I. SCOPE:

This policy applies to [insert facility/hospital name here] (“Hospital”). It is a hospital-wide policy that would apply to any department providing patient care.

II. PURPOSE:

The purpose of this policy is to define the Hospital’s approach to the application of restraint and seclusion for patients in a way that protects the patient’s health and safety, and preserves his or her dignity, rights and well-being.

III. DEFINITIONS:

A. “Restraint” means any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body. If the effect of using an object fits the definition of restraint for a specific patient at a specific time, then for that patient at that time, the device is a restraint. The definition renders unnecessary the otherwise impossible task of naming each device and practices that can inhibit a patient’s movement. There are some devices which are specifically prohibited by the hospital due to the risk associated with using these devices. Vest or belt type restraints are prohibited in any population. (See Attachment D)

B. “Violent or self-destructive” and “non-violent or medical” are terms used to describe behaviors which cause the need for restraint. These restraints are not setting specific, but can occur on any unit in the hospital. The type of restraint ordered (violent or non-violent) determines the documentation and monitoring requirements for the patient. (See chart under section Authorization and Ordering of Restraints.)

C. “Violent or self-destructive” behavior jeopardizes the immediate physical safety of the patient, a staff member or others and preventive, de-escalative, or verbal techniques have not been effective. (See Attachment A)

D. “Non-violent or medical” behaviors are behaviors resulting from a non-psychiatric medical condition and/or do not jeopardize the immediate safety of others. If these behaviors are not interrupted then medical healing may not occur or the patient could cause harm to self. (See Attachment A)
E. “Seclusion” is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving. For example, a staff member standing in front of the unlocked door of a patient’s room with the intent of not allowing the patient to leave the room has placed the patient in seclusion. Seclusion may only be used for the management of violent or self-destructive behaviors.

F. “Constant Observer” is the utilization of a competent staff member in order to provide continuous observation of a patient to support safety. See CO-2.033 Constant Observer Usage Assessment, Implementation, and Discontinuation (“Constant Observer Policy”)

NOTE: Restraint Standards do not apply to the following defined situations:
- Voluntary mechanical support
- Age appropriate protective safety interventions
- Forensic and correction restrictions used by law enforcement (see Attachment C)

IV. POLICY:

It is the policy of the Hospital to limit the use of restraint and seclusion to those situations where it is necessary to ensure the immediate physical safety of the patient, staff members, or others with appropriate physical assessment and adequate clinical justification and to facilitate the discontinuation of restraint or seclusion as soon as possible based on an individualized patient assessment and re-evaluation.

V. PROCEDURE:

A. Methodology

1. If indicated, only staff who have been trained and demonstrated competence in applying the restraint being used are to apply restraints using the guidelines documented in the manufacturer’s instructions.

2. If patient requires non-violent application of restraints, always consider use of 2 point restraints first. When patient assessment indicates a need for restraints, consider 3 point first, with a constant observer. If patient fails to calm, implement 4 point restraints with a constant observer.
3. Inform the Rapid Response Team (RRT) of a Restraint Alert for patients in 3-4 point non-violent restraint so that the Rapid Response team can conduct a physiological assessment. Note: for patients in the Emergency Department, it is the ED physician’s responsibility to assess for underlying causes which are contributing to the need for restraint. Once patient is transferred from the ED, staff may need to activate Rapid Response Team (see attached sample form).

4. Obtain order from a physician or other Licensed Independent Practitioner (LIP) authorized by the organized medical staff and in accordance with law and regulation. Document the physician/LIP’s order for restraint on the Physician/LIP’s Order Sheet for Restraint or Seclusion.

5. Implement constant observer policy for 4 point restraints

6. As early as feasible in the restraint process, make the patient aware of the rational for the intervention.

7. Once the patient is de-escalated, calm, and safe, begin documentation on the Restraint Flowsheet.

8. When a restraint is implemented, the patient’s plan of care must be modified to reflect this change.

9. RN assessments are documented on the Restraint Flowsheet following the Observation and Monitoring guidelines.

10. Document in the patient’s medical record any injuries that occur during the restraint or seclusion episode, as well as the treatment provided for those injuries.

11. Once the patient meets the criteria for release, the restraint is discontinued. The decision to discontinue the intervention must include a determination that the patient’s behavior is no longer a threat to himself/herself.
B. Authorization and Ordering of Restraints

