Subject: Restraint and Seclusion

Purpose: To ensure the safety of patients, staff or others and eliminate the inappropriate use of restraints or seclusion, while respecting patient rights and complying with applicable standards and regulations.

Policy: It is the practice of UnityPoint Health-Marshalltown to assess the patient’s behavior and identify alternative methods to restraint and seclusion. If alternative methods are unsuccessful, based on the assessment of the patient, made by a qualified medical provider, the least restrictive medically necessary option will be used. The RN will apply or request assistance from trained members of the health care team (a qualified trained staff member) with the application of the necessary physical restraint at the direction of the qualified medical provider. In case of emergency, trained security personnel may be requested to assist the team. The Department Director, Nursing Supervisor or Department Clinical Supervisor should be requested to assist prior to, or at the time Public Safety is requested. It is the responsibility of the RN to provide continuous assessment and monitoring of the patient’s behavior. The patients’ rights, dignity, and well-being will be supported and maintained and the restraint or seclusion will be discontinued at the earliest possible time.

Patient Rights:
Patients and residents have the right to receive care in a safe setting and be free from any physical or chemical restraints imposed for purposes of coercion, discipline, convenience or retaliation. Restraint or seclusion may only be used to ensure the immediate physical safety of the patient, staff or others and will be removed when the behaviors are no longer present or when the unsafe behaviors can be managed using less restrictive interventions. Patients and residents have the right to participate in care planning and the right to refuse treatment, which includes the right to accept or refuse restraints. In the case of a patient or resident who is incapable of making a decision, the legal decision-maker may exercise this right based on the same information that would have been provided to the patient or resident. The decision-maker cannot give permission to use restraints for the sake of discipline, staff convenience or when the restraint is not necessary to ensure the safety of the patient or resident. Patients have the right to privacy and dignity. The restrained patient will be provided the same rights given to all hospitalized patients.

Definitions:
1. Restraint: Includes either a physical restraint or a drug that is being used as a restraint. A restraint is:
   a. “Any manual method or 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.”
   b. “A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.”

Exemptions: The following situations are not considered restraint under this policy:
• Standard practices that include limitation of mobility or temporary immobilization related to medications, dental, diagnostic or surgical procedures and the related post-procedure care processes (for example, surgical positioning, intravenous arm boards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients)
• Adaptive support in response to assessed patient need (for example, postural support, orthopedic appliances, table top chairs)
• Measures taken to protect the patient from falling out of bed
• Helmets
• Forensic and correctional restrictions applied and monitored by law enforcement officials. See Administrative Policy 226 FORENSIC PATIENTS for additional guidelines. The forensic patient will receive the same assessment and quality of care provided to all UnityPoint Health-Marshalltown patients.
• Age or developmentally appropriate protective safety interventions such as raised crib rails, swing safety belts and crib covers, that a safety conscious child care provider would utilize.
• When a medication is used to maintain a patient’s safety or the safety of others and is a standard treatment or dosage for the patient’s medical or psychiatric condition, and enables the patient to better interact, function and participate in their care.
• An escort to physically guide or provide gentle physical prompting techniques

2. **Violent & Self-Destructive Restraint** is the restriction of patient movement for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff member, or others.

3. **Seclusion** is the involuntary confinement of a person alone in a room or in an area where the person is physically prevented from leaving. Seclusion may only be used for management of violent or self-destructive behavior.

4. **Chemical Restraint** is the use of a medication to control behavior or to restrict the patient’s freedom of movement and is **not a standard treatment or dosage** for the patient’s medical or psychiatric condition. The use of PRN of a standing order medications is **prohibited** if the medication meets the definition of a chemical restraint. UnityPoint Health-Marshalltown uses chemical restraints such as, but not limited to, benzodiazepines, antipsychotics, and dissociative anesthetics, to sedate and restrict patient movements only when it is medically necessary for patient care and safety, and not solely for convenience. Medical necessity includes situations where the patient’s medical condition, behavior, or symptoms indicate the patient is or will likely engage in violent or aggressive behaviors towards himself/herself, other patients, and/or staff. Chemical restraints will not be used in situations where the patient is not currently demonstrating or the likelihood of engaging in self-harming or violent behaviors, and is competent in consenting to make their own treatment decisions.

