FLOYD MEDICAL CENTER
POLICY AND PROCEDURE MANUAL
PATIENT CARE SERVICES

TITLE: Restraint/Seclusion	Policy No.: PCS-03-006
Purpose: To provide consistent guidelines for safe use of restraints and/or seclusion; as well as to define and delineate the procedures that governs the appropriate use of restraints and/or seclusion. This policy provides procedures for the use of restraint with non-violent/self-destructive patients as well as patients exhibiting violent and self-destructive behavior, to identify patient's basic rights, ensure patient safety, and eliminate the inappropriate use of restraint or seclusion. Each patient has the right to receive care in a safe setting. The safety of the patient, staff, or others is the basis for initiating and discontinuing the use or restraint or seclusion.	**Developed Date:** 1992 **Review Date:** 1994, 1995, 1996, 3/14 **Revised Date:** 1/97, 5/98, 8/99, 2/03, 7/05, 10/06, 2/07, 8/07, 8/09, 7/11, 8/12, 1/15, 1/17, 3/17, 4/18, 12/18, 10/19, 6/20 **Review Responsibility:** Executive VP; Chief of Patient Services/CNO, Nursing Leadership; Administrator and Director of Nursing at Floyd Behavioral Health; Director of ECC; Executive Committee of the Medical Staff; Executive Staff
Expected Outcomes: Patients requiring the implementation of restraints or seclusion should be provided care based on individual need, appropriate medical and mental status assessment, and preserving and maintaining the patient's rights and personal dignity. There will be limited, justified use of restraint only to the extent required when less restrictive methods and preventive attempts fail to be effective in dealing with behavior that clearly endangers the life or physical well-being of a patient or others. Restraint and seclusion will not be utilized for punitive measures or as a part of a behavior management program.	
Reference Standards: PC.03.05.01; PC.03.05.03, PC.03.05.05, PC.03.05.07, PC.03.05.09, PC.03.05.11, PC.03.05.13, PC.03.05.15, PC.03.05.17, PC.03.05.19, 42 CFR Part 482.13	

Policy:
It is the policy of FLOYD that the use of restraints and/or seclusion should be limited to emergencies in which there is an imminent risk of a patient physically harming himself or herself, staff, or others, and when alternative nonphysical interventions have been determined to be ineffective to promote safety. Restraint and/or seclusion should only be implemented with consideration given to the patient's assessed physical and emotional needs, exploration of the patient's history to determine the most appropriate and effective intervention to meet the patient's specific needs, clinical indications, and the protection of the patient's rights, dignity, and well-being. FLOYD leadership will communicate the organization's philosophy on the use of restraint and/or seclusion to all staff that have direct patient care responsibility.

The goal of FLOYD leadership is to limit restraint and/or seclusion use to appropriate clinical episodes and to utilize the least restrictive method possible; to prevent, reduce, and strive to eliminate the use of restraint and/or seclusion while providing a safe environment for all patients and staff; facilitate the discontinuance of restraint and/or seclusion as soon as possible; to raise awareness among staff about how the use of restraint and/or seclusion may be experienced by

the patient; to provide ongoing education and training for all staff who provide patient care to the patient who may potentially require interventions to promote safety to self or others, and to create an environment that minimizes circumstances that give rise to restraint and/or seclusion use and that maximizes safety when they are used. FLOYD is committed to providing an environment that is as least restrictive and restraint free as possible for the patients entrusted to our care.

The use of Vest restraints is prohibited. In the event a patient is transferred to our facility from another facility with a vest restraint in place, the need for continued restraint use should be immediately assessed and appropriate interventions implemented.

DEFINITIONS

Adequate Clinical Justification: A listing and discussion of symptoms and other behaviors that indicate imminent self harm or harm to others, where less restrictive interventions are ineffective, and restraint use is necessary to promote safety.

Assessed Needs: The assessment of each patient at the time of admission or intake to consider the patient's current clinical condition and to obtain information about the patient that could help minimize the use of restraint or seclusion. Clinical information may include identifying:

- **Techniques, methods, or tools that would help the patient control his or her behavior
- **Pre-existing medical conditions or any physical disabilities and limitations that would place the patient at greater risk during restraint or seclusion
- **Any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint or seclusion

Behavioral/Violent/Self Destructive Restraints: The use of restraints for behavior management includes emergency measurements reserved for occasions when unanticipated, severely aggressive or destructive outburst places the patient or others in imminent danger.

Medical Surgical/Non-Violent/Non-Self-Destructive Restraints: Medical Surgical Restraint requires a time limited (not to exceed 24 hours) physician order when the need for restraint has been determined by the physician in collaboration with the registered nurse. These are based on situations where less restrictive methods have been tried and where the patient's assessed behavior meets clinical justification criteria.

Patient Needs: The physiological and psychological needs that a restrained or secluded patient requires to protect his or her well-being, dignity, and comfort. A nurse may determine a patient's needs based on the needs of average patients or on an assessment of the patient, whichever seems most effective in the situation. These needs include at least liquids, food, toilet access, skin integrity, circulatory and neuro-sensory well-being, bathing, and limb movement.

Protocol: A directive for the nursing staff that consists of a set of standardized criteria and clinical steps for the application and termination of restraint, as well as contacting the physician for orders, as indicated within the specific protocol. Protocols for the use of restraints may be established, based upon the frequent presentation in those conditions or procedures of behavior by patients that seriously endangers the patient or seriously compromises the effectiveness of the procedure (i.e. intubation/vents). Only a registered nurse that has completed required training and has demonstrated competence is authorized to initiate restraint use in accordance with the criteria and procedures stated in the appropriate protocol. When a restraint is applied via protocol, the protocol should reflect FLOYD's policies and procedures on the appropriate and safe use of

restraint. In addition, nurses must meet requirements regarding restraint which include patient and family education and protection of the patient's rights, dignity, and well-being.

