SUBJECT: RESTRAINT OR SECLUSION USE	REFERENCE #8126
DEPARTMENT: ORGANIZATIONWIDE	PAGE: 1 OF: 21
	EFFECTIVE:
APPROVED BY:	REVISED:

NOTE:

- This policy and procedure meets CMS Conditions of Participation.
- This policy and procedure is for those hospitals that use Joint Commission (TJC) accreditation for deemed status purposes.
- This policy and procedure meets the National Integrated Accreditation for Healthcare Organizations (NIAHO) standard.
- This policy and procedure does not apply to forensic and correctional restrictions used for security purposes. However, if the restraint or seclusion is related to the clinical care of an individual under forensic or correctional restrictions, then the standards and this policy and procedure apply.
- Restraint policies and procedures must incorporate State regulations.
- *Restraint or Seclusion Policies and Procedures for those hospitals that do not use The Joint Commission for accreditation for deemed status purposes are available upon request.*

DEFINITIONS:

- The restraint or seclusion regulations/standards used for this policy and procedure are not specific to treatment setting or diagnosis. This policy and procedure applies to all uses of restraint in all hospital care settings.
- Restraint or seclusion is based on nonviolent, non-self destructive behavior and violent or self-destructive behavior.
- Restraint use associated with nonviolent or non-self destructive behavior shall be used only when the restraint directly supports medical healing.

- Pursuant to CMS current hospital Conditions of Participation (CoPs) under Subpart B, Administration at Sec. 482.13 (e):
  - A restraint is defined as:
    - 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, including, but not limited to:
      - Tucking a patient's sheets in so tightly that the patient cannot move
      - Use of "net bed" or an "enclosed bed" that prevents the patient from freely exiting the bed
        - Exception: Placement of a toddler in an "enclosed" or "domed crib"
      - Use of "Freedom" splints that immobilize a patient's limb
      - Using siderails to prevent a patient from voluntarily getting out of bed
      - The application of force to physically hold a patient in order to administer a medication against the patient's wishes is considered a restraint
      - Geri-chairs or recliners, appliances that prevent the patient from getting out of the chair on his or her own
    - A general rule of thumb is that if a patient can easily remove a device, the device would not be considered a restraint. In this context, easily remove means that the manual method, device, material or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff (i.e., siderails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied) considering the patient's physical condition and ability to accomplish objective (i.e., transfer to a chair, get to the bathroom in time). Anything that prevents the patient access to his/her body, moving his/her arms, legs or ambulating in a normal manner is a restraint.

- A restraint is also defined as:
  - 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" includes:
      - Medication that is used in accordance with FDA guidelines and manufacturer indications (including dosing parameters)
      - Medication that is used in accordance with national practice standards or recognized by the medical community and/or professional medical association or organization
      - Medication is used based on the patient's symptoms, overall condition and on the licensed independent practitioner's knowledge of the expected and actual patient responses to the medication
      - Another component of "standard treatment or dosage" for a drug or medication is the expectation that the standard use of a drug or medication to treat the patient's condition enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of the drug or medication. If the overall effect of a drug or medication, or combination of drugs or medications, is to reduce the patient's ability to effectively or appropriately interact with the world around the patient, then the drug or medication is **NOT** being used as a standard treatment or dosage for the patient's condition.
  - The use of PRN orders is prohibited for drugs or medications that are being used as restraints.

- Seclusion is defined as:
  - The involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.
    - Timeout is not considered seclusion. Timeout is an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses.

- Restraints do **NOT** include the following:
  - Standard practices that include the limitation of patient mobility or temporary immobilization for medical, dental, diagnostic or surgical procedures and the related post-procedure care
  - Methods to hold a patient during routine examination or procedure are not considered restraints as long as the patient's right to refuse treatment is honored
  - Orthopedically prescribed devices, dressings or bandages
  - Hand mitts unless they are pinned or otherwise attached to bedding using a wrist restraint in conjunction with the hand mitts; or if the mitts are applied so tightly that the patient's hands or fingers are immobilized; or if the mitts are so bulky that the patient's ability to use his/her hands is significantly reduced
  - An IV board to maintain IV access
  - Supports used in Imaging Services or the operating room
  - Therapeutic holding or comforting of children
  - Adaptive support devices are used in response to an assessed patient need, such as postural supports, orthopedic appliances, tabletop chairs