5. **Nonviolent Restraint** is the use of a restraint to protect the patient from unintentional self-harm such as the confused patient who is interfering with the provision of care, or the patient who is pulling at tubes, lines or dressings when less restrictive means have been ineffective in protecting the patient.

6. **Temporary Physical Hold** is the use of a hold that restricts the patient’s movement against their will, to provide care or administer medications. A physical hold can be as restrictive and dangerous as a mechanical device. If a temporary physical hold is necessary to administer medication, provide care or physically escort a violent or self-destructive patient, it is a form of restraint. The 1 hour face-to-face evaluation
and a physician order would be required. The hold will be released as soon as safety is assured.

7. **Attending Physician** is the physician responsible for the care and treatment of the patient or his or her designee.

8. **Licensed Independent Practitioner** (LIP) for the purpose of this policy refers to any medical provider on staff at UnityPoint Health-Marshalltown.

**General Provisions:**

1. **Restraint Reduction Plan:**
   The decision to use a restraint or seclusion is not driven by a diagnosis, but by an ongoing individualized, physical and psychological patient assessment to identify medical problems that may cause behavioral changes. Restraint definitions apply to all patients in all departments. The use of either violent and self-destructive restraint or seclusion, or non-violent restraint is based upon the patient’s behavior and not the department in which the patient is located.
   According to assessment/reassessment:
   a. Treat underlying conditions such as: pain, sleep deprivation, hypoxia, infection, medication toxicity, electrolyte imbalance, and depression.
   b. Attempt interventions of non-restrictive nature and evaluate for effective patient outcome including, but not limited to:
      • Providing guides such as signs in the room to help keep patient oriented to date and staff.
      • Educating family members about the reasons restraints are used, the means by which restraints can be avoided, state regulations, and the roles they can play in helping their relative avoid the need for restraints.
      • Identifying patients who are at high risk for restraints so that nursing staff can increase observation and preventative efforts.
      • Paying close attention to physiologic problems that can lead to confusion such as infection, electrolyte imbalance, etc.
      • Evaluating medications to reduce possible side effects, such as hypotension, poor balance and physical weakness.
      • Providing diversion activities for patients.
      • Taking patients to the bathroom more frequently.
      • Removing lines and tubes if possible.
      • Eliminating slippery floors. Eliminate dark or obstructed areas.
      • Evaluate low bed interventions.
      • Encouraging use of bed alarms.
      • Increasing intensity of nursing.
      • Providing regular ambulation – exercise opportunities.
      • Reduction of sensory stimulation.
      • Use of loved one for supervision.
      • Consistent staff.
      • Utilizing monitored rooms close to nursing station.
   c. Attempt interventions of less restrictive devices and evaluate for effectiveness including:
      • Recliners/geri-chairs;
      • Bed alarms;
      • Time out;
      • Wheelchairs.

2. **Orders:**
   a. The use of restraint or seclusion must be in accordance with the order of a physician, or PA/ARNP under the direct supervision of a Physician, who is
responsible for the care of the patient as specified and authorized to order restraint or seclusion.

b. Orders for the use of restraint or seclusion will NOT be written as a standing order or on an as needed (PRN) basis.

c. The order shall specify the method of restraint and/or seclusion to be used.

d. The attending physician must be consulted as soon as defined in A2 (Nonviolent Restraints) and B2 (Violent and Self-Destructive Behavior).

e. As patient condition warrants you may transition to less restrictive restraint without a new order. The type of restraint along with date and time of transition to the less restrictive restraint must be documented. When the original order expires, if restraints are still necessary, the new order must reflect the current restraint in use.

f. To transition to a more restrictive restraint, or return to a more restrictive restraint from non-violent to violent and self-destructive) REQUIRES A NEW PHYSICIAN ORDER.

3. **Indications:** Restraints shall only be used for the protection of the patient, staff members or others. Such indication shall be present and documented at the initiation of and throughout the episode of restraint. This documentation may be found in provider notes, Restraint/Seclusion Initial Assessment/eform and Restraint/Seclusion Reassessment and Management flow sheet/eform.