1. Restraint is initiated only upon the order of a physician or LIP.

   a. In an emergent situation, and when a physician or LIP is not readily available, a Registered Nurse competent in restraint usage may initiate restraint use based on an appropriate assessment of patient needs. An important assessment for the non-violent patient is to include the minimum type of restraint which can be safely applied with consideration of 2, 3 or 4 point restraints. The comprehensive assessment shall include physical assessment to identify medical problems that may be causing a change in the patient’s behavior. If the patient requires 3-4 point restraints, the Registered Nurse will activate the hospital Rapid Response Team (RRT) for a Restraint Alert when the behavior of a non-violent patient changes rapidly. The application of 4 point restraints requires a constant observer. The RRT will assess medical problems known to change behavior such as changes in vital signs, drug or medication interactions, electrolyte imbalances, hypoxia, or sepsis among others. (Note: A history of falling without a current clinical basis for restraint interventions is inadequate to demonstrate the need for restraints.) The order must be obtained either during the emergency application of the restraint or immediately (defined as without time interval) after the restraint has been applied. (See Attachment E for RRT Restraint Checklist)

   b. If restraint continues to be clinically justified, continued use of restraint must be authorized by the physician or other LIP. Restraint orders must be renewed on a daily basis. The attending physician or LIP’s progress note must address the need for continued use of non-violent restraints every calendar day. A face-to-face physical examination is required by the physician or LIP every 24 hours for violent restraint to determine the clinical justification for the continued use of restraints. Restraint orders must be dated and timed when signed by the physician or LIP, and include: 1) criteria for
release; 2) type of restraint used; 3) reason for restraint; 4) and specify duration of restraint order.

<table>
<thead>
<tr>
<th>Non-Violent or Medical Support Restraint Track</th>
<th>Violent Restraint Track</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess patient for minimum type of restraint needed. Consider 2 point first, then 3 point. If patient fails to calm then consider 4 point.</td>
<td>• Maximum time for violent restraint:</td>
</tr>
<tr>
<td>• When 3 point restraints are applied, consider Constant Observer policy using 1:1 monitoring.</td>
<td>• 4 hours ages 18 and up</td>
</tr>
<tr>
<td>• When 4 point restraints are applied implement constant observer process for 1:1 monitoring.</td>
<td>• 2 hours ages 9-17</td>
</tr>
<tr>
<td>• Activate RRT for physiological assessment to ensure a catastrophic physiological event is not occurring.</td>
<td>• 1 hour less than 9 years of age</td>
</tr>
<tr>
<td>• Maximum time for non-violent, non-self-destructive restraint is a calendar day based on physician face to face assessment.</td>
<td>• May be renewed by phone up to 24 hours</td>
</tr>
<tr>
<td>• Attending physician or LIP must address continued need for restraint in daily progress note entry.</td>
<td>• Face to face assessment by physician or LIP required at least every 24 hours with phone contact every 4,2,1 hour for renewal</td>
</tr>
<tr>
<td></td>
<td>• Additional assessment by physician or trained RN or PA required within 1 hour of order regardless of removal of restraint/seclusion</td>
</tr>
</tbody>
</table>

2. If the ordering physician or LIP is not the attending physician or LIP, the attending physician or LIP must be consulted as soon as possible. The attending physician or LIP may have information regarding if the patient’s history significantly impacts the use or selection of the restraint.
3. Restraint orders are never written on an “as needed” basis or as PRN orders or standing orders. Trial releases are not permitted as the release of the patient is considered as discontinuation of the restraint order. Therefore, to allow the patient to again be restrained using the same order equals a PRN restraint order.

   a. A temporary release that occurs for the purpose of caring for a patient’s needs, i.e., toileting, feeding, and range of motion, is not considered a discontinuation of the intervention.

4. If the need for restraint is based on a significant change in the patient’s condition, the Registered Nurse must immediately notify the physician or LIP and activate the RRT for a full assessment (see B.1.a. above) to ensure a catastrophic event is not occurring.

C. Documentation

1. Each episode of restraint use shall be documented in the patient’s medical record, and shall include but not be limited to:

   a. Assessment and reassessment, including:
      • Significant changes in the patient’s condition that warranted restraint use
      • Patient’s response to restraint

   b. Relevant orders for use of restraints, including time limit, clinical justification, type of restraint to be used, and criteria for release.

   c. Results of patient monitoring will occur at regular intervals according to the individual’s assessed needs but not to exceed 2 hours between intervals. All patients in 4 point restraints will be continuously monitored following the Constant Observer Policy.

   d. Use of restraints must be addressed in the patient’s modified plan of care.

   e. Discontinuation of restraint at earliest possible time.
- Decision based on the determination that the medical need for restraint is no longer present or that the patient’s needs can be met with less restrictive methods.

2. Patient needs will be met during restraint use
   a. Restraint may not act as barrier to the provision of safe and appropriate care, treatments, and other interventions to meet the needs of the patient.
   b. The plan of care will not be compromised by the use of restraints and shall include:
      - Provision of nutritional needs
      - Provision of hydration needs
      - Provision of elimination needs
      - Provision of hygiene needs
      - Provision of exercise and range of motion
      - Provision of patient safety and comfort
      - Discuss restraint, when practical, with patient and family around the time of use

3. Monitoring and Reassessment
   a. The restrained patient is assessed, monitored, and reassessed.
   b. Individual patient need and health status is used to establish the frequency, nature, and extent of monitoring that is required by the patient in restraints. Patients in the medical setting such as ICU and medical surgical units who experience a sudden change in behavior may be experiencing a critical decline in physiological status such as hypoxia, blood clots, sepsis, etc. When the non-violent patient is placed in 4 point restraint, a Constant Observer (according to the Constant Observer Policy) will be assigned to monitor the patient until the 4 point restraint is discontinued.
Monitoring is accomplished by observation, direct face-to-face interaction with the patient or related direct examination of the patient by trained and competent staff. (See Constant Observer Policy).

d. Appropriate interval for re-assessment is based on the patient needs, condition, and type of restraint use.