After assessing a patient and determining that the patient requires restraint and meets the criteria stated in a protocol, a nurse must document:

- the assessment;
- evidence that the patient meets the criteria in the protocol;
- the placement of the patient in restraints;
- the monitoring of the patient and attention to the patient's needs;
- periodic re-evaluations for the need to continue restraint; and
- when the patient meets the criteria for release from restraint, as outlined in the protocol.

Restraint: Restraint is defined as the direct application of physical force to a patient, with or without the patient's permission, to physically restrict his or her freedom of movement, physical activity, or normal access to his or her body. The physical force may be human mechanical devices, or a combination thereof. Restraint differs from the use of mechanisms usually and customarily employed during medical diagnostic or surgical procedures that are considered a regular part of such procedures.

Seclusion: The involuntary confinement of a patient alone in a room which the patient is physically prevented from leaving for any period of time. Seclusion is most commonly implemented in a patient room, Emergency Department, designated psychiatric behavior control room or other specified area for the safe containment of a patient presenting with behaviors harmful to self or others. The patient is prevented from leaving the area either by supervision provided by an individual, or by Behavior Control Room Locked Door.

Target Behaviors: Target behaviors should be formulated by the RN and Treatment Team as soon as possible in order to provide the patient opportunities to meet those targets for early release from restraints or seclusion. If target behaviors are met prior to the expiration of the time limited order; the use of restraints may be discontinued. Established target behaviors should be documented and reviewed with the patient when the patient is capable of understanding.

Time Out: A procedure used as part of a patient's treatment plan to assist the patient to regain emotional control. Situations where patients are removed from the immediate environment and restricted to 30 minutes or less to a quiet area or unlocked room are not considered as episodes of seclusion.

Weapons: Include, but is not limited to, pepper spray, mace, nightsticks, tasers, cattle prods, stun guns, and pistols. (CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention).

TYPES OF RESTRAINTS

Chemical Restraint: A Chemical Restraint is defined as a drug or medication that is used to control behavior or restrict the individual's freedom of movement that is not a standard treatment for the individual's medical or psychological condition.

Physical Restraint: 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 used as a restriction to manage the patient's

violent or self-destructive behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. The mechanical device, material, or equipment is defined as a restraint based on the particular purpose for which it is used rather than the particular type of device. Restraint devices include but are not limited to:

- Enclosure Beds that prevent the patient from voluntarily getting out of bed. (exception: toddlers placed in enclosed cribs)
- "Freedom" splints that immobilize a patient's limb.
- Lap belts, geri-chairs, wheelchair safety bars
- Mobile Board Restraint (only used in extreme circumstances, supervisor must be notified prior to use)
- Papoose wraps, bed rails, nets
- Roll Belts
- Soft Extremity Restraints
- Use of side rails to prevent a patient from voluntarily getting out of bed

Arm boards and monitoring devices do not, in and of themselves, restrict freedom of movement and should not be considered restraint devices. However, if the arm board is tied down or attached to the bed, or the patient's entire limb is immobilized such that the patient cannot access his or her body, the use of an arm board would be considered a restraint.

Physical Hold: Physically holding a patient during a forced psychotropic medication procedure is considered a restraint. The application of force to physically hold a patient to administer a medication against the patient's wishes is considered a restraint. The use of force to medicate a patient, as with other restraints, must have a physician's order prior to the application of the restraint (use of force). (Refer to policy: Informed Consent for Voluntary Administration of Psychotropic Medications and Involuntary Administration of Psychotropic Medication for Unsafe Patients). ***Physician must place a communication order for physical hold and Registered Nurse document in nurse's notes only the physical hold and time frame of hold.***

Therapeutic Hold in the Behavioral Heath Inpatient Setting: A therapeutic hold is when a staff member helps a patient regain control of themselves by keeping them safe, physically. It is a non-aggressive staff-assisted hold for the patient, where the patient is considered dangerous.

NON-RESTRAINTS

The following devices and methods would typically NOT be considered "restraints" as defined by CMS standards and this policy, and therefore, will not be subject to the requirements of this policy and DO NOT require a physician's order:

Adaptive Support: The use of a device utilized in response to assessed patient need that compensates for muscular or skeletal weakness and assists a patient in assuming or maintaining normal posture. (***Example:*** orthopedic appliances, tabletop chairs)

Forensic Devices: Handcuffs, leg cuffs or other devices used by forensic staff for criminal custodial purposes. A Restraint Order will not be required for patients in the custody of a law enforcement officer. Patients who require the application of restraint devices or seclusion for legal purposes will be monitored for patient safety, by the RN assigned to care for the patient, every two hours and more frequently as the patient condition warrants. In addition, the patient's circulation,

skin color, hygiene, elimination and nutritional needs will be monitored, and care provided documented in the patient's medical record. Responsibility for the application and maintenance of forensic restraint devices used for security purposes will be with the accompanying law enforcement officer.

Hand Mitts: Most hand mitts are not considered to be restraints. (However, pinning or attaching mitts to bedding or using a wrist restraint in conjunction with hand mitts would be considered a restraint). If the mitts are applied so tightly that the patient cannot freely move their hands or fingers or the mitts are so bulky that the patient's ability to use their hands is significantly reduced, then that would be considered to be a restraint and the requirements of this policy would apply.

Infant Immobilization: Since infants may be totally dependent, lack purposeful movement and lack the cognitive abilities to educate, a soft wrist restraint may be applied to an infant or toddler to prevent pulling/tugging on tubes or wires. Documentation of care rendered such as hydration, nutrition, elimination and skin care will occur at a minimum of every two hours.