4. **Least Restrictive Means:**
   a. Restraints shall not be used when less restrictive interventions would be effective.
   b. When restraints are indicated, the least restrictive method of restraint shall be chosen that will be effective to protect the patient, a staff member, or others from harm. The restraint method should allow the patient the greatest sense of independence, freedom of movement and preservation of dignity.

5. **Early Release and Reapplication:** Based on an ongoing assessment of the patient, restraints shall be discontinued by a RN or attending physician when the patient’s behavior is no longer a threat to self, staff or others, regardless of the duration of the original order.
   a. RECORD behaviors and response on the Restraint flow sheet/eform.
   b. Trial release to determine readiness for discontinuation is considered a PRN order and not permitted. The temporary release of a restraint to provide care is permitted.
   c. If it is necessary to reapply restraints a new physician order must be obtained, consent signed, and initial assessment completed.

6. **Patient and Family Involvement:** Efforts shall be made to discuss the issue of restraint the patient and the family around the time of use. Inclusion of the family or others in this discussion is governed by overriding policies related to patient privacy and confidentiality. Explain to the patient and family the risks, benefits and alternatives for restraint and obtain informed consent from the patient, family and/or legal representative if possible. Families requesting restraints will be provided information explaining why UnityPoint Health-Marshalltown is not able to apply restraints that are not medically indicated. Upon initiation of restraints instruct patient/family of the following:
   - Reason for the restraints
   - Use of call system
   - Rounds/expected care
   - Participation that could reduce needs for restraints.

7. **Care Plan:** The patient’s written plan of care shall be modified to indicate the type of restraint and the goals of the restraint episode.
8. Safety:
   a. The patient’s safety will be ensured at all times.
   b. USE quick release clips when applying the restraint.
   c. DO NOT attach straps to side rails or cross behind patient. Secure restraints to bed frame.
   d. KEEP the top two side rails up at all times.
   e. EVALUATE patient’s ability to use call light and PLACE within patient’s reach.
   f. KEEP sharp objects away from patient.
   g. DO NOT use a draw sheet tied around the waist of a patient as a restraint.
   h. USE only hospital approved restraints on wrists and ankles.
   i. If patient is combative, have minimum of two people present whenever a restraint is released.
   j. Use of a temporary hold requires enough staff to maintain patient and staff safety. One staff member will be assigned to observe hold technique and monitor the patient during the hold. Vital signs will be obtained upon release and the patient’s physical and psychological condition along with their response to any medication will continue to be monitored by CPR trained staff.

9. Side Rails:
   a. Side rails will only be used per assessed need or as required by the patient.
   b. Top 2 side rails should be used:
      • For bed operation and communications
      • To assist in mobility or to treat medical symptoms
   c. Full side rails should be used:
      • Any bed in the up or high position.
      • All postoperative patients until alert, oriented, with a return of baseline sensation.
      • All patients being transported.
      • Patients on seizure precautions with pads on the rails.
   d. Patients not physically able to get out of bed, such as a quadriplegic, have no restriction on their freedom of movement regardless of whether side rails are raised. Therefore, the use of 4 side rails are not considered a restraint.

10. Reporting of Death:
    UnityPoint Health-Marshalltown will record deaths that occur in the following circumstances in the internal hospital log:
    a. 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.
    b. Each death that occurs within 24 hours after the patient has been removed from restraints, 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.
    The log entry must be made no later than seven days after the patient’s death. The log must include the information specified in 42 CFR 482.139g) (4) (ii), which includes:
    • Patient’s name
    • Date of birth
    • Date of death
    • Name of attending physicians or other LIP who is responsible for the care of the patient
    • Medical record number
    • Primary diagnosis/diagnoses
UnityPoint Health-Marshalltown will 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 after learning of the patient’s death. Contact “Nurse Consultant” CMS regional office via facsimile 443-380-8907. Form to be utilized is CMS-10455- death reporting form.

a. Each death that occurs while a patient is in restraint or seclusion, excluding those in which only two-point soft wrist restraints were used and the patient was not in seclusion at the time of death.

b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion, excluding those in which only two-point soft wrist restraints were used and the patient was not in seclusion within 24 hours of his or her death.

c. 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 types of restraints used on the patient during this time.

