

Restraints and Seclusion (MGMC)

■ Introduction

PHILOSOPHY

Mary Greeley Medical Center is committed to preventing, reducing, and eliminating the use of restraint and seclusion except in emergencies when there is an imminent risk of the individual physically harming himself/herself or others and to assure the immediate physical safety of patient, staff, or others. The organization will strive to prevent emergencies that have the potential to lead to the use of restraint and/or seclusion. Nonphysical interventions, alternatives and least restrictive forms are the preferred interventions. Restraint or seclusion will only be used when least restrictive interventions are ineffective. Application of restraint or seclusion will not be based on the diagnosis but will be based on the individualized assessed needs of the patient. If a restraint/seclusion is deemed necessary and appropriate, the patient shall be given care in a manner that maintains the patient's rights, privacy, and dignity; respects the patient as an individual; allows himself/herself if able, to participate in care processes; and insures his/her physical well-being is safeguarded. Restraint/seclusion therapy shall be discontinued as soon as possible based on the individual patient's assessment that determines there is no longer imminent risk of injury to the patient or others regardless of the expiration of the order. Restraint and/or seclusion will not be used for coercion, discipline, convenience, staffing issues, or retaliation by staff. The use of restraint/seclusion is not based on a patient's restraint history or history of dangerous behavior. Direct care staff who apply and remove restraints/seclusion receive effective, ongoing, competency-based education and training which includes Mary Greeley Medical Center's philosophy of restraint and seclusion use and awareness about how restraint or seclusion may be experienced by the patient.

Leaders at Mary Greeley Medical Center define the approach for safe use of restraint and seclusion in the care of patients in accordance with law and regulation, create a culture that minimizes circumstances that give rise to restraint and seclusion use, and that maximizes safety when they are in use and assesses and monitors the use of restraint and seclusion in the facility. Leaders provide supportive plans, policies, and priorities and understand staffing needs associated with alternatives to restraint. Leaders ensure initial orientation and ongoing education for direct care staff who monitor the restrained or secluded patient as well as establish processes for patient and, as appropriate, family education.

Mary Greeley Medical Center recognizes the importance of involvement of the individual's family in decisions and activities that relate to the use of restraint and seclusion. Therefore, when appropriate, the family will be involved to promote communication, support, and advocacy for the individual.

POLICY

All patients have the right to be free from physical or mental abuse, corporal punishment, and restraint/seclusion that is not medically necessary or is used for purposes other than patient benefit and safety. Restraint/seclusion shall be used only as a last resort where least restrictive methods are not sufficient to protect patients or others from injury and are not a substitute for less restrictive forms of protective restraint/seclusion. Restraints may be used for the physical safety of a non-violent or non-self-destructive patient or for patients who are exhibiting violent or self-destructive behaviors. Seclusion may only be used for the management of violent or self-destructive behavior. The use of restraint or seclusion in accordance with a written notification to the patient's plan of care.

Restraint/seclusion will be discontinued at the earliest possible time based on re-evaluation of the patient and regardless of the scheduled expiration of the order.

This policy applies to all medical center patients when the use of restraint or seclusion becomes necessary regardless of patient location.

OBJECTIVE

The patient will remain free from injury. Staff will remain free from injury. Other patients will remain free from injury. Patient will not develop complications because of restraint / seclusion.

■ Special Considerations

Supportive Data

- Physical Restraint is defined as: any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of the patient to move his or her arms, legs, body, or head freely, 4 side rails, or if belts used to keep a patient from voluntarily getting out of bed or from getting up are restraints.

Patients on a specialized bed to improve aeration or to prevent skin breakdown with raised side rails to prevent the patient from falling out of bed is not a restraint. Hand mitts are not restraints and can be used unless secured to the bed. A therapeutic hold is a restraint. A physical hold during forced administration of a psychotropic medication is a restraint. (Other restraint examples: sheets tucked in so tightly that movement is restricted; wrist holders, padded mitts or similar devices; geri chairs or seat belts used to restrict movement and can't easily be removed by the patient.)

- Chemical Restraint is defined as: a drug/medication that restricts a patient's freedom of movement and is not a standard treatment or dosage for the patient's condition, is a restraint.

The following criteria is used to determine whether the use of a drug/medication is a standard treatment or dosage for the patient's condition and NOT a restraint includes the following:

- The drug/medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indication it is manufactured and labeled to address including listed dosage parameter.
- The use of the drug/medication follows national practice standards established or recognized by the medical community or professional medical associations or organizations; and,
- The use of the drug/medication to treat a specific patient's clinical condition is based on the patient's symptoms, overall clinical situation, and on the LP or APP's knowledge of that patient's expected and actual response to the medication.

Another component of "standard treatment or dosage" for a drug/medication is the expectation that the standard use of a drug/medication to treat the patient's condition enables the patient to function in the world more effectively or appropriately around them than would be possible without the use of the drug/medication. If the overall effect of a drug/medication or combination of drug/medications, is to reduce the patient's ability to interact with the world effectively or appropriately around the patient, then the drug/medication is **NOT** being used as standard treatment or dosage for the patient's condition.

Drugs/medications, such as the following, are **NOT** considered restraints when based on the assessed needs of the patient with careful monitoring to minimize adverse effects:

- Therapeutic doses of psychotropic medication for patients who are suffering from serious mental illness to improve their level of functioning so they can more actively participate in their treatment.
- Therapeutic doses of anti-anxiety medication to calm the patient who is anxious.
- Appropriate doses of sleeping medication prescribed to treat insomnia.
- Appropriate doses of analgesic medication ordered for pain management.