- Methods used to permit the patient to participate in activities without the risk of harm, i.e., Merry-Walkers
- Protective helmets
- Devices to prevent a patient from falling out of bed:
  - If two (2) bedrails are raised, the patient is able to get out of bed; this is not a restraint.
  - If four (4) bedrails are raised to prevent the patient from getting out of bed, this is considered a restraint if the patient is not able to lower the siderails without assistance.
- The use of siderails on a stretcher
- Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, highchair lap belts, raised crib rails and crib covers) that a safety-conscious child care provider outside a healthcare setting would utilize to protect an infant, toddler or preschool-aged child would not be considered restraint or seclusion for the purposes of this regulation
- A physical escort would include a “light” grasp to escort the patient to a desired location
  - If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint and all the requirements would apply.

- For the purpose of ordering restraint or seclusion, an LIP is any practitioner permitted by State law and hospital policy as having the authority to independently order restraints or seclusion for patients.

POLICY:

- The use of restraint or seclusion shall be based on a comprehensive patient assessment that includes a physical assessment to identify medical conditions that may be causing behavior changes in the patient.

- The use of restraint or seclusion shall be documented in the patient's plan of care. This plan of care shall be reviewed and revised every _____.

- _____ Hospital ensures the use of restraint or seclusion is clinically justified and guided by criteria present in current evidence-based national practice guidelines, practice parameters, pathways of care or other standardized care procedures developed by the appropriate professional organizations.

- The use of restraint or seclusion may only be used to ensure the immediate physical safety of the patient, staff or others, and must be discontinued at the earliest possible time.

- Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.

- All patients have the right to be free from physical or mental abuse and corporal punishment.

- All patients have the right to be free from restraint or seclusion, of any form, imposed by staff as a means of coercion, discipline, convenience or retaliation.

- Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm.

- Restraint or seclusion must be used in accordance with a written modification to the patient's plan of care.

- Use of restraint must be implemented in accordance with safe and appropriate restraint techniques as determined by hospital policy and in accordance with State law.

- The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member or others from harm.

- Restraints shall be ended at the earliest possible time regardless of the timeframe specified in the order.

- Only those individuals who have completed restraint application training may apply restraints to patients.

- If the restraint or seclusion is discontinued prior to the expiration of the order, a new order must be obtained prior to re-initiation of the restraint or seclusion.

RESTRAINT OR SECLUSION ORDERS:

- Any order for restraint must be preceded by attempts and documentation that other, less restrictive, measures have been found to be ineffective to protect the patient or others from harm.

- Restraint orders are to be written in accordance with modifications to the patient's plan of care.

- Any order for restraint shall not be written as a PRN or standing order basis.

    - If a patient was recently released from restraint and exhibits behavior that can only be handled by the reapplication of restraint, a new order would be required.

    - Staff cannot discontinue an order and then re-start it under the same order, because that would constitute a PRN order.

    - A "trial release" constitutes a PRN use of restraint or seclusion and, therefore, is **NOT** permitted.

- Each episode of restraint use must be initiated in accordance with the order of an MD/DO or other LIP. However, a temporary release that occurs for the purpose of caring for a patient's needs (i.e., toileting, feeding, range of motion) is not considered a discontinuation of the intervention. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint or seclusion.

- Restraint or seclusion must be used in accordance with the order of a physician or other licensed independent practitioner (LIP) who is responsible for the care of the patient as specified under CMS §482.12 (c), and is authorized to order restraint or seclusion by hospital policy in accordance with State law. [CMS §482.13(e)(5)]

    - In some situations, however, the need for a restraint or seclusion intervention may occur so quickly that an order cannot be obtained prior to the application of restraint or seclusion. In these **emergency application situations**, the order must be obtained either during the emergency application of the restraint or seclusion, or immediately (within _____ minutes) after the restraint or seclusion has been applied.

    - The following trained staff may initiate restraint or seclusion during an **emergency** situation:

      _____ _____

      _____ _____

      _____ _____

- The attending physician shall be consulted as soon as possible if the attending physician did not order the restraint or seclusion. [CMS §482.13(e)(7)]

- **Orders for Restraint for the Management of Nonviolent, Non-Self Destructive Behavior:**

    - Orders for <u>restraint for the management of nonviolent, non-self destructive behavior</u> are renewed in accordance with hospital policy at least each calendar day.

    - Orders for restraint for the management of nonviolent, non-self destructive behavior must be renewed every _____.