Medical Immobilization: Standard practices where the intended use of a device includes limitation of mobility or temporary immobilization related to medical, surgical, dental, or diagnostic procedures and the related post-procedure care process. (***Example:*** Mechanical device to position a patient's body during a certain surgical procedure, IV arm boards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients)

Medical Protective Device: A device that prevents accidental injury due to temporary loss of consciousness or diminished alertness usually resulting from a treatment procedure - not from permanent cognitive dysfunction or deliberate misbehavior. (***Example:*** Devices that prevent patients from unintentionally harming themselves, such as bedrolls, helmets for head injury patients, and mechanisms that improve a patient's functioning or prevent further accidental injury, such as tabletop chairs used to support the hemiplegic patient and plaster casts, bandages, cervical collars, and limb braces)

Physical Escort: A physical escort to assist a patient to a desired location in not considered a restraint if the patient can easily remove or escape the grasp. (However, if the patient cannot easily remove or escape the grasp, this would be considered a restraint.

Physical Holds: When a staff member(s) physically redirects or holds a child without the child's permission for 30 minutes or less, for the purposes of a medical procedure (i.e. lumbar puncture).

Use of immobilizing or restraining devices for purposes other than restraint - When the use of a device for some purpose other than restraint is not an inherent part of a medical procedure, its use must be documented in the patient's record and the documentation must substantiate that the purpose of the device is not restraint. Even when a device is not used for restraint, however, regular, periodic attention to the patient's needs must be carried out and documented.

PROCEDURE

ASSESSMENT OF THE NEED FOR RESTRAINTS

The registered nurse is responsible for a comprehensive assessment of the patient to determine that the risks associated with the use of restraints are outweighed by the risk of not using it. The RN will ensure that, where possible, alternative interventions to restraints were tried and

documented in the nurse's notes prior to obtaining an order for restraints. Factors to consider as part of the assessment include but are not limited to:

1. Pre-existing medical conditions or any physical disabilities and limitations that would place vulnerable patients at greater risk during restraint.
2. If alternatives were deemed to be inappropriate (RN will document reason).
3. Patient's age, previous or chronic sensory impairments, previous level of mobility, ambulatory aids used, and general health history.
4. Alterations of sensory or motor abilities, or emotional adaptation due to illness, injury, or hospitalization.
5. Patient's present level of consciousness, orientation, mobility and any sensory or motor restraint.
6. Patient's ability to comprehend instruction and judgments.
7. Patient's need for specific precautions to promote a safe environment.
8. Identification of techniques, methods, or tools that would help the patient control his or her behavior.
9. History of sexual or physical abuse that would place the patient at greater psychological risk during restraint or seclusion.

The following causative factors also should be considered as part of the assessment:

1. Pain or other physical discomfort.
2. Types and/or combinations of medications to determine if any may be contributing to the behavior.
3. Types and/or combinations of treatment modalities.
4. Evaluate the patient to identify physiological changes that may be causing or contributing to the altered behavior patterns, such as oxygen perfusion, blood glucose changes, blood chemistry, etc.

PREVENTION: ALTERNATIVES TO RESTRAINT

The policy of FLOYD is to reduce the frequency of the use of restraints and/or protective devices to the greatest extent possible. Care for those patients assessed to have potential or actual behaviors harmful to self or others should be based on the policy "Care for the Assaultive Patient."

Appropriate preventive steps and de-escalating techniques should be employed in order to prevent further conflict and confrontation reducing aggressive/potentially violent behavior. Special attention to the reduction of stimuli, removal of unnecessary personnel and verbal techniques should occur. Further interventions may include the following:

ALTERNATIVE MEASURES	EXAMPLES
Monitoring	- Identifying patients who are at high risk for restraint so that nursing staff can increase observation and preventive efforts - companionship staff or family stay with patient - room near or visible from nursing station - close, frequent observation - intermittent monitoring via room camera and monitoring equipment
Environment Measures	- decrease stimulation: quiet surroundings, appropriate lighting, relaxing music - call light accessible at all times; two upper bed rails alleviated - orientation of patient to surroundings - occupied bed in low position with brakes locked - room/halls clear of obstacles such as excess equipment - use of bed check alarm devices to alert staff when the patient is getting out of bed - availability of bedside commode - allow familiar possessions, photographs - clear the environment of other patients and allow the patient to vent utilizing verbal techniques to de-escalate the patient's behavior
Comfort Measures	- comfortable positioning and clothing; keep patient clean and dry - assess c/o discomfort and intervene as indicated - reduce noise and avoid waking up patient during periods of sleep if possible - gentle touch, soothing voice
Interpersonal Skills	- pleasant, consistent interaction with patient and family - actively listen to patient, calm reassurance
Staffing	- consider assessed patient needs and behavior as well as patient/staff safety when making assignments - flexibility to allow for assignment changes as per patient needs/behavior - consistency in staffing assigning staff familiar to patient as often as possible
Regular Toileting	- establish consistent toileting schedule: q 2 hours while awake, 1 – 2 times at night - encourage patient to ask for assistance at first feeling of toileting need; respond to patient's toileting needs promptly and positively - check for constipation/full bladder as indicated
Education	- educate patient/family/significant other to patient deficits and have consistent plan of approach; reeducate/remind on an ongoing basis about the reasons restraint is used, the means by which restraint can be avoided, and the roles they can play in assisting their family member in avoiding the need for restraint - solicit patient or family/ideas for alternative measures - provide patient/family significant other with opportunities for control; offer choices - educate patients who are at risk for restraint regarding behaviors that may trigger restraint and/or seclusion
Diversional Activities	- redirect the patient; videos, TV photos, reading materials, engage in conversation - purposeful activity; stimulus objects (puzzles, sorting), involve family and relate to patient's interests
Sensory Aides	- ensure patient has and is using visual/hearing aides if applicable - provide alternative system if needed
Medication	- thorough review and update of current medication - use medication which is prescribed as standard treatment for the patient's medical or psychiatric condition (i.e. anxiety) - observe for/consider side effect of medication

WHO MAY ORDER RESTRAINT OR SECLUSION

An order may be obtained from a physician, or other authorized licensed practitioner who is responsible for the care of the patient. When a physician or authorized licensed practitioner is not immediately available to issue a restraint order, an RN with demonstrated restraint competence may initiate the use of restraint based upon skilled assessment of the patient. The RN practice should

occur only in emergency situations, and the physician must be consulted as soon as possible (within 1 hour for Violent/Self Destructive restraints and within12 hours for Medical Surgical/Non-Violent restraints) following the application or restraint and an order for the restraint must be obtained. Each episode of restraint or seclusion must be initiated in accordance with the order of a physician or other authorized licensed practitioner following a clinical assessment of the patient.

