

**Policy Title: Restraints/Seclusion
#5391**

Department: Nursing	
Audience: Nurse (Patient Care)	Last Review/Revision Date: 5/12/2024
Category: Patient Care	Classification: DNV Survey; Patient Care
Applies to but is not limited to: Nursing	
Location(s): Waconia campus; Arlington campus; Two Twelve campus; Le Sueur campus	

Accreditation/Regulatory Standard (if applicable): §482.13 (e) Standard: Restraint or Seclusion**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, dignity and well-being. When restraints are deemed necessary, such activity will be undertaken in a manner that protects the patient's health and safety and preserves their dignity, rights, and well-being.

DEFINITIONS**Restraint:**

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; or

Any 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 it is not a "standard treatment" or dosage for the patient's condition (CMS 42.C.F.R.).

The following are NOT considered restraints:

- Forensic restraints such as handcuffs, manacles, shackles, or other devices applied by non-hospital employed or contracted law enforcement officials. (Please refer to policy [# 5510 Prisoner Care](#))
- Recovery from anesthesia that occurs when the patient is in PACU is considered part of the surgical procedure; therefore, medically necessary restraint use (i.e., full side rails) is permissible until the patient recovers from the effects of anesthesia.
- Bedrails if used to protect the patient from falling out of bed or to assist patient to reposition themselves (A-0161).
- Raised side rails on a stretcher (a narrow, elevated, and highly mobile cart used to transport patients and to evaluate or treat patients).
- Age or developmentally appropriate protective safety interventions for children (i.e., cribs) that would typically be utilized outside of the healthcare setting are not considered a restraint.
- Prescribed orthopedic devices, surgical dressings or bandages, protective helmets ordered by a health care professional used to treat or manage a medical condition.
- Padded side rails put up for a patient on seizure precautions.
- Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests. Patients have the right to refuse treatment including physical examinations and tests.
- Use of an IV arm board to stabilize an IV line unless it is tied down or attached to bed.
- Physically holding a patient (i.e., child) to administer an injection and protect them from injury.
- Mitts unless tied down or pinned down or unless so bulky or applied so tightly that the patient cannot use or bend their hand.
- Devices worn by the patient that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement.

- A staff member picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient is not considered restraint.

Chemical Restraint:

- Drug or medication used 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.
- Medications are considered standard treatment if any of the following apply:
 - The drug or medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters.
 - The use of the drug or medication follows national practice standards established or recognized by the medical community, or professional medical associations or organizations.
 - The use of the drug or medication to treat a specific patient's clinical condition is based on the patient's symptoms, overall clinical situation, and on the physician's or other provider's knowledge of the patient's expected and actual response to the medication.

Mechanical Restraint:

- The use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior.

Physical Hold:

- Physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint.
- The application of force to physically hold a patient, in order to administer a medication against the patient's wishes.
- If a patient cannot easily remove or escape a grasp.

Restraint for Violent or Self-Destructive Behaviors:

- Behaviors that place the patient at risk for injuring self or others.

Restraint for Non-Violent Behaviors:

- Used to promote healing and improve the patient's well-being.

Prolonged Restraint:

- Non-violent restraints: > 48 hours
- Violent or self-destructive restraints: > 24 hours

Seclusion:

- Removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room.
- Otherwise involuntarily removing or separating a person from an area, activity, situation, or social contact with others and blocking or preventing the person's return.
- Seclusion may only be used for the management of violent or self-destructive behavior.

Physician or Other Licensed Practitioner:

A medical doctor (MD), doctor of osteopathy (DO), physician's assistant (PA), nurse practitioner (NP) or psychiatrist shall be referred to as providers for this policy.

