Restraint and Seclusion

Lesson 1: Objectives

After completion of this course you will be able to:

- Define restraint and seclusion;
- Identify interventions that may be effective in preventing the use of restraint;
- Recognize an accurate order for restraint or seclusion;
- Recall the important elements of monitoring and assessment;
- List documentation requirements;
- Appropriately report and document deaths associated with restraint or seclusion.

Introduction

Every patient should be treated with respect and dignity. Each patient has the right to be free from physical or mental abuse, and corporal punishment. This includes the right to be free from the inappropriate or unnecessary use of restraint or seclusion and to be safe when use of either intervention is necessary. Restraint or seclusion has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, violation of one's rights, and even death. However, restraint or seclusion is sometimes necessary in clinically justified situations given a healthcare organization's population and clinical services, the current state of knowledge, and availability of effective alternatives. Therefore, it is essential that healthcare professionals be competent in providing care for a patient in restraint or seclusion.

Lesson 2: Restraint and Seclusion Defined

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; or
- A drug or medication when it is used as a restriction to manage behavior or restrict freedom of movement and is not a standard treatment or dosage for the patient's condition. A drug or medication used as a standard treatment:
  - Is given within pharmacy parameters set by the Food and Drug Administration (FDA) and manufacturer;
  - Follows national practice standards; and
  - Is given to treat a specific condition based on a patient's symptoms.

Restraint may only be used to ensure the immediate physical safety of a patient, a staff member, or others. The restraint used must be the least restrictive and applied in compliance with safe and appropriate techniques. It is never acceptable to use restraints for discipline, retaliation by staff, coercion, as a substitute for adequate staffing, monitoring, assessment, or investigation of the reasons behind patient behavior. Restraints include, but are not limited to, vest jackets, hard wrist soft limb

restraints, elbow immobilizers, restraint belts, and hand mitts that are pinned or tied down. Mitts that are bulky and prevent the patient from use of their hands are also considered restraints.

A restraint does not include devices, such as orthopedically prescribed devices (slings and casts), surgical dressings or bandages, or protective helmets. A restraint does not include the physical holding of a patient for the purpose of conducting a routine physical examination or test. Therefore, holding a child to give an injection or start an IV is not a restraint. A device's intended use, its application, and/or the identified patient need determines whether the use of a device is considered a restraint. For example, if a patient requests or the physician or other licensed practitioner (LP) orders that all four bedrails be raised to protect the patient from falling out of bed and the patient can show that he or she can lower the side rails and get out of bed safely and appropriately when wanted, the bedrails are not a restraint. The ability of the patient to lower the side rails must be documented. If the patient cannot lower the side rails and the only way to exit is over the rails or out the end of the bed, then the side rails are considered a restraint. The same is true about the use of a geriatric chair the patient cannot exit safely and appropriately on their own. Refer to your organization's policy for what is and is not considered a restraint within your facility.

Age or developmentally appropriate protective safety interventions, such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers, that a safety-conscious child care provider outside a healthcare setting would use to protect an infant, toddler, or preschool-aged child would not be considered a restraint. A staff member picking up or holding an infant, toddler, or preschool-aged child to comfort the patient is also not considered a restraint. Refer to your organization's policy for use of these safety interventions within your facility.

Forensic devices (such as handcuffs and shackles) that are applied by outside law enforcement officials to patients that are prisoners are not considered restraints. The law enforcement officers who maintain custody and direct supervision of the prisoner (the patient) are responsible for the use, application, and monitoring of these devices. However, the organization is still responsible for providing safe and appropriate care and ensuring the devices are not injuring the patient.

A request from a patient or family member for the application of a restraint is not ample reason for the intervention. Regardless of whether restraint use is voluntary or involuntary, if it is used, then the requirements must be met.

Seclusion is the involuntary confinement of a patient alone in a room or area from which he or she is physically prevented from leaving. Seclusion may only be used for the management of violent and or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

Lesson 3: Restraint as a Last Resort

Restraint can only be used as a last resort when less restrictive interventions have been determined to be ineffective. That said, it is not always appropriate for these interventions to be attempted prior to the use of restraint.