RESTRAINT AND/OR SECLUSION USE IN THE ACUTE AND SURGICAL (Non-Violent, Non-Self Destructive) CARE

ACTIONS	KEY POINTS
1. The registered nurse will complete a comprehensive assessment of the patient to identify any pre-existing medical conditions or any physical disabilities and limitations that would place vulnerable patients at greater risk during restraint. The RN will ensure that alternative interventions to restraints were attempted (where possible) prior to obtaining a physician order for implementation of restraint and/or seclusion. The RN should enter into the patient's record, documentation describing these alternative interventions.	1. **Patient Selection** ♦ Patients demonstrating repeated direct attempts at removing necessary therapeutic lines, tubes, interfering with necessary medical treatment, appropriate alternative measures have failed. Examples include self–removal of IV lines, NG tubes, ET tubes, Foley catheter, complex dressings, and picking at open wounds. ♦ Patients who have exhibited a direct attempt to climb/fall out of bed with grave potential for injury, unable to follow directions to avoid self-injury, and appropriate protective, alternative measures have been attempted. Examples are climbing out of bed, wandering in rooms or hallway without the strength or cognitive ability to safely do so. ♦ High risk for falls combined with documented evidence or confusion, disorientation, inability to understand the consequences of disruption of clinical therapy, or intent for self-harm. ♦ Endotracheal tracheally intubated patients when there is evidence that: ♦ The trach is unstable, bleeding, ill-fitting, or slipping; ♦ The patient is confused or disoriented and is unable to understand the consequence of unplanned extubation or is unable to control random movements that might result in unplanned extubation.

ACTIONS	KEY POINTS
2. When restraints must be initiated based on the RN's assessment, the RN must contact a physician or other authorized licensed practitioner for orders. If a physician or other authorized licensed practitioner is not available to issue an order, restraint use can be initiated by the RN. In this case, the physician or other authorized licensed practitioner is notified **within 12 hours** of the initiation of restraint and a verbal or written order is obtained from the practitioner and entered into the patient's medical record. *(Medical/Surgical Restraint Orders)* ***When the initiation of restraint is based on a significant change in the patient's condition, the RN immediately notifies the physician or licensed practitioner.***	2. A physician or licensed practitioner is responsible for authorizing the use and continued use of restraints. If the patient's treating physician is not the physician or licensed practitioner who gave the order, the treating physician must be notified and consulted as soon as possible. The physician reviews with the staff the physical and psychological status of the patient. The physician supplies the staff with guidance in identifying ways to help the patient regain control in order for restraint and/or seclusion to be discontinued.
3. Twenty-four (24) hours is the time limit for orders for medical/surgical conditions.	3. PRN orders are NOT acceptable.
4. Continued use of restraint beyond the first 24 hours must be authorized by a new physician or licensed practitioner order entered into the medical record each calendar day. NOTE: Continuation order must be within 24 hours of previous order.	4. The physician or licensed practitioner determines whether restraint and/or seclusion should be continued. The physician or licensed practitioner will document his reassessment of the patient's status for continued use of restraints in the progress notes of the patient's record. Reassessment will include a physical examination of the patient.
5. Identify target behaviors that will determine early release. The patient will be informed of behavior criteria for discontinuance of the restraints and/or seclusion.	5. Restraints must be discontinued when criteria for release are met. This is regardless of the time specified in the time limited order for restraint. Temporary releases are allowed when staff is caring for the patient such as feeding, range of motion, and toileting.

6. Notify the patient's family promptly of the restraint and/or seclusion episode when the patient has consented to have the family kept informed of his or her care and the family has agreed to be notified.
7. Provide patient/family education as appropriate and as indicated.

ACTIONS	KEY POINTS
8. Perform patient monitoring A qualified staff member will assess the patient's level of consciousness, orientation and adequacy of safety measures **every 2 hours** in the inpatient setting for medical and surgical restraint. In addition, the restrained extremities and dependent body parts will be assessed **every 2 hours** for color, warmth, capillary refill, movement and skin status on the limb(s). Documentation of monitoring should be entered on the *Medical/Surgical Restraint Flowsheet.*	8. Special attention should be provided to the patient's personal needs to include comfort, nutrition needs, hygiene, elimination needs, range of motion, and safety needs **every 2 hours**. If upon assessment, the patient's physical condition has deteriorated, removal of restraints should occur immediately, and the physician notified with appropriate supportive measures instituted.
9. **Reassessment by the RN** should be performed at least **every 4 hours**. A **full systems assessment** should be completed **every 12 hours**.	9. Reassessment of the patient's status by the RN should include current behaviors, appropriate placement of the restraint device, whether the restraint device continues to meet the patient's specific needs, patient care situation, resources available and meeting of established target behaviors.
10. Documentation should be entered on the patient monitoring form as to whether to continue or discontinue the restraints based on established target behaviors.	10. Documentation of monitoring should be entered on the Medical/Surgical Restraint Flowsheet.
11. The RN will ensure modification is made to the patient's Plan of Care.	11. The Plan of Care should clearly reflect assessment, intervention, evaluation and reassessment. Mandatory IPOCS to initiate: Alteration in Safety requiring restraints and Risk for Injury.