POLICY

1. Patients have the right to the delivery of safe care and to be free from restraints or seclusion.
2. Restraint 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.
3. All direct care staff restraint education will focus on the Ridgeview 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
4. The use of restraints is not specific to any geographic location and is not diagnosis specific.
5. The use of physical restraints or seclusion 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; and
 - Be least restrictive, removed as soon as possible.
6. As needed or 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.
7. 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 by using least restrictive restraint when necessary and removing the restraint as soon as possible; and
 - 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; and changes in behavior or clinical condition necessitating the removal of restraints.
8. 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. On units without advanced training, Security (Waconia and Chaska) and 911 (Arlington and Le Sueur) is to be called for assistance with the patient evaluation and along with the supervisor or charge nurse and provider determine the best placement for the patient.
9. 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.
10. Rigid restraints are permitted in Emergency Department (ED) and CICU settings only.

PROCEDURE**Restraints for NON-VIOLENT and NON-SELF-DESTRUCTIVE Behavior****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.

2. Provider Assessment:

- A face-to-face evaluation by a physician or other licensed practitioner will be documented in the medical record within 24 hours of restraint initiation, even if the restraint is removed before the order expires.
- The physician or other licensed practitioner will assess the patient a minimum of daily thereafter.

3. Patient Monitoring/Documentation: (RN)

- Initiate patient care plan to reflect the rationale for restraint application and review and update every shift within the EHR based on assessment/evaluation of the patient
- Document assessment, alternatives attempted, ongoing monitoring, and patient response on MEDEX form #09943 Restraint Care Flow Sheet or in the patient's electronic health record
- Monitor and reassess the patient upon restraint application and a minimum of **every 4 hours** thereafter
- Patients in non-violent restraints for > 48 hours shall have an interdisciplinary team meeting to review and determine if any alternatives are available.
- Assessment documentation may include:
 - Alternative or less restrictive interventions attempted
 - Comfort measures offered, such as
 - Hydration needs
 - Elimination needs
 - Position change
 - Reason for restraints
 - Patient's response to interventions used
 - Vital signs
 - Circulation, motion, and sensation (CMS) status
 - Mental status
 - Skin condition

4. Termination of Restraint: (RN/provider)

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

Use of Physical Hold**• Physical Hold**

Using a physical hold when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own does not constitute an emergency.

• Physical Hold:

- Will be implemented only by staff trained in its use;
- Will be implemented properly as required; and
- The mental, physical, and emotional condition of the person who is being physically held will be assessed and intervention is provided when necessary to maintain the person's health and safety and

prevent injury to the person, staff involved, or others involved.

Conditions for Use of a Physical Hold

Use of a physical hold must meet the following conditions:

- Immediate intervention must be needed to protect the person or others from imminent risk of physical harm.
- The severity of the behavior places the patient or others in immediate and serious danger to physical safety.
- The type of physical hold used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety.
- The physical hold must end when the threat of harm ends.

When a physical hold is used, the same requirements as outlined for violent and self-destructive behavioral restraints apply.

The following conditions, on their own, are NOT conditions for use of a physical hold:

- The person is engaging in property destruction that does not cause imminent risk of physical harm.
- The person is engaging in verbal aggression with staff or others.
- The person is refusing to receive or participate in treatment or programming.

Positive support strategies and techniques, such as the following, must be used to attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others:

- Use of verbal guidance and feedback;
- Offering choices, including diversional activities;
- Speaking calmly with reassuring words;
- Actively listening; and/or
- Using positive reinforcement for desired behavior

Restrictions When Implementing Use of Physical Hold

Use of a physical hold must not:

1. Be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury;
2. Be implemented with an adult in a manner that constitutes abuse or neglect;
3. Be implemented in a manner that violates a person's rights and protection;
4. Be implemented in a manner that is medically or psychologically contraindicated for a person;
5. Restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing;
6. Restrict a person's normal access to any protection required by state licensing standards and federal regulations governing this program;
7. Be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment or services provided by this program;
8. Use prone restraint. "Prone restraint" means use of physical hold that places a person in a face-down position. It does not include brief physical holding of a person who, during an emergency, rolls into a prone position, and the person is restored to a standing, sitting, or side-lying position as quickly as possible;
9. Apply back or chest pressure while a person is in a prone position, supine (meaning a face-up) position, or side-lying position; or
10. Be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.

Restraints/Seclusion for VIOLENT or SELF-DESTRUCTIVE Behavior

Simultaneous use of restraint and seclusion are not permitted at any Ridgeview facility.