Interventions that may be effective in preventing the use of restraint include:

- Management of pain or discomfort;
- Verbal instructions and reality orientation;
- A toileting routine;
- Ensuring food and hydration needs have been met;
- Limiting caffeine intake in the evening;
- Using a sleeve to cover the arm and hide an IV line;
- Consideration of medication changes;
- A quiet environment;
- Soothing music;
- Massage;
- Aromatherapy;
- Lighting changes;
- Activities such as puzzles, movies, television, coloring books, games, or activity books;
- Adjusting the room temperature;
- Ensuring glasses and hearing aids are in use and working;
- Adhering to a patient's routine or the development of a routine;
- Speaking to the patient often, especially while providing care;
- Returning to the patient when agreed upon or visiting with the patient frequently;
- Regular ambulation and exercise;
- Use of a low bed and padded mats;
- Use of movement sensors; and
- Placement of the patient closer the nurse's station.

Lesson 4: Plan of Care

The use of restraint or seclusion must be reflected in a patient's plan of care or treatment plan. The plan should be reviewed and updated within a timeframe specified by your organization.

Lesson 5: Restraint Order

Restraint or seclusion may be ordered by a physician or other licensed practitioner (LP), as permitted by your organization. If the order is not obtained by the attending physician, he or she must be notified as soon as possible, as defined by policy. When the attending physician is unavailable and has delegated responsibility to another physician, the covering physician can be notified.

Patients who are not violent and or self-destructive (sometimes referred to as non-behavioral health) must have an assessment performed and restraint order written, including what restraint device may be used, by a physician or other LP within a timeframe defined by policy. Each order for restraint may be renewed as authorized by policy.

Patients who are violent and or self-destructive (sometimes referred to as behavioral health) must be seen face-to-face within one hour after the initiation of restraint or seclusion by a physician or other LP, or a trained registered nurse **(RN),** physician assistant (PA), or nurse practitioner (NP) to evaluate the patient's immediate situation, reaction to the intervention, and medical and behavioral condition. The need to continue or end the intervention must also be evaluated. If the evaluation is conducted by an RN,

PA, or NP, he or she must consult the attending physician or other LP as soon as possible. The evaluation must be documented in the medical record. If the intervention is discontinued prior to the 1-hour point the evaluation is still required and an order must still be entered into the medical record. Patients who are violent and or self-destructive must have a time limited order for the restraint or seclusion. The order may be renewed in accordance with the following limits for up to a total of 24 hours: 4 hours for adults 18 years of age or older, 2 hours for children and adolescents 9 to 17 years of age; or 1 hour for children under 9 years of age. The physician or other LP has the discretion to write the order for a shorter length of time. After 24 hours, before writing a new order, a physician or other LP must see and assess the patient.

Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. If staff ends an ordered intervention, they have no authority to start it again without the initiation of a new order. However, a temporary release that occurs for the purpose of caring for a patient's needs, for example, toileting, feeding, and range of motion, is not considered a discontinuation of the intervention. Follow your organization's policy for the appropriate discontinuation of restraint or seclusion.

Generally, a restraint order cannot be written as needed (PRN) or as a standing order. A protocol cannot serve as a substitute for obtaining a physician or other LP order before initiating restraint use. However, a protocol may contain information that is helpful for staff, such as how a restraint is to be applied and monitored. The medical record must include documentation of the assessment, symptoms, and diagnosis that triggered the protocol.

Restraint or seclusion may be initiated before receiving an order in certain situations, such as an emergency, or as determined by your organization's policy. The policy should address this process, including who can initiate the use of restraint and the timeframe in which an order is to be obtained.

Lesson 6: Monitoring and Assessment

Ongoing assessment and monitoring of the patient's condition by a physician, other LP, or trained staff are crucial for the prevention of injury, death, or adverse event. The appropriate interval for the assessment and monitoring of a patient's needs, such as hydration needs, circulation checks, level of distress and agitation, mental status, cognitive functioning, skin integrity, nutritional needs, range of motion, elimination needs, and other care needs are based on the individual requirements of the patient, his or her condition, and the type of restraint, as defined by policy. The importance of appropriate assessment and monitoring of the patient's physical, emotional, and behavioral condition when restraint is used cannot be overemphasized. Reassessments of the patient's condition are essential to assure that the intervention ends as soon as possible.

Lesson 7: Documentation

It is important to have meticulous documentation when restraint or seclusion is used. When used, the following must be documented in the medical record:

- A description of the patient's behavior and the intervention used;

- Alternatives or less restrictive interventions attempted (as applicable);
- The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and
- The patient's response to the intervention used, including the need for its continued use.