RESTRAINT AND/OR SECLUSION USE FOR VIOLENT AND/OR SELF-DESTRUCTIVE BEHAVIOR

ACTIONS	KEY POINTS
1. The registered nurse will complete a comprehensive assessment of the patient to identify any pre-existing medical conditions or any physical disabilities and limitations that would place vulnerable patients at greater risk during restraint. The RN will ensure that alternative interventions to restraint were attempted (when possible) prior to obtaining a physician order for implementation of restraint and/or seclusion. The RN should enter into the patient's record documentation describing these alternative interventions.	1. **Patient Selection** ♦ Restraint use for violent and/or self-destructive behavior may occur regardless of where the patient is receiving treatment within the organization, to include the ECC and Intensive Care units. Restraint or seclusion use is limited to emergencies in which there is an imminent risk of the patient physically harming himself or herself, staff, or others. Examples include hostile, combative behaviors and failure to respond to less restrictive interventions. ♦ The patient should be searched for items that may be harmful to self prior to the implementation of restraints or seclusion. Patient's belt, shoes, jewelry, and other items that might be used to harm should be removed. Items left in the room will depend on the patient situation. ♦ When the Behavior Control room is utilized, the bed and mattress may be removed if indicated.
2. When restraints must be initiated based on the RN's assessment, the RN must contact a physician or licensed practitioner for orders. If a physician or licensed practitioner is not immediately available to issue an order, the RN can initiate restraint use. In this case, the physician or licensed practitioner is to be notified as soon as possible…**not to exceed one (1) hour of the initiation of restraint and/or seclusion.** The RN must consult with the physician or licensed practitioner about the patient's physical and psychological conditions. The nurse should obtain an order (verbal or written) if it is determined that restraint or seclusion should be continued. *(Restraint Orders for Violent and/or Self-Destructive Behaviors)*	2. In the event a physician or licensed practitioner, other than the patient's attending physician provides the restraint order, the attending physician must be notified as soon as possible. The physician or licensed practitioner should provide guidance in identifying ways to help the patient regain control in order for restraint or seclusion to be discontinued.

ACTIONS	KEY POINTS
3. A physician or other licensed practitioner or RN trained in accordance with this policy responsible for the care of the patient should evaluate the patient in person within 1 hour of the initiation of restraint/seclusion used for the management of violent/self destructive behavior that jeopardizes the physical safety of the patient, staff, or others. When the 1 hour in person evaluation is performed by an RN, he or she should consult the attending physician as soon as possible after the evaluation (within 1 hour). The evaluation should include the following elements: ♦ An evaluation of the patient's immediate situation ♦ The patient's reaction to the intervention ♦ The patient's medical and behavioral condition ♦ The need to continue or terminate the restraint or seclusion	3. The physician or licensed practitioner reviews the patient's physical and psychological status with staff; determine whether restraint or seclusion should be continued; supply staff with guidance in identifying ways to help the patient regain control so that restraint or seclusion can be discontinued.
4. The physician or licensed practitioner should provide a time limited order based on the patient's age, if the use of restraint/seclusion is to be continued.	4. The maximum time limit should be based on the patient's age as follows: ♦ 4 hours for adults > 17 years of age ♦ 2 hours for children/adolescents ages 9 – 17 years of age ♦ 1 hour for children, < 9 years of age
5. The registered nurse who is trained and competent to minimize the use of restraint and seclusion, and when their use is indicated, will re-evaluate the patient when the original order expires.	
6. If the restraint or seclusion is still clinically necessary, the registered nurse contacts the physician or licensed practitioner for a new time-limited, written or verbal order continuing the restraint or seclusion for another four (4) hours for adults age 18 years and older, two (2) hours for children/adolescents, ages 9 – 17, and one (1) hour for children under 9 years of age.	6. At a minimum, if a patient remains in restraint or seclusion for the management of violent or self-destructive behavior 24 hours after the original order, the physician or other licensed practitioner must see the patient and conduct a face-to-face re-evaluation before writing/entering a new order for the continued use of restraint or seclusion. 24 hours of restraint or seclusion for the management of violent or self-destructive behavior is considered an extreme measure with the potential for serious harm to the patient.

ACTIONS	KEY POINTS
7. Identify target behaviors that will determine early release.	
8. Notify the patient's family promptly of the restraint and/or seclusion episode when the patient has consented to have the family kept informed or his or her care and the family has agreed to be notified.	
9. Provide patient/family education as appropriate and as indicated.	
10. Continuous, uninterrupted observation, 1:1 monitoring, is to be provided to patients in restraint or seclusion to ensure that the patient is physically safe.	10. In-person uninterrupted observation means that the observer must have direct eye contact with the patient. However, this can occur through a window or through a doorway, since staff presence in the room in which the patient is restrained or secluded could be dangerous or add to the agitation of the patient. If the patient is in a physical hold, a second staff person is assigned to observe the patient.
11. Continuous face to face monitoring is to be provided to patients that are simultaneously restrained and secluded.	11. The face to face monitoring is performed by a trained staff member or through the use of both video and audio equipment that is in close proximity to the patient.
12. If the patient's physical condition deteriorates, removal of restraints should occur immediately, and the physician notified with appropriate supportive measures instituted.	