    - The LIP does not have to be physically present to re-evaluate the need for continuing restraint for nonviolent and non-self destructive behavior.

- **Orders for Restraint or Seclusion for the Management of Violent or Self-Destructive Behavior:**

  - Unless superseded by State law that is more restrictive, each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others, may only be renewed in accordance with the following limits for up to a total of 24 consecutive hours [CMS 482.13(e)(8)(i)]:

    - Four (4) hours for adults 18 years of age or older
    - Two (2) hours for children and adolescents nine (9) to 17 years of age
    - One (1) hour for children under nine (9) years of age

  - At the end of the above timeframes, if the continued use of restraint or seclusion to manage violent or self-destructive behavior is necessary, based on patient assessment, another order is required.

  - A trained RN shall contact the patient's physician when the original order is about to expire. The RN shall report the results of the patient's most recent assessment and request that the original order be renewed.

  - It is at the discretion of the physician in conjunction with a discussion with the patient's RN whether an onsite assessment is necessary prior to renewing the order.

  - Another one (1) hour face-to-face patient evaluation is not required when the original order is renewed.

  - The original restraint or seclusion order may only be renewed within the required time limits for a total of 24 hours. After the original order expires, a physician must see and assess the patient before issuing a new order.

- **Orders for Restraint or Seclusion Must Specify:**
  - The reason (medical necessity; rationale for the use of restraint or seclusion) for the restraint or seclusion
  - The type of restraint
  - The extremity or body part(s) to be restrained
  - The duration (timeframe) for restraint application or seclusion and the date and time
    - Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
- **Protocols That Include the Use of Restraint:**
  - As stated in this policy, PRN or standing orders for patient restraint are not allowed by this organization.
  - However, application of patient restraint may be included in diagnosis-specific clinical protocols and/or pathways. The restraint requirements when included in a protocol or pathway must meet the same requirements listed in this policy, and there must be a patient-specific order, by an LIP, authorizing the use of each episode of restraint or seclusion.
  - When implementing a protocol that includes the use of a restraint, a separate order must be obtained for the restraint.
  - When using a protocol that includes the use of restraint, the patient assessment and symptoms that meet use-triggering criteria listed in the protocol must be documented in the patient's medical record.
  - The medical staff shall develop, review and monitor the use of protocols that include the use of restraint.

PROCEDURE:

- _____ Hospital requires the following procedures be followed for the use of restraint or seclusion:
    - Any order for restraint or seclusion shall be preceded by attempts and documentation that other, less restrictive measures have been found to be ineffective to protect the patient or others from harm.
- Verify that the order for restraint or seclusion includes rationale for restraint, length of time and type of restraints to be used, and the extremity or body part(s) to be restrained.
- The restrained patient may feel isolated, angry, anxious or confused. Frequent patient contact and reassurance are necessary.
- Explain to the patient and/or family the plan and rationale for using restraint or seclusion and the condition/behavior required for release from restraint or seclusion.
- **Application of Restraint:**
    - Apply the appropriate-sized restraint snugly to the body part, but not tight enough to interfere with circulation or breathing:
        - Using a slipknot, fasten restraints to the bed frame, not to the siderails.
        - Place the call light within reach of the patient.
        - Applying a vest restraint for the patient who is in bed:
            - With the patient in a sitting position, place the vest over the patient's gown. Make sure a correctly sized vest is used.
                - A vest or belt that is too large can cause strangulation, a vest/belt that is too small can cause asphyxiation.
            - Criss-cross the cloth flaps at the front, placing the V-shaped opening at the patient's throat.

- Pass the tab on one (1) flap through the slot on the opposite flap. Adjust for patient comfort.
- Tie the vest straps securely to the bed frame. Use a knot or bow that can be released quickly. Ensure the straps are secured at a juncture of the bed frame and will not slide in any direction changing the position of the vest.
- Leave one to two (1-2) inches of slack in the straps for movement.
- Straps should be snug, but should not interfere with the patient's breathing.
- You should be able to slide your hand (flat hand) between the vest and the patient.
- Monitor the patient to ensure the patient is not able to slide down.

- Limb Restraint:
  - Pad the wrist or ankle of the patient with gauze if the restraint is not made of a soft material, or use a padded limb restraint.
  - Pass the strap on the narrow end of the restraint through the slot in the wider end, and adjust for a snug fit.
  - Tie the restraint's long strap ends securely to the bed frame or out of the patient's reach if the patient is sitting in a chair. Flex the patient's arm or leg slightly before securing straps, and leave one to two (1-2) inches of slack. Tie a bow or knot that can be released quickly.
  - Release the limb restraint and perform range of motion on the affected limb every two (2) hours at a minimum. If the skin appears blue or feels cold, or if the patient complains of a tingling sensation, burning or numbness, the restraint should be loosened and the patient's condition reassessed.