Additional elements of documentation are specified in your organization's policy.

Lesson 8: Simultaneous Use of Restraint and Seclusion

Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored face-to-face by an assigned, trained staff member. If the patient is too dangerous for the staff member to be in the room, it can be done by trained staff using both video and audio equipment. This monitoring must be near the patient.

Lesson 9: Reporting

Healthcare organizations must report certain deaths associated with the use of restraint or seclusion to the Centers for Medicare and Medicaid Services (CMS) Regional Office. This includes:

- Each death that occurs while a patient is in restraint or seclusion.
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
- Each death known to the organization that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a 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.

Each death must be reported to the CMS Regional Office no later than the close of business the next business day following knowledge of the death. The date and time the death was reported to CMS must be documented in the medical record.

When death occurs and only one or two soft wrist restraints were used without seclusion this can be recorded in an internal log instead of reported to CMS. The entry must be made no later than seven days after the death and must include the patient's name, date of birth, date of death, name of attending physician or other LP, medical record number, and primary diagnosis. This information must be made available to CMS immediately upon request. The date and time the death was recorded in the log must also be documented in the medical record.

It is your role to report deaths associated with the use of restraint or seclusion to the designated person(s) within your organization responsible for reporting to CMS or recording in the internal log.

Lesson 10: Conclusion

Your organization is committed to preventing, reducing, and eliminating the unnecessary use of restraint or seclusion. And it takes your help. If you have questions about restraint or seclusion, contact the appropriate personnel within your organization for guidance and assistance.

Restraint

Lesson 1: Objectives

After completion of this course you will be able to:

- Define restraint;
- Identify interventions that may be effective in preventing the use of restraint;
- Recognize an accurate order for restraint;
- Recall the important elements of monitoring and assessment;
- List documentation requirements; and
- Appropriately report and document deaths associated with restraint.

Introduction

Every patient should be treated with respect and dignity. Each patient has the right to be free from physical or mental abuse, and corporal punishment. This includes the right to be free from the inappropriate or unnecessary use of restraint and to be safe when use of the intervention is necessary. Restraint has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, violation of one's rights, and even death. However, restraint is sometimes necessary in clinically justified situations given a healthcare organization's population and clinical services, the current state of knowledge, and availability of effective alternatives. Therefore, it is essential that healthcare professionals be competent in providing care for a patient in restraint.

Lesson 2: Restraint Defined

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; or
- A drug or medication when it is used as a restriction to manage behavior or restrict freedom of movement and is not a standard treatment or dosage for the patient's condition. A drug or medication used as a standard treatment:
  - Is given within pharmacy parameters set by the Food and Drug Administration (FDA) and manufacturer;
  - Follows national practice standards; and
  - Is given to treat a specific condition based on a patient's symptoms.

Restraint may only be used to ensure the immediate physical safety of a patient, a staff member, or others. The restraint used must be the least restrictive and applied in compliance with safe and appropriate techniques. It is never acceptable to use restraint for discipline, retaliation by staff, coercion, as a substitute for adequate staffing, monitoring, assessment, or investigation of the reasons behind patient behavior. Restraints include, but are not limited to, vest jackets, hard wrist soft limb restraints, elbow immobilizers, restraint belts, and hand mitts that are pinned or tied down. Mitts

that are bulky and prevent the patient from use of their hands are also considered restraints.

A restraint does not include devices, such as orthopedically prescribed devices (slings and casts), surgical dressings or bandages, or protective helmets. A restraint does not include the physical holding of a patient for the purpose of conducting a routine physical examination or test. Therefore, holding a child to give an injection or start an IV is not a restraint. A device's intended use, its application, and/or the identified patient need determines whether the use of a device is considered a restraint. For example, if a patient requests or the physician or other licensed practitioner (LP) orders that all four bedrails be raised to protect the patient from falling out of bed and the patient can show that he or she can lower the side rails and get out of bed safely and appropriately when wanted, the bedrails are not a restraint. The ability of the patient to lower the side rails must be documented. If the patient cannot lower the side rails and the only way to exit is over the rails or out the end of the bed, then the side rails are considered a restraint. The same is true about the use of a geriatric chair the patient cannot exit safely and appropriately on their own. Refer to your organization's policy for what is and is not considered a restraint within your facility.