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. Alternative interventions should be attempted and documented prior to the use of restraints.

2. Provider notification:

- The attending physician or other licensed practitioner, who is responsible for the care of the patient, must be consulted as soon as possible if the attending physician or other licensed practitioner did not order the restraint or seclusion.

3. Obtain Order:

Orders for use of restraint must never be written as a standing order or on a needed basis; PRN).

- Whenever possible, an order for restraint or seclusion will be written prior to the application of restraints or seclusion.
- In an emergency situation, the restraint may be applied by a trained Registered Nurse (RN). In this circumstance, an order shall be obtained during application of the restraint or immediately (within a few minutes) after it has been implemented.
- The initial order for violent restraints/seclusion is entered in the electronic medical record. The order for violent restraints/seclusion must be re-entered into the electronic medical record according to 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.
 - Every 1 hour for children under 9 years of age.

After 24 hours, the physician or other licensed practitioner who is responsible for the care of the patient must complete a face-to-face assessment BEFORE writing a new order for restraints or seclusion.

4. Provider Assessment:

- A physician or other licensed practitioner must see the patient face-to-face **within 1 hour** after the initiation of restraint or seclusion and perform an evaluation. This evaluation needs to occur even if the restraint is discontinued prior to the 1-hour time frame. This face to face includes:
 - 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.

5. Patient Monitoring/Documentation: (RN)

- Initiate patient care plan to reflect the rationale for restraint application and review and update every shift within the EHR based on assessment/evaluation of the patient
 - Check and assess the patient upon restraint or seclusion initiation and **every 15 minutes** thereafter.
 - Patients placed in seclusion will receive continuous face-to-face monitoring for the **first hour**. After the first hour, continuous monitoring can be done with both video and audio equipment located in close proximity to the patient, but the patient will still be checked and reassessed every 15 minutes.
 - Document assessment, alternatives attempted, ongoing monitoring, and patient response on MEDEX form #09943 Restraint Care Flow Sheet or in the patient's electronic health record (EHR).
 - Documentation for patients in Seclusion should be done in the patient's EHR.
- Assessment documentation may include:
 - Alternative or less restrictive interventions attempted comfort measures offered, such as

1. Hydration needs
 2. Elimination needs
 3. Position change
- Reason for restraints
 - Patient's response to interventions used
 - Vital signs
 - CMS status
 - Mental status
 - Skin condition
- Patients in restraints for violent or self-destructive behaviors for more than 24 hours, which is defined as prolonged, need to have an interdisciplinary team evaluation for alternatives or better options to minimize restraint use.

6. Termination of Restraint:

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

Additional Information Regarding the Use of Seclusion

In addition to the requirements as outlined in the 'Restraints/Seclusion for VIOLENT or SELF-DESTRUCTIVE Behavior' section above, the following guidelines apply to patients placed in seclusion.

1. All patients placed in the Seclusion Room will be:

- Searched for weapons; and
- Disrobed and placed in a gown.
- Documentation of the search will be noted in the medical record.
- The patient's belongings will not be allowed in the seclusion room.

2. Patients will be informed of the following:

- Observation will be occurring by video and audio, (in-patient units have 1:1 observation)
- Door may be locked

3. Family/significant others:

- Are notified of restraint/seclusion episode if patient consents to notification.
- Will not be allowed to bring belongings/items to the patient unless have first been checked by staff.
- Will be allowed to be with the patient as long as they do not escalate the violent or disruptive behavior and the patient consents to their presence.

4. Staff members are discouraged from entering the Seclusion Room of a potentially violent patient without being accompanied by another staff member.

Training

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

2. **Annual Training includes:**

- **For direct care staff:**
 - Application of restraints and competency assessment
 - Review of monitoring and assessment requirements of a patient in restraints or seclusion
 - RidgeU eLearning module on de-escalation
- **For ED RNs, CICU RNs, Tele RNs, tele NAs and nursing supervisors:**

- Application of restraints and competency assessment
- Review of monitoring and assessment requirements of a patient in restraints or seclusion
- Use of rigid restraints (Waconia and Chaska campuses)
- Use of seclusion
- RidgeU eLearning module on de-escalation
- **For ED techs and Security**
 - Use of rigid restraints
 - Use of seclusion
 - RidgeU eLearning module on de-escalation

For additional information on MOAB training content, please see [Workplace Violence Prevention Plan \(WVPP\)](#).