The following will be documented in the medical record for any patient whose death is associated with the used of restraint or seclusion:

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

11. Training and Qualifications: Hospital and medical staff members ascribed duties in the policy shall receive training and shall be qualified for the respective duty as specified in Section C of this policy. **Student nurses may never apply restraints.**

**Nonviolent Restraints Standard**

1. **Indications:**
   Nonviolent restraints may be used for the following indications when less restrictive means have not been effective in protecting the patient:
   a. The patient is pulling at tubes, lines or dressings.
   b. The confused patient is interfering with the provision of care.

2. **Physician Order:**
   a. If the Attending Medical Provider is not available, a RN may initiate restraints in advance of a physician’s order as follows:
      The Medical Provider shall be contacted immediately by a RN to report the assessment of the patient’s condition, failure of alternative interventions, the rational for restraint use and the need for restraint.
   b. The Attending Physician shall perform an in-person assessment of the restrained patient at least once every calendar day, at which time restraint shall be either reordered or discontinued as indicated.

3. **Patient Monitoring:**
   a. Observe patient every 15-30 minutes.
   b. Type and location of the restraining device(s) shall be documented at least every 2 hours and when changed.
   c. Rationale for restraints (observed behavior) shall be assessed on an on-going basis and documented at least every 2 hours.
   d. Alternatives to and less restrictive forms of restraint considered by the caregiver shall be documented at least every 2 hours.
   e. Examine restrained extremity for evidence of circulatory restriction (loss of sensation, decreased pulses, change in color, edema) and skin breakdown at least every 2 hours.
f. Release all extremities (one at a time) from restraint and perform passive/active exercises, and provide skin care at least every 2 hours.

g. Offer the patient at least every 2 hours: hydration, nutrition, toileting and comfort needs.

h. Turn and position patient at least every 2 hours.

i. Other monitoring and interventions as described in General Provisions #5.

4. **Documentation:**
   The above described indications and patient monitoring must be documented every 2 hours on the Restraint/Seclusion flow sheet/eform.

**Violent And Self-Destructive Behavior Restraint And Seclusion Standard:**

1. **Indications:** Restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.

   c. A restraint/seclusion for behavioral management is to be used as an emergency measure when a patient’s behavior, aggressive, combative, violent and puts the patient or others in immediate danger.

2. **Initiation of Restraint for Violent and Self-Destructive Behavior/Seclusion**
   a. A RN may initiate restraint or seclusion in advance of the physician’s order.
   b. The patient must be seen face to face within 1 hour after the initiation of the intervention and the patient’s physical and psychological status assessed by either:
      - The Attending Physician
      - LIP/Physician Assistant/ARNP who has been trained and is able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment and providing care for a patient in restraint or seclusion for Violent and Self-Destructive Behavior.
   c. The assessment is documented on the Physicians Progress Note and will include:
      - Evaluation of the patient’s immediate situation.
      - Evaluation of the patient’s reaction to the intervention.
      - Evaluation of the patient’s medical and behavioral condition, including a review and assessment of the patient’s history, medications, most recent lab results, etc.
      - The need to continue or terminate the restraint or seclusion.
   d. If the face to face evaluation is conducted by a trained Physician Assistant/ARNP this individual must consult the attending physician responsible for the care of the patient as soon as possible, but no longer than 1 hour after the completion of the 1 hour face to face evaluation. This consultation is documented on the Physicians Progress Notes.

3. **Physician Order:**
   a. The initial and all subsequent restraint orders shall expire in:
      - 1 hour or less for patient 8 years of age or younger
      - 2 hours or less for patient from 9 years to 17 years of age
      - 4 hours for adults 18 years of age or older
   b. These restraint orders may only be renewed in accordance with the above limitations for up to a total of 24 hours. After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, the attending physician or LIP must see and assess the patient.

4. **Patient Monitoring:**
   a. A competent RN shall assess the patient at the initiation of restraint or seclusion and every 15-30 minutes thereafter.
   b. The assessment shall include the following:
- Signs of any injury associated with applying the restraint or seclusion
- Skin integrity
- Nutrition and hydration
- Respiratory and circulatory status
- Range of motion in the extremities
- Vital signs
- Hygiene and elimination
- Physical and psychological state and comfort
- Readiness for discontinuation of restraint or seclusion

5. **Continuous patient monitoring:** Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored.
   - Face to face by an assigned, trained staff member; or
   - By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

6. **Documentation:** When violent and self-destructive restraint or seclusion is used, there must be documentation in the patient’s medical record of the following:
   - The 1 hour face to face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior.
   - A description of the patient’s behavior, physical and mental status assessments, environmental factors that may have contributed to the need for intervention, and the intervention used.
   - Non-restrictive or less-restrictive interventions attempted.
   - The patient’s response to the interventions used, including the rational for continued use of the intervention.
   - Documentation of observation and assessment is completed a minimum of every hour.