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A request from a patient or family member for the application of a restraint is not ample reason for the intervention. Regardless of whether restraint use is voluntary or involuntary, if it is used, then the requirements must be met.

Lesson 3: Restraint as a Last Resort

Restraint can only be used as a last resort when less restrictive interventions have been determined to be ineffective. That said, it is not always appropriate for these interventions to be attempted prior to the use of restraint.

Interventions that may be effective in preventing the use of restraint include:

- Management of pain or discomfort;
- Verbal instructions and reality orientation;
- A toileting routine;
- Ensuring food and hydration needs have been met;
- Limiting caffeine intake in the evening;

- Using a sleeve to cover the arm and hide an IV line;
- Consideration of medication changes;
- A quiet environment;
- Soothing music;
- Massage;
- Aromatherapy;
- Lighting changes;
- Activities such as puzzles, movies, television, coloring books, games, or activity books;
- Adjusting the room temperature;
- Ensuring glasses and hearing aids are in use and working;
- Adhering to a patient's routine or the development of a routine;
- Speaking to the patient often, especially while providing care;
- Returning to the patient when agreed upon or visiting with the patient frequently;
- Regular ambulation and exercise;
- Use of a low bed and padded mats;
- Use of movement sensors; and
- Placement of the patient closer the nurse's station.

Lesson 4: Plan of Care

The use of restraint must be reflected in a patient's plan of care or treatment plan. The plan should be reviewed and updated within a timeframe specified by your organization.

Lesson 5: Restraint Order

Restraint may be ordered by a physician or other licensed practitioner **(LP),** as permitted by your organization. If the order is not obtained by the attending physician, he or she must be notified as soon as possible, as defined by policy. When the attending physician is unavailable and has delegated responsibility to another physician, the covering physician can be notified.

Patients who are not violent and or self-destructive (sometimes referred to as non-behavioral health) must have an assessment performed and restraint order written, including what restraint device may be used, by a physician or other LP within a timeframe defined by policy. Each order for restraint may be renewed as authorized by policy.

Patients who are violent and or self-destructive (sometimes referred to as behavioral health) must be seen face-to-face within one hour after the initiation of restraint or by a physician or other LP, or a trained registered nurse **(RN),** physician assistant (PA), or nurse practitioner (NP) to evaluate the patient's immediate situation, reaction to the intervention, and medical and behavioral condition. The need to continue or end the intervention must also be evaluated. If the evaluation is conducted by an RN, PA, or NP, he or she must consult the attending physician or other LP as soon as possible. The evaluation must be documented in the medical record. If the intervention is discontinued prior to the 1-hour point the evaluation is still required and an order must still be entered into the medical record. Patients who are violent and or self-destructive must have a time limited order for the restraint. The order may be renewed in accordance with the following limits for up to a total of 24 hours: 4 hours for adults 18 years of age or older, 2

hours for children and adolescents 9 to 17 years of age; or 1 hour for children under 9 years of age. The physician or other LP has the discretion to write the order for a shorter length of time. After 24 hours, before writing a new order, a physician or other LP must see and assess the patient.

Restraint must be discontinued at the earliest possible time, regardless of the length of time identified in the order. If staff ends an ordered intervention, they have no authority to start it again without the initiation of a new order. However, a temporary release that occurs for the purpose of caring for a patient's needs, for example, toileting, feeding, and range of motion, is not considered a discontinuation of the intervention. Follow your organization's policy for the appropriate discontinuation of restraints.

Generally, a restraint order cannot be written as needed (PRN) or as a standing order. A protocol cannot serve as a substitute for obtaining a physician or other LP order before initiating restraint use. However, a protocol may contain information that is helpful for staff, such as how a restraint is to be applied and monitored. The medical record must include documentation of the assessment, symptoms, and diagnosis that triggered the protocol.

Restraint may be initiated before receiving an order in certain situations, such as an emergency, or as determined by your organization's policy. The policy should address this process, including who can initiate the use of restraint and the timeframe in which an order is to be obtained.