- Body Holder (Belt) Restraint for the patient who is in bed:
  - Center the larger section of the belt on the bed with the soft side up.
  - Center the patient on the belt. The belt should be centered in the small of the patient's back.
  - Wrap the shorter strap around the patient's waist, and buckle the strap onto itself.
  - Attach the straps at waist level to the bed frame. Use a knot or bow that can be released quickly. Ensure the straps are secured at a juncture of the bed frame and will not slide in any direction changing the position of the vest.

- **Assessment, Monitoring and Evaluation of Patients in Restraint or Seclusion:**
  - Patients in restraint or seclusion shall be monitored and assessed at least every 24 hours by a physician or trained staff that have completed the training criteria.
  - The LIP must evaluate the patient even if the patient is removed from restraint prior to the expiration of the order within 24 hours of the order initiation.
  - Assessment of the patient in restraints, including assessment intervals, shall be based on the individual patient's needs, the patient's condition and the type of restraint or seclusion used. [CMS §482.13(e)(4)]
  - Assessment of the patient shall include (as applicable):
    - The physical and emotional well-being of the patient
    - That the patient's rights, dignity and safety are maintained
    - If less restrictive methods may be used
    - Identification of specific behavioral changes that would indicate that restraint is no longer necessary

- Whether the restraint has been applied and removed correctly
- Respiratory status
- Circulatory status:
  - Check the circulation in the restrained extremity(ies) to assure that the restraints are not too tight and a pulse is present
- The mental status and cognitive functioning of the patient
- Level of distress and agitation of the patient, i.e., restless, resting, agitated, talking in normal tone of voice, yelling
- Assess for skin breakdown:
  - Active or passive exercise shall be given to the effected extremity before replacing the restraint
  - Release the restraints for 10 minutes to apply skin care and range of motion exercises when the patient is awake and if appropriate
- Nutrition, presence/absence of hunger and thirst
- Personal hygiene
- Toileting
- Vital signs
- Any injuries caused by the application of the restraint

- Change the patient's position every two (2) hours and as needed.

- **Pediatric Considerations:**
  - The reason for applying a restraint must always be explained to both the parent and the child. A doll or stuffed animal may be used for demonstration.
  - During the application of the restraint, stimulation and diversion should be provided to relieve the sense of helplessness and loneliness.
  - Removal of restraints is reasonable when the child is attended by family members or by staff who are observing and supervising the patient closely.
  - Papoose board restraint (infant treatment restraint):
    - Open straps on board
    - Place infant in supine position on board
    - Secure straps around body, limbs, head of infant

- **Patients Who Are Simultaneously Restrained and Secluded Must Be Continuously Monitored (Ongoing Without Interruption):**
  - Face-to-face by a trained staff member *or*
  - By a trained staff member using both audio and video equipment
    - If using audio and video equipment, the staff member must still be in close proximity to the patient [CMS § 482.13(e)(15)]

- **One (1) Hour Face-to Face Evaluation of a Patient in Restraint or Seclusion for the Management of Violent or Self-Destructive Behavior:**

  - When restraint and/or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff or others, the patient must be seen face-to-face within one (1) hour after the initiation of the intervention by either a physician or other LIP, or a registered nurse or physician assistant who has received the appropriate training. The evaluation shall include a physical and behavioral health assessment which includes evaluation of: [CMS §482.13(e)(12)]

    - The patient's immediate situation

      - Review with staff patient's physical and psychological status

    - The patient's reaction to the intervention

    - The patient's medical and behavioral condition

    - The need to continue or terminate the restraint or seclusion

  - The attending physician or other LIP, who is responsible for the patient, must be consulted as soon as possible after completion of the one (1) hour face-to-face exam if this evaluation is conducted by an RN or PA. [CMS §482.13(e)(14)

  Note: Ending the intervention prior to the one (1) hour point does not mean that the mandated assessment and consultation are no longer necessary. These steps are still required even if the intervention ends within one hour of initiation.