**Training Of Staff:**
Hospital and medical staff members shall receive training in the following subjects as it relates to duties performed under this policy. Such training shall take place during departmental or medical staff orientation (before the trainee is asked to implement the provision of this policy) and shall be repeated annually and as needed, based on results of quality monitoring activities. Individuals trained shall exhibit their knowledge of the subject matter through the consistent implementation of the matters taught. The training programs may also include return demonstrations or post-training tests at the discretion of the trainer.

1. **Physicians who order restraint or seclusion** shall be trained in the requirements of this policy and shall demonstrate knowledge of this policy through ongoing compliance.

2. **Hospital staff members who assess patient for restraint or who apply restraint** shall receive training in the following:
   - Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that result in the use of a restraint or seclusion.
   - The use of nonphysical intervention based on an individualized assessment of the patient’s medical or behavioral status or condition.
   - The safe application and use of all types of restraint or seclusion used by the staff member, including how to recognize and respond to signs of physical and psychological distress.
   - Clinical identification of specific behavior changes that indicate that restraint or seclusion is no longer necessary.
• Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1 hour face to face evaluation.
• The relationship between medical problems and behavior changes, i.e. temperature evaluation, electrolyte imbalance drug interactions and potential drug side effects that may result in the use of restraint or seclusion.
• The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
• Recognizing how age, development consideration, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a patient reacts to physical contact.
• Using behavior criteria for discontinuing restraint or seclusion and how to help patients in meeting these criteria.

Staff members who are authorized to perform 15-30 minute observation of patient in restraint receive training in:

• Taking vital signs and interpreting their relevance to the physical safety of the patient in restraints.
• Recognizing nutritional and hydration needs.
• Checking circulation and range of motion in the extremities.
• Addressing hygiene and elimination.
• Helping patients meet behavior criteria for discontinuing restraint.
• Recognizing readiness for discontinuing restraint.
• Recognizing signs of any incorrect application of restraints.
• Recognizing when to contact the physician to evaluate and/or treat the patient's physical status.

3. **Hospital staff members who assess, monitor or apply restraint and seclusion for Violent and Self-Destructive Behavior** shall also receive training in the following:

• The underlying causes of threatening behaviors exhibited by the patients.
• Relationship of patient aggressive behaviors to medical conditions (for example, threatening behavior that may result from delirium in fevers or other medical conditions).
• How staff behaviors can affect the behaviors of the patients.
• De-escalation, mediation, self-protection and the application and removal of mechanical restraint.

Staff members who are authorized to perform 15-30 minute assessment of patient in restraints or seclusion also receive training in:

• Taking vital signs and interpreting their relevance to the physical safety of the patient in restraints or seclusion.
• Recognizing nutritional and hydration needs.
• Checking circulation and range of motion in the extremities.
• Addressing hygiene and elimination.
• Addressing physical and psychological status and comfort.
• Helping patients meet behavior criteria for discontinuing restraint or seclusion.
• Recognizing readiness for discontinuing restraint or seclusion.
• Recognizing signs of any incorrect application of restraints.
• Recognizing when to contact the physician to evaluate and/or treat the patient’s physical status.

Departmental QAPI activities will assess and monitor the use of restraint/seclusion implementation to ensure only medically necessary restraints are used. The method to assess and monitor will be the use of a log to include:

• Shift
• Date, time or order
• Staff who initiated
• Length of each episode
• Date and time each episode initiated
• Day of week each episode initiated
• Type of restraint used
• Injuries sustained by the individual or staff
• Gender of individual
• Ethnicity

Originated by: Administration
Medical Staff
Nursing

Effective date: August 1990

Authorized by: ________________
Administration

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President, Medical Staff

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Chair, Board of Trustees

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References:
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