<table>
<thead>
<tr>
<th>Non-Violent or Medical Support Restraint Track</th>
<th>Violent Restraint Track</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Real-time documentation of assessment of restrained patient status at a minimum of every 2 hours for 2 point restraints.</td>
<td>• Constant Observer with real time documentation of assessment of restrained patient at least every 15 minutes.</td>
</tr>
<tr>
<td>• Constant Observer for patients in 4 point restraints</td>
<td>• A patient in 3-4 point restraints shall have continuous observation/monitoring according to the Constant Observer Policy.</td>
</tr>
<tr>
<td>• Notify rapid response team for all patients in 3-4 point restraints.</td>
<td></td>
</tr>
</tbody>
</table>

e. A patient in 2 point restraints is monitored at least every two hours or sooner according to patient need. A patient in 3-4 point restraints shall have continuous observation/monitoring according to the Constant Observer Policy. (Example: continuous face-to-face monitoring may be needed when restraint leaves a patient vulnerable.)

f. Monitoring determines the following:

- Patient’s physical and emotional well-being with close attention paid to changes in physiological status (See Constant Observer Checklist for Patient in Restraint)
- Maintenance of patient’s right, dignity, and safety
- Assessment of patient’s condition to determine if the current restraint should be continued or if less restrictive methods could be used or restraints could be discontinued
- Safety of restraint application, removal or re-application
g. Assessment and Reassessment must include, but are not limited to:
   • Ability to clear airway
   • Circulation (including vascular checks such as capillary refill, temperature, and color of skin
   • Heart Rate
   • Respirations
   • Skin Integrity
   • Sensation
   • Ability to move extremities
   • Level of distress and agitation
   • Behavior
   • Mental status
   • Cognitive functioning
   • Elimination needs
   • Patient safety and comfort, during and after restraint is removed
   • Other criteria based on the type of intervention used and the patient’s condition.

D. Death Reporting Requirement

The Hospital must report deaths associated with the use of restraint or seclusion. Refer to Clinical Operations policy CO-2.010 Sentinel Event Response and Reporting for guidance on reporting of deaths which occur while the patient is in restraint or seclusion, occur within 24 hours after the removal from restraint or occur within 1 week after use of restraint or seclusion and it is reasonable to assume that the cause of death was directly or indirectly related to the restraint or seclusion (see attached sample reporting form).

1. The Hospital will report the following information to the Centers for Medicare and Medicaid Services (CMS) (see 42 CFR 482.13 Conditions of Participation: Patient Rights) by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient’s death:
   • 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 Hospital 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, regardless of the type(s) of restraint used on the patient during this time. “Reasonable to assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or deaths related to chest compression, restriction of breathing or asphyxiation.

• The staff must document in the patient’s medical record the date and time the death(s) was reported to CMS.

2. When no seclusion has been used and when the only restraints 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 Hospital staff must record in an internal log or other system, the following information:

• Any death that occurs while a patient is in such restraints
• Any death that occurs within 24 hours after a patient has been removed from such restraints
• Entries into the internal log or other system must be documented as follows:
  o Each entry must be made not later than seven days after the date of death of the patient;
  o Each entry must document the patient’s name, date of birth, date of death, name of attending physician or other LIP who is responsible for the care of the patient, medical record number, and primary diagnosis;
  o The information must be made available in either written or electronic form to CMS immediately upon request.

E. Responsible Person

The ____[insert title]_____ is responsible for ensuring that all individuals adhere to the requirements of this policy, that these procedures are implemented and followed at Facility and that instances of non-compliance with this policy are reported to the ____[insert title of senior individual with leadership/operational oversight for the area]_____.

F. Enforcement
All Hospital staff and Medical Staff Members whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, including the Medical Staff Bylaws, Rules and Regulations.

VI. REFERENCES:


- Medicare Conditions of Participation for Hospitals, 42 CFR 482.13

- Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation Final Rule Federal Register, 77 FR 29034


- Clinical Operations policy CO-2.010 Sentinel Event Response and Reporting

- CO-2.033 Constant Observer Usage Assessment, Implementation, and Discontinuation

VII. ATTACHMENTS:

- Attachment A: Restraint Flowcharts

- Attachment B: Performance Improvement and Competency

- Attachment C: Definitions and Information Points

- Attachment D: Special Considerations Associated with Special/Vulnerable Populations

- Attachment E: Rapid Response Restraint Checklist