongings/items to the patient unless they have first been checked by staff.
4. Staff members are discouraged from entering the Seclusion Room of a potentially violent patient, without being accompanied by another staff member

Patient Monitoring for seclusion

- Patients in seclusion only, after first hour of continuous face to face monitoring, continuous monitoring can be done with both video and audio equipment in close proximity to the patient. (If patient is in both restraint and seclusion, continuous, in-person monitoring must continue for the duration)
- Documentation done on OPTIO form # 09941 or CCS

IV. Training

Training is done as part of orientation and reviewed on an annual basis.

Annual Training includes:

1. For direct care staff and Respiratory Therapists
   - Application of restraints and competency assessment
   - Monitoring and assessment of a patient in restraints

2. For ED RNs, ED techs, and Security
   - Use of seclusion

3. For ED RNs, ED techs, CICU, and Security
   - Use of rigid restraints

Biennial Training (for selected staff) Content:

- *Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.*
- *The use of non-physical intervention skills.*
- *Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition.*

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- *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, vital signs and any special requirements specified by hospital policy associated with the 1 hour face to face evaluation.*
- *The use of first aid techniques and certification in the use of cardiopulmonary resuscitation*

Licensed Independent Practitioners:

Biennial (every 2 years) review of the restraints/seclusion policy is required by all physicians as part of credentialing/re-credentialing process.

VII. Report of Death

Hospitals must report deaths associated with the use of restraint or seclusion directly to CMS.

Reportable deaths include:

- Death occurred while the patient was in restraint or in seclusion
- Death occurred within 24 hours after restraint or seclusion was removed
- Death occurred within one week after restraint, seclusion which may have contributed to the Patient's death

Each death referenced in this section must be reported to CMS by telephone or fax no later than the close of business the next business day following knowledge of the patient's death. Staff must document in the patient's medical record the date and time the death was reported to CMS. (Use OPTIO Form #10330)

The Chicago Regional Office (Region 5) should be your initial point of contact at:

CMS – Region 5
233 North Michigan Avenue, Suite 600
Chicago, Ill 60601
Phone: 312-353-2853
Fax: 312-353-2852

VIII. Performance Improvement

A Restraint/Seclusion Documentation log will be completed for every restraint episode with the patient's name, shift, date, time of order, staff who initiated process, length of each episode, day of week each episode was initiated, type of restraint used, injuries to staff or individual, age, gender. This is then forwarded to the Nurse Manager for review and may be used in performance improvement initiatives.

ATTACHMENTS:

Restraints Flowsheet (#09943) can be printed from Optio.

Seclusion Flowsheet (#09941) can be printed from Optio.

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