Lesson 6: Monitoring and Assessment

Ongoing assessment and monitoring of the patient's condition by a physician, other LP, or trained staff are crucial for the prevention of injury, death, or adverse event. The appropriate interval for the assessment and monitoring of a patient's needs, such as hydration needs, circulation checks, level of distress and agitation, mental status, cognitive functioning, skin integrity, nutritional needs, range of motion, elimination needs, and other care needs are based on the individual requirements of the patient, his or her condition, and the type of restraint, as defined by policy. The importance of appropriate assessment and monitoring of the patient's physical, emotional, and behavioral condition when restraint is used cannot be overemphasized. Reassessments of the patient's condition are essential to assure that the intervention ends as soon as possible.

Lesson 7: Documentation

It is important to have meticulous documentation when restraint is used. When used, the following must be documented in the medical record:

- A description of the patient's behavior and the intervention used;
- Alternatives or less restrictive interventions attempted (as applicable);
- The patient's condition or symptom(s) that warranted the use of the restraint; and
- The patient's response to the intervention used, including the need for its continued use.

Additional elements of documentation are specified in your organization's policy.

Lesson 8: Reporting

Healthcare organizations must report certain deaths associated with the use of restraint to the Centers for Medicare and Medicaid Services (CMS) Regional Office. This includes:

- Each death that occurs while a patient is in restraint.
- Each death that occurs within 24 hours after the patient has been removed from restraint.
- Each death known to the organization that occurs within 1 week after restraint where it is reasonable to assume that use of restraint contributed directly or indirectly to a 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.

Each death must be reported to the CMS Regional Office no later than the close of business the next business day following knowledge of the death. The date and time the death was reported to CMS must be documented in the medical record.

When death occurs and only one or two soft wrist restraints were used this can be recorded in an internal log instead of reported to CMS. The entry must be made no later than seven days after the death and must include the patient's name, date of birth, date of death, name of attending physician or other LP, medical record number, and primary diagnosis. This information must be made available to CMS immediately upon request. The date and time the death was recorded in the log must also be documented in the medical record.

It is your role to report deaths associated with the use of restraint to the designated person(s) within your organization responsible for reporting to CMS or recording in the internal log.

Lesson 9: Conclusion

Your organization is committed to preventing, reducing, and eliminating the unnecessary use of restraint. And it takes your help. If you have questions about restraint, contact the appropriate personnel within your organization for guidance and assistance.

Status **Active** PolicyStat ID **8934878**

Origination	2/1/2015	Owner	Lily Peck: Patient Safety Officer
Last Approved	8/30/2021	Area	Provision of Care
Effective	8/30/2021	Applicability	Mon Health Medical Center
Last Revised	8/30/2021		
Next Review	8/29/2024		

Restraint/Seclusion

POLICY:

Mon Health Medical Center is committed to appropriate use of restraints. Restraint/seclusion will only be used if less restrictive interventions have been assessed and determined to be ineffective to protect the patient/staff/others from harm and with an order from Medical Staff or Advanced Practice Professional. During the use of restraint, the patient's rights, dignity, and wellbeing will be protected and respected. There are two types of restraint recognized at Mon Health Medical Center: Non-Violent, Non-Self-Destructive restraint and Violent or Self-Destructive Restraint. The decision to use a restraint/ seclusion is not driven by the diagnosis, but by a comprehensive individual patient assessment.

RESPONSIBILITY:

Administration, Medical Staff and/or Advanced Practice Professionals, All Direct Care Staff

DEFINITIONS:

Restraint - A restraint is

a. any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body, with or without the patient's permission, that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely.

b. 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. Standard treatment enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of the drug/ medication. Criteria for Standard Medication Treatment include:

    1. Drug/medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and manufacturer indications.

2. Follows national practice standards established/recognized by the medical community/medical professional associations.
3. Drug/medication is used to treat specific patient clinical condition that is based on that patient's specific symptoms, overall clinical situation, and on the Medical Staff/ Advanced Practice Professionals' knowledge of that patients expected and actual response to the drug/medication.

Non-Violent, Non-Self-Destructive Restraint - used to limit mobility or temporarily immobilize in relation to a medical, post-surgical or dental procedure. The patient's behavior is nonviolent and non-aggressive. The primary reason for use directly supports the medical healing of the patient.

Violent or Self-Destructive Restraint - used in an emergency or crisis in which a patient's behavior becomes aggressive or violent; the behavior presents an immediate, danger that jeopardizes the immediate physical safety of the patient/staff members/others.

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/staff member/others.