DOCUMENTATION:

- Documentation in the medical record should include:
  - Restraint orders, including the rationale for the restraint, the type of restraint, the extremity or body part(s) to be restrained and the duration (timeframe) for restraint application, LIP authentication
  - Alternatives or other less restrictive interventions attempted, as applicable
  - The patient's condition or symptom(s) that warranted the use of restraint or seclusion
  - The patient's response to the restraint or seclusion, including the rationale for continued use of the intervention
  - The one (1) hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior
  - Monitoring, assessment and reassessments of the patient
  - Revisions to the plan of care
  - Unanticipated changes in the patient's condition
  - The protocol or references to the protocol, when patient restraint is an element of the protocol
  - Criteria used for continuation and discontinuation of the restraint
  - The discussion with the patient/family regarding the need for restraints
  - Any injuries to the patient
  - Death associated with the use of a restraint, date and time
  - Notification of the attending physician
  - Consultations

- Restraint Flowsheet:
    - The restraint flowsheet will be used for each incident of restraint:
        - Date and time the patient is placed in restraints
        - Type of restraint and extremity restrained
        - Times of assessment
        - Time of rotation of restraint and/or time the patient is removed from restraints
        - Reassessment of the patient regarding clinical condition, comfort level, circulation, condition of limbs, skin and attention to hydration, elimination and nutrition based on individual patient needs

STAFF EDUCATION:

- Staff applying restraints will have training in, and demonstrate competency in the physical application and use of restraints, as well as the requirements and regulations regarding restraints.
- LIPs shall receive training on the use of restraint or seclusion and the hospital's policies and procedures addressing restraint or seclusion.

REPORTING OF PATIENT DEATHS ASSOCIATED WITH RESTRAINT OR SECLUSION:

- The hospital must report deaths associated with restraint or seclusion to its CMS Regional Office no later than the close of business the next business day following knowledge of the patient's death. [CMS §482.13(f)(7)]

- CMS has replaced the requirement that hospitals must report deaths that occur while a patient is only in soft, 2-point wrist restraints, with a requirement that hospitals must maintain a log (or other system) of all such deaths. This log must be made available to CMS immediately upon request. The log is internal to the hospital and the name of the practitioner responsible for the care of the patient may be used in the log in lieu of the name of the attending physician if the patient was under the care of a non-physician practitioner and not a physician.

PERFORMANCE IMPROVEMENT:

- The use of restraint or seclusion shall be monitored and evaluated on a continual basis as a part of this hospital's organizational Performance Improvement Plan.

- _____ Hospital shall identify opportunities to reduce the risks associated with restraint use through preventive strategies, alternatives and process improvement.

    - Areas to be monitored shall include (not all inclusive):

        - Evidence of prolonged restraint
        - Patient injury
        - Patient death
        - Staff injury
        - Excessive use of restrain

- Nursing staff shall enter patient information in the restraint log for all episodes of restraint. This information will be used for performance improvement activities. The log shall contained the following information:
    - Shift
    - Date/time of order
    - Staff who initiated the process
    - Length of each episode
    - Date and time each episode was initiated
    - Type of restraint or seclusion used
    - Compliance with requirements defined in the standards
    - Whether injuries were sustained by patient or staff
    - Age of patient
    - Gender of patient

NOTES:

- Pregnant patients, the elderly, obese patients and patients with breathing difficulties should have the head of the bed elevated 30 degrees if using any type of restraint on the abdomen.
- All restraints are to be kept in full view and not covered with sheet or bedspread.
- A registered nurse with appropriate training will direct the procedure.
- Soft restraints must be easily removed in the event of fire or other emergencies.
- Hospitals should review State laws, CMS Regulations and accrediting agency standards regarding restraint and seclusion, and follow the strictest standard/regulation.
- See restraint manufacturer's instructions for application and removal of restraints.

REFERENCES:

- Centers for Medicare and Medicaid Services (CMS), *Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation*, Federal Register, Vol. 77, No. 95, Wednesday, May 16, 2012, Rules and Regulations, http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/CMS-3244-F.pdf

- Application Instruction Sheet Posey® Criss-Cross Vests, http://www.posey.com/files/I9203-Posey%C2%AE-Criss-Cross-Vests.pdf

- Application Instruction Sheet Posey® Limb Holders, http://www.posey.com/files/I9214C-Posey%C2%AE-Limb-Holders.pdf

- Application Instruction Sheet Posey® Body Holders, http://www.posey.com/files/I9227-Posey%C2%AE-Body%20Holders.pdf