ACTIONS	KEY POINTS
13. **Reassessment of the patient by the RN** must be at least **every 4 hours for adults, 2 hours for children and adolescents ages 9 – 17 and 1 hour for children under 9 years of age.** A **full systems assessment** should be completed **every 8 hours**.	13. Patients can experience harm, unintentional limitation of their rights and dignity, deterioration in well-being and feeling of isolation when in restraints. Monitoring and reassessment are essential to prevent or reduce such occurrences. Patient reassessment during monitoring permits the reduction or early termination of restraint use when indicated. **Reassessment by the RN** of the patient's status should include current behaviors, appropriate placement of the restraint device, whether the restraint device continues to meet the patient's specific needs, patient care situation, resources available and meeting of established target behaviors. If the patient meets the established target behaviors, restraints may be removed.
14. For physical restraint, a **qualified member of the nursing staff** will assess for proper placement and securing of restraints, and assess comfort, hygiene, nutrition and elimination needs **every 2 hours**.	14. Documentation of monitoring should be entered on the Restraint flowsheet for *Monitoring of Violent and/or Self-Destructive Behaviors.*
15. A qualified member of the nursing staff will assess level of consciousness, orientation and adequacy of safety measures **every 15 minutes**. **Restrained extremities** will be **assessed every 15 minutes** for color, warmth, capillary refill movement and skin status on the limb(s) restrained and dependent body part.	
16. Remove restraints every 2 hours to perform range on motion.	16. Two staff members are required for the purpose of removing the restraint. Members of the nursing staff, who have demonstrated competency, may release restrained extremities to provide access for diagnostic studies; and may reapply restraints as currently being used.

ACTIONS	KEY POINTS
17. **Restraints and/or seclusion may be discontinued** when the patient has met established target behaviors and is no longer a threat to self or others. The RN assesses all physical restraints and/or seclusion episodes that may be discontinued when they no longer meet the patient's needs. **If the patient's behavior escalates** again and is clearly related to the original episode described in the medical record, restraints or seclusion may be reapplied without a new order when the total time of restraint or seclusion does not exceed the period specified in the original order.	17. The following may be evidence that the patient no longer requires restraint and/or seclusion: ♦ The patients tolerated release of at least one extremity at a time without posing harm to self or others. ♦ Improved mental status ♦ The patient agrees and complies with instructions for safety. ♦ Less restrictive measures are effective.
18. The RN will ensure modification to the patient's plan of care.	18. The plan of care should clearly reflect assessment, intervention, evaluation, and reassessment. Mandatory IPOCS to initiate: Alteration in Safety requiring restraints and Risk for Injury.
19. Notify supervisor and/or other appropriate administrative staff of any instance in which a patient remains in restraint or seclusion for more than 12 hours or experiences two or more separate episodes of restraint and/or seclusion of any duration within 12 hours.	

CHEMICAL RESTRAINTS

Patients receiving chemical restraints will be monitored by nursing staff with demonstrated competency every 15 minutes after administration for as long as the patient is under the influence of the drug to ensure recognition of adverse side effects and appropriate action taken.

PLAN OF CARE

The decision to use a restraint or seclusion is driven by a comprehensive individual patient assessment. Patient care is individualized, taking into consideration variable such as the patient's condition, cognitive status, mobility, and risks associated with the use of the chosen intervention. The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care. When the patient wishes, every effort is made to involve the family or significant other in their care. The patient in restraint is high risk for injury, may have self-care deficits, cognitive impairment and knowledge deficits. The goal is to keep the patient, family and staff free from injury and maintain their dignity in the least restrictive manner.

The plan of care for Restraint and/or Seclusion Management of Non-Violent or Non-Self-Destructive Behavior is based on the RN assessment and includes the problems and interventions, the frequency of assessment and monitoring, and patient/family education.

The plan of care for Restraint or Seclusion Management of Violent or Self-Destructive Behavior is based on the RN assessment and includes the problems and interventions, the frequency of assessment and monitoring, and patient/family education.

STAFF EDUCATION, TRAINING, AND COMPETENCY

Limiting the use of restraint or seclusion to those situations with appropriate and adequate clinical justification requires ongoing staff orientation and education; the integration of restraint and seclusion into the organization's performance-improvement activities, and when appropriate, patient and/or family education.

Staff education is designed to provide the knowledge, skills and behaviors necessary to comply with the hospital's restraint policies and procedures and to make staff aware of strategies for limiting the use of restraint and seclusion. Individuals that provide staff training and determine staff competence are qualified as evidenced by education, training, and experience in techniques used to address patient behaviors. The competence of staff is assessed and determined before they participate in any use of restraint and seclusion.

Staff involved with the use of restraint and seclusion will receive annual training, and demonstrate competency in:

1. Policies and procedures related to restraint and seclusion, physician orders and protocols.
2. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
3. Appropriate and safe application of all types of restraint and implementation of seclusion, including how to recognize and respond to signs of physical and psychological distress.
4. Establishment of time frames associated with the one-hour face-to-face evaluation by an independent licensed practitioner and obtaining a new order in the absence of a licensed independent practitioner (authorized staff) when needed.
5. Documentation requirements.
6. The impact of restraint and seclusion on the patient and his/her rights and dignity.
7. Assessment and techniques to identify staff and patient behaviors, events, environmental factors, or potential patient behavioral risk factors that may trigger circumstances resulting with violent and/or self-destructive behaviors that require the use of restraint or seclusion.
8. Comprehensive physical assessment to identify medical problems that may be causing patient behavioral changes, for example medical problems including temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions and drug side effects. (Addressing medical issues may eliminate or minimize the need for use of restraint/seclusion).
9. Underlying causes of threatening behaviors exhibited by the patients they serve.
10. The use of de-escalation, mediation, self-protection, and other techniques, such as time-out.
11. Care planning incorporating strategies to prevent or manage risk factors.
12. The use of nonphysical interventions or alternatives to restraint and seclusion that are effective for different patient behaviors.