Restraint does not include devices such as orthopedic prescribed devices, surgical dressings, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations/tests or to permit the patient to participate in activities without risk of physical harm. Examples include, but not limited to:

1. IV arm board to stabilize an IV line.
2. Mechanical support used to achieve proper body position/balance/alignment (e.g., leg brace).
3. Medically necessary positioning/securing device used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, diagnostic, or surgical procedures.
4. Recovery from anesthesia that occurs when the patient is in critical care or post anesthesia (PACU) is considered part of the surgical procedure.
5. Age/developmentally appropriate protective safety interventions (e.g., high chair, lap belts, raised crib rails) that a safety-conscious child care provider outside a health care setting would utilize to protect an infant/toddler/pre-school child would not be considered restraint/ seclusion.

The following restraints used at Mon Health Medical Center are listed from least restrictive to most restrictive:

- 4 side-rails up
- Soft limb - 2 extremities
- Soft limb - 4 extremities
- Hard limb

Staff education/training - All staff that have direct patient contact will have ongoing education and training in the proper and safe implementation of restraint application, techniques, and alternative methods for handling events, symptoms, situations, and documentation upon orientation and annually.

PROCEDURE:

1. Patient assessment will reflect medical factors, behavioral factors, and a functional status prior to applying a restraint.
2. The use of alternatives or less restrictive device/intervention will be attempted, determined ineffective, and documented. Examples include, but are not limited to, use of diversional activity, bed exit alarms, or change in patient environment.
3. A family member will be contacted and made aware of the patient assessment prior to application of a restraint, if possible.
4. An RN may apply a physical restraint prior to obtaining a provider order only when the patient is in immediate danger of harm to himself or others. An assessment of the patient must determine that the risk associated with use of restraint/seclusion is outweighed by the risk of not using the restraint/seclusion.
    1. *When applying restraints for non-violent, non-destructive reasons*, Medical Staff/ Advanced Practice Professional must **be notified immediately** and a verbal or written order obtained. Medical Staff or Advanced Practice Professional should examine the patient within 24 hours of restraint initiation.
    2. *When applying restraints for violent, self-destructive reasons,* Medical Staff or Advanced Practice Professional must see the patient face-to-face and evaluate the need for restraint **within one hour** after initiation of the intervention to evaluate the patient's immediate situation, patient's reaction to intervention, patient's medical and behavioral condition, and the need to continue or terminate the restraint/seclusion, and document the assessment in the patient's medical record. **If the patient recovers quickly and is released from restraint within the first hour of use, Medical Staff or Advanced Practice Professional must still complete the one-hour face-to-face evaluation.**
    3. When the face to face is performed by a Physician Assistant (PA) he/she must consult the Medical Staff attending that is responsible for the care of the patient as soon as possible after completion of the one-hour face-to-face evaluation.
    4. In some situations, the need for a restraint/seclusion intervention may occur so quickly that an order cannot be obtained prior to the application of restraint/ seclusion. In these emergency application situations, the order must be obtained either during the emergency application of the restraint or seclusion, or immediately after the restraint/seclusion has been applied.
    5. The Medical Staff or Advanced PRactice Professional must be consulted as soon as possible if the Medical Staff or Advanced Practice Professional did not order the restraint.
5. The restraint order must:
    1. Be time limited - time limits for restraint orders are as follows:
        - For non-violent, non-destructive restraint each calendar day up to 24 hours, and orders must be renewed daily
        - For violent, self-destructive restraint =

Up to 4 hours for adults 18 years and older
Up to 2 hours for ages 9 to 17 years
Up to one hour for children less than 9 years

The violent, self-destructive original order may only be renewed in accordance with these limits for up to a total of 24 hours. At the end of the time frame, if the continued use of restraint/seclusion to manage violent or self-destructive behavior is deemed necessary based on an individualized patient assessment, another order is required. A face-to-face evaluation by the physician/midwife must be conducted every 24 hours for violent, self-destructive restraints. Prior to writing new order, the Medical Staff or Advanced PRactice Professional will document their findings in patient's medical record to support the continued use.

2. Identify the type of restraint to be used.
3. Indicate the reason for restraint.
4. Each episode of restraint/seclusion must be initiated per Medical Staff or Advanced Practice Professional order. If a patient was released from restraint/seclusion and exhibits behavior that can only be handled through the reapplication of restraint/seclusion, a new order must be obtained.
5. Be automatically discontinued if not renewed.
6. Orders must never be written as a PRN or as a standing order.