3. Guidelines for Staff Education:

- Staff education and training will be provided to all caregivers that provide direct patient care to patients in restraints/seclusion including initiation of restraints, assessment of use, and ongoing patient evaluation/reevaluation during restraint use.
- The goal of staff education is to promote the minimal use of restraints and patient/staff safety if restraints are in use.
- Training and competency assessment will occur upon orientation, before applying restraints or Seclusion for the first time, and periodically on an as needed basis.
- Physicians or other licensed practitioners authorized to order restraints and/or seclusion must have a working knowledge of the hospital policy.
- Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.

4. Biennial Training 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.
- 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. (All direct care staff are required to maintain their BLS certification)

5. Provider Training:

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

6. EMT and Paramedics Training:

- Required to complete continuing education on behavioral emergencies and the use of restraints using CAPCE accredited Distance CME for EMTs and Paramedics on a bi-annual basis in addition to the required annual training for Paramedic staff via RidgeU modules.

Deaths

Reportable Deaths

1. Any death of a patient after they have been in restraints is reported to Ridgeview Administration and Centers for Medicare and Medicaid Services (CMS).
2. Hospitals must report deaths associated with the use of restraint or seclusion directly to their CMS Regional

Officer (RO) no later than the close of business on the next business day following knowledge of the patient's death in accordance with 42 CFR Section 482.13(g), the Conditions of Participation, and the State Operations Manual.

3. Reportable deaths include:

- Death occurred while the patient was in restraint or in seclusion; **excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion at the time of death.**
- Death occurred within 24 hours after restraint or seclusion was removed.
- Death occurred within one week after restraint, where it is reasonable to assume that the restraint or placement in seclusion contributed directly or indirectly to the patient's death.
 - "Reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

4. If a patient death is within ONE WEEK of being in restraints or seclusion, RN must complete the following:

- Print and complete Medex form #10330 Restraint/Seclusion Death Report Worksheet.
 - This worksheet helps determine if we are required to report a patient death to CMS.
 - If it is determined that the death is reportable, use the information on Medex form #10330 "Restraint-Seclusion Death Report Worksheet" to complete the CMS restraint death reporting (number 5 below).

5. If patient meets criteria on Medex form #10330 to report to CMS, navigate to the [CMS Restraint Death Reporting Link](#).

- Complete the hospital, patient and restraint information as the form prompts and when finished, select "Submit."

6. Send the original Medex worksheet via interoffice mail to Ridgeview Waconia ED Nurse manager.

Non-Reportable Deaths:

1. When no seclusion has been used and when the only restraint used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the following information should be recorded on Death in Restraints log by reporting to the Emergency department manager no later than 7 days after the date of death of the patient:
 - Patient's Name;
 - Date of Birth;
 - Name of Attending Provider;
 - Medical Record Number; and
 - Primary Diagnosis
2. Hospital must **NOT** send reports of these deaths directly to the RO.

Performance Improvement

1. Restraint log:

- 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 the restraint or seclusion, length of each episode, day of week each episode was initiated, type of restraint used, injuries to staff or individual, age and gender. This data is reviewed for trends and performance improvement activities and reviewed at the Safety and Risk Committee.

References

Centers for Medicare and Medicaid Services. (2020, October 12). *State Operations Manual - Appendix A*. Retrieved from Centers for Medicare and Medicaid Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

MN Department of Human Services: Officer of Inspector General (2020). Sample Policy: Emergency Use of Manual Restraint (EUMR) Policy.

Statutes, M. (n.d.). *Minnesota Statutes 2020*. Retrieved from Minnesota Statutes - 245D.02: <https://www.revisor.mn.gov/statutes/cite/245D.02/pdf>

42 CFR 482.13(g), *Death Reporting Requirements*