13. The safe use of restraint to include the correct application and removal of mechanical restraints (as guided by the manufacturer's directions) when restraint is used, physical holding techniques, and take down procedures.
14. Appropriate patient re-assessment and monitoring of physical and psychological status and needs; and, age specific clinical strategies to identify and meet emergent needs and comfort for the patient while in restraint/seclusion as follows:
    a. Taking vital signs and interpreting their relevance to the physical safety of the patient in restraint or seclusion
    b. Recognizing nutritional and hydration needs
    c. Checking respiratory status, circulation, skin integrity, and range of motion in the extremities
    d. Addressing hygiene and elimination
    e. Assisting patients in meeting behavior criteria for discontinuing restraint or seclusion (i.e. clearly describing established behavioral criteria to patient that will support discontinuance of restraint or seclusion, administering prescribed medication, or minimizing environmental stimuli), and how to assess a patient's readiness for discontinuation of restraints and/or seclusion by using behavioral criteria and clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
    f. Recognizing signs of any incorrect application of restraint
    g. Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services to evaluate and/or treat the patient's physical status.
15. Use of first aid techniques, and certification in the use of cardiopulmonary resuscitation, including required periodic re-certification.
16. How developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a patient reacts to physical contact.
17. Determining when aggressive behavior is related to a patient's medical condition, and not to his or her emotional condition. For example, threatening behavior that may result from delirium in fevers or from hypoglycemia.
18. How their own behaviors can affect the behaviors of the patients they serve.
19. The hospital report process for communicating information related to any patient death occurring while in restraint or seclusion, occurring within 24 hours after removal from restraint or seclusion, or within1 week after restraint or seclusion (when known by the hospital) where it is reasonable to assume restraint/seclusion contributed to the patient's death.

The viewpoints of patients (and their family members) that have experienced restraint or seclusion are incorporated into staff training and education. (i.e. The patient's perception of his/her restraint or seclusion experience (obtained during debriefing with the patient) may be discussed with staff to promote an understanding of the need to eliminate the use of restraint and seclusion). As appropriate, such patients may contribute to the training and education curricula and/or participate in staff training and education (i.e. (1) Patients may share feelings related to the restraint/seclusion episode with staff; or, how staff may have provided increased emotional support. (2) As a result of the patient's shared or observed experience, staff may identify additional /alternative preventive measures for de-escalating patient behaviors).

STAFFING

Staffing levels and assignments are set to minimize circumstances that give rise to restraint or seclusion use and to maximize safety when restraint and seclusion are used. Staffing levels and assignments will consider staff qualifications, the physical design of the environment, and diagnoses, co-occurring conditions, acuity levels, and age and developmental functioning of patients. A sufficient number of staff members are available at all times who are competent to initiate first aid and cardiopulmonary resuscitation.

PERFORMANCE IMPROVEMENT

FLOYD's leadership is dedicated to limiting the use of restraints or seclusion to clinically justified situations only, and seeks to reduce the use of restraint and seclusion through the following mechanisms: leadership commitment to limiting the use of restraints; supportive policies; an understanding of the human resource implications of limited use and choices related to reduced use; ongoing staff orientation and education; patient, and when appropriate, family education; the development and promotion of preventive strategies and use of safe and effective alternatives; and the integration of restraints and seclusion, to include information from staff, patient and family debriefing as indicated into the Performance Improvement activities.

FLOYD incorporates monitoring and evaluation of restraint use and the restraint use process into the performance improvement program, as by definition, the use of restraints is a high-risk process with the potential for significant patient-safety issues.

Restraint processes are identified as a priority within the organization's priority matrix, therefore resulting in measurement, evaluation and improvement actions, when appropriate.

Process measurements will be collected monthly by all nursing units and submitted to the Quality Management department. Data collection should be done for each restraint/seclusion episode on the psychiatric unit. Data collection should be done on a minimum of five (5) charts per month per inpatient unit and the ECC. Information will be aggregated monthly with improvement opportunities targeted and discussed at the Restraint/Seclusion Performance Improvement Team meetings. Recommendations for actions will be forwarded monthly to the Executive VP Chief of Patient Services/CNO and Nursing Leadership Team. Data collection results, conclusions, actions, recommendations and evaluation will be forwarded to MCE and to the Quality Steering Committee.

Measurements for the restraint process will focus on appropriate use of restraints and/or reduction of restraint use when applicable; orders initiated by appropriate practitioners as defined within the policy; time-limited orders; regular patient evaluated/monitored, assessment and assistance as outlined in the policy; appropriate discontinuance of restraints when appropriate.

PROTECTION OF PATIENTS' RIGHTS, DIGNITY, AND WELL-BEING

Specific efforts should be taken to protect the patient's rights, dignity, and well-being. Restraint must be applied humanely and as briefly as possible, and staff must keep in mind the danger restraint presents to a patient's self-esteem, feelings of independence, and dignity. Staff should also exercise special care to avoid the negative physical and psychological effects of restraint and

should meet all of a patient's essential needs during a restraint episode, including food, liquids, access to the toilet, exercise, and protection of skin. To the extent feasible, a patient's treatment program should continue during restraint and the patient's participation in treatment should be facilitated.

EQUIPMENT SAFETY AND REVIEW OF MANUFACTURER'S INSTRUCTIONS

Product information and manufacturer instructions are available with each protective device utilized at Floyd Medical Center and Floyd Behavioral Health.

PATIENT/FAMILY EDUCATION

Education on restraint use will be provided to patients who are candidates for restraint use or patients who are already being restrained. Education will include information describing measures that the patient can take to prevent or end restraint use. When patients are not able to be educated or are not competent to make decisions, the appropriate family members will be educated on restraint use and, when appropriate on ways they can assist the patient in preventing or ending restraint use. Where appropriate, the patient and/or family should assist in the identification of techniques that may help the patient control his/her behavior. The role of the family should be in conjunction with the patient's right to confidentiality.