6. Prior to order expiration, the RN will report to the provider the results of the most recent assessment and request a renewal of the original order for another period. This time cannot exceed the time limits noted above.
    1. Restraints/seclusion will be discontinued at the earliest possible time, regardless of the length of time identified in the order.

7. The patient in restraints will be cared for as follows:
    1. Restraints will not be used as a disciplinary action.
    2. Patients will be restrained in a face up position.
    3. The RN will document in the patient medical record:
        - Communication with patient, family, physician
        - Patient behavior or symptoms that warrant the use of restraint/seclusion; response to the intervention used.
        - Patients will be assessed prior to restraint/seclusion to identify medical problems that may be causing behavior changes in the patient, e.g., hypoxia, hypoglycemia, electrolyte imbalances.
        - Type of restraint needed and time of application.
        - Alternatives to a restraint that were attempted.

8. The frequency of monitoring should be determined based on the assessed needs of the patient. At a minimum, patients will be observed on an ongoing basis at least **every two hours**

for non-violent, non-destructive restraint and **every 15 minutes** for violent, destructive restraint and documented in the medical record.

- At a minimum, documentation will include circulation, motion, sensitivity, cognitive functioning, vita! signs, level of distress, hydration/elimination needs met, mental status, and skin integrity. Direct supervision or release is not considered a discontinuation of restraint/seclusion.
- The actual monitoring may be delegated to assistive personnel with oversight by the registered nurse. However, the registered nurse is responsible for reassessing the behavior and need for continued restraint.
- After restraints are applied, the patient will be assessed immediately to ensure that restraints were properly applied, as well as **every two hours** for non-violent, non-destructive restraints and **every 15 minutes** for violent, destructive restraints.

9. Restraints and seclusion should be ended as soon as the patient's status permits or other alternatives are available, as assessed by the Registered Nurse.
10. Patient assessment and the time the restraint is removed will be documented.
11. The patient plan of care will be updated and individualized to indicate that restraints are in use.
12. The Unit Director or designee will be notified of any patient in violent, destructive restraints for greater than 24 hours to work with the patient and staff in identifying ways for the patient to regain control and to revise the treatment plan as appropriate.
13. Patients requiring a re-application of restraints after discontinuation, based on the RN's assessment, will require a new order.
14. Simultaneous restraint/seclusion use is only permitted if the patient is continually, without interruption, monitored face-to-face by assigned, trained staff members.
15. The use of handcuffs, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this rule.

PERFORMANCE IMPROVEMENT:

1. Mon Health Medical Center is committed to reducing the risk associated with restraint use by using performance improvement strategies to identify preventive strategies and innovative alternatives. The goal is to understand why restraints are used and, when appropriate, to reduce the use.
2. Data will be collected and aggregated on restraint episodes. Data will be analyzed to identify performance improvement opportunities and reported through the appropriate committees of our performance improvement structure.
3. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS) regarding deaths related to restraint or seclusion (this requirement does not apply to deaths related to the use of soft wrist restraints)
    1. Reporting of death to CMS must occur:
        a. Death that occurs while a patient is in restraint/seclusion.

b. If death occurs while a patient is only in soft, 2-point restraints, CMS does not need to be notified; however, the hospital will maintain a log of all such deaths.

c. If a patient dies within 24 hours after removal from restraint/seclusion.

d. Any death known to the hospital that occurs within one week after restraints/seclusion were used when it is reasonable to assume that the restraints or seclusion contributed directly or indirectly to the patient's death.

e. The death must be reported to the Centers for Medicare & Medicaid Services (CMS) Regional Office (RO) by telephone/fax no later than the close of business the next business day following knowledge of the patient's death.
Regional Office Contact Information:
RO contact phone 1-215-861-4662, FAX 1-215-861-4146

4. The event will be forwarded to the Risk Management Department for reporting or logging and documentation in the medical record.

Reference:

The Joint Commission Accreditation Standards Manual July 1, 2020

Approval Signatures

Step Description	Approver	Date
Administrative Approval	Krystal Atkinson: Chief Nursing Executive	8/30/2021
Patient Care and Safety Committee	Laura Evans: Sr. Director of Quality [DH]	8/30/2021
	Erin Johnston: Patient Safety Officer	8/24/2021