DOCUMENTATION

The use of restraint or seclusion is recorded in the patient's medical record. Each episode of use is recorded and includes:

- Clinical justification for use which may include the following criteria:
  - Emergent, dangerous behavior with suspected intent for self harm and/or personal injury;
  - Protection of patients from harming themselves, other patients or staff;
  - Verbally aggressive behavior leading to potential harm of self or others;
  - Disruptive behavior with potential to harm self or others;
  - To prevent falls, the pulling of tubes, IV's, wires or other invasive lines;
- Evidence of attempts to use less restrictive measures
- The assessment prior to initiation of physical restraints or seclusion including the use of less restrictive interventions.
- Type of restraint(s).
- Safety measures.
- Skin assessment, release and ROM.
- The patient's level of consciousness, orientation response to, and adequacy of safety measure every shift.
- Patient and family/significant other education concerning restraint and seclusion (if family available).
- Consideration of the patient's general medical condition, and condition of the restrained extremity(s).
- Notification of physician; physician orders; physician's face – face evaluation of patient's status.

- Monitoring, reassessment, and attention to patient's needs. *(Example: medical status, need to continue/discontinue restraint/seclusion, target behaviors met)*; and attended to *(Example: circulation, hydration, feeding, toileting, range of motion).*
- Evidence that restraint was not used for punishment or convenience
- Documentation reflects that policies and procedures were followed
- Evidence that measures were used to protect the patient's rights, dignity, and well-being *(Example: the environment is safe and clean, maintaining the patient's modesty, comfortable room temperature)*; and that the patient was monitored and reassessed.

NOTIFICATION OF CLINICAL LEADERS and CLINICAL REVIEW OF RESTRAINT

All uses of restraint or seclusion shall be monitored daily by the clinical team leader (RN) and/or nursing director and by the medical staff member who has patients in restraint/seclusion. Review should consider the following:

- Frequent or prolonged episodes
- The medical staff's total use of restraint
- Frequency and patterns of restraint use
- A treatment team or conference if a patient is restrained for more than 72 hours or for more than four episodes in seven days

The nursing director/manager should review the care to assess whether additional resources are needed to facilitate the discontinuation of restraint/seclusion and to minimize recurrent instances of restraint and to minimize recurrent instances of restraint/seclusion.

The licensed independent practitioner's responsibilities will include:

- Overseeing the meeting of patient needs
- Participating in the daily review of their own patients
- Participating in measuring and assessing restraint use for all patients

In the **Behavioral Health setting**, the nursing director/manager should be immediately notified of any instance in which a patient is placed in restraints or seclusion.

MULTIDISCIPLINARY APPROACH TO CARE, ROLES, AND RESPONSIBILITIES COMPETENCY

All health care providers implementing and participating in the care of patients placed in restraint or protective devices will complete inservice education specific to the appropriate and safe use of restraints, protective devices, verbal interventions to de-escalate patient behaviors, alternatives to less restrictive measures, and seclusion. Each setting for the implementation of restraint or seclusion will require staff members to participate in educational training specific to restraint or seclusion to be implemented.

A clinical application process will be required with return demonstration components. Only those qualified staff identified within the specific departments will participate in the application of restraint devices.

The application of restraint or seclusion should occur with personnel trained in theoretical and clinical implementation. The multidisciplinary approach to care includes a variety of health care

personnel with patient management directed by the physician and direct patient care supervised by the Registered Nurse. The multidisciplinary members and responsibilities may include:

- **Registered Nurse:** Subject to appropriate physician order and protocol, the Registered Nurse who has met appropriate competency requirements is responsible for overseeing the patient care involving implementation of care to the patient requiring protective devices and patient presenting the behavioral disorders. The three protocols of care may be initiated and discontinued by the Registered Nurse based on specific protocol and patient target behaviors.

- **Licensed Staff:** LPN, Paramedic, OT, PT, ACSW, and others**.** Other licensed staff who have completed appropriate competency packets may participate in the ongoing assessment, patient checks and direct patient care as appropriate to job description.

- **Support Staff**: Other clinical staff (i.e. Student Tech, CNAs, and Transporters) that have completed appropriate competency packets may provide assistance to the RN and other licensed staff. The support staff may assist in direct patient care and patient checks as appropriate to job description.

- **Security Staff:** Security Staff completing appropriate competency packets may assist the RN and healthcare team in providing supervision and assistance in application of devices and/or restraints/seclusion as appropriate to job description.

DEATH RELATED TO RESTRAINT/SECLUSION USE

Under 42 CFR §482.13(g), the following hospital reporting of deaths associated with use of restraint or seclusion is required;

1. FLOYD must report the following deaths associated with restraint and seclusion directly to the CMS Regional Office 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, ***excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion at the time of death***;

   - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion, ***excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion within 24 hours of their death***; and

   - Each death known to the hospital that occurs within one 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.

Restraint deaths are reported to CMS via telephone, facsimile, or electronically. The date and time that the patient's death was reported is documented in the patient's medical record.

2. When no seclusion has been used and when only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which 2 point and composed solely of soft, non-rigid, cloth like materials, FLOYD must record in an internal log or other system deaths that occur in the following circumstances listed below. The log must include the information specified at 42 CFR §482.13(g)(4)(ii) and the log entry must be made no later than seven days

after the date of death of the patient. Hospitals must not send reports of these deaths directly to the Regional Office.

- Each death that occurs while a patient is in restraint but not seclusion and the only restraints used on the patient were applied exclusively to the patient's wrist(s) and were composed solely of soft, non-rigid, cloth-like materials; and
- Each death that occurs within 24 hours after the patient has been removed from restraint, when no seclusion has been used and the only restraints used on the patient were applied exclusively to the patient's wrist(s) and were composed solely of soft, non-rigid, cloth-like materials.

3. The information in the log must be made available in either written or electronic form to CMS immediately upon request.

4. The following must also be documented in the patient's medical record for *any* patient whose death is associated with the use of restraint or seclusion:

   - The date and time the death was reported to CMS for deaths required to be directly reported; and
   - The date and time the death was recorded in the hospital’s internal log or other system for deaths that are required to be logged and not directly reported to CMS.

The Accreditation/Compliance Coordinator will be responsible for reviewing the medical record of the deceased patient, determining if the above criteria were met, notifying the CMS Regional Office (if indicated) and documenting the required information.