The use of PRN orders is prohibited for drugs/medications that are being used as restraints.

- Seclusion is defined as: the involuntary confinement of a patient alone in a room or an area which the patient is physically prevented from leaving. A situation where a patient is restricted to a room or area alone and staff are physically intervening to prevent the patient from leaving the room or area is also considered seclusion (i.e., security staff in the doorway to prevent leaving). Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others. Confinement in a locked area with others is not seclusion.
- Violent and self-destructive behaviors: An emergency situation in which a patient is in immediate danger of physically harming himself/herself, staff, or others and less restrictive interventions have been determined to be ineffective. Examples include hitting, kicking, punching, spitting, biting, choking, self-mutilation, assault.
- Non-violent and non-self-destructive restraint: Restraints used to prevent a patient from harming self by removing or tampering with a product or piece of equipment needed for treatment, e. g. pulling out a NG, IV or ET tube; a restraint used to prevent a patient from wandering or independently getting out of a bed or chair as when there is a risk for fall.
- Time-out is defined as: A procedure used to assist the patient to regain emotional control by removing the patient from his or her immediate environment to a quiet area or unlocked quiet room. A quiet area/room is an area separate from other patients and staff that allows for decreased stimulation and time for patient to regain control of behaviors. These areas/rooms often have limited furniture and accessories in the event behavior escalates but may have soothing items that assist the patient in modulating behavior.
- Emergency is defined as: An emergency is an instance in which there is an imminent risk of a patient harming him or herself or others, including staff; when nonphysical interventions are not viable; and safety issues require an immediate physical response.
- Family: The person(s) who plays a significant role in the individual's life which may include a person(s) not legally related to the individual receiving care. This person(s) is often referred to as a surrogate decision-maker, if authorized legally or by the patient to make medical care decisions for the individual if he or she loses decision-making capacity.
- Licensed Practitioner (LP): any individual who is responsible for the care of the patient and is authorized to order restraint or seclusion by Mary Greeley policy in accordance with state law.
- Advanced Practice Provider (APP): an individual including licensed physicians (residents), certified provider in psychology, certified registered nurse midwife, physician assistant, certified

Psychiatric Mental Health Nurse Practitioner, and advanced registered nurse practitioner, who is privileged to provide certain patient care services by virtue of his/her professional credentials and documented current competencies within the limits established by the Board of Trustees, the Medical Staff, the applicable State Practice Acts, and the provisions of this manual. APPs are either independent or dependent. Examples of APPs include certified registered nurse anesthetist, certified nurse midwife, advanced practice nurse practitioners, physician resident, certified psychologist, certified psychiatric mental health nurse practitioner. Examples of a dependent APP include physician assistant.

- **Weapon:** Includes but not limited to pepper spray, mace, night sticks, tazers, cattle prods, stun guns, or pistols. Use of weapons by security staff or law enforcement on a person in a hospital to protect people or hospital property from harm would be expected to be handled as criminal activity and the perpetrator be placed in the custody of law enforcement.
- **Prolonged Restraint/Seclusion:** A violent restraint or seclusion that exceeds 24 continuous hours. A non-violent, prolonged restraint would be in excess of 72 continuous hours.

■ Implementation

A. General Provisions

Exclusions:

- Medical immobilization: Mechanisms usually and customarily employed during medical, dental, diagnostic or surgical procedures / tests that are considered a regular part of such procedures / tests and the related post-procedure care processes. These mechanisms usually include body restraint for operative or procedural positioning (IV arm boards, radiotherapy procedures, dressing drainage tube, transport carts).
- Orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve physically holding of a patient for conducting routine physical examinations or tests; or to protect patient from falling out of bed; or to permit the patient to participate in activities without risk of physical harm (this does not include escort). However, patients have the right to refuse treatment. Holding a patient that restricts their movement against his/her will is a restraint.
- Use of any psychoactive medication or dosage that is a usual or customary part of a medical diagnostic or treatment procedure.
- Patients recovering from anesthesia carts (e.g., PACU, GI, and ACS) will have full side rails up to prevent falling out of bed until patient is awake or alert sufficiently to eat or ambulate.
- Adaptive support /positioning/ protective device: Mechanisms intended to permit a patient to achieve maximum normative bodily functioning, including orthopedic appliances, braces, tabletop chair, gait belt, wheelchairs, helmets, or other devices used for postural support.
- Any device that can easily be removed by the patient in the same manner as it was applied by staff would not be a restraint.
- Pediatric and developmentally appropriate devices such as crib side rails, crib safety tops, highchairs, and straps, infant swing straps to protect an infant, toddler or pre-school age child and is used as would any safety conscious childcare provider outside the health care setting.
- Comforting children and helping them regain emotional control.

- A time-out when the patient is restricted for 30 minutes or less from leaving an unlocked room and when its use is consistent with the patient's treatment plan.
- Forensic Restriction: used for security purposes by law enforcement agency personnel including handcuffs, manacles, shackles, other chain-type restraint devices. The use of such devices is considered law enforcement restraint devices and not governed under this policy. The medical record documentation reflects that forensic staff applied the restraint, monitored, and maintained custody and direct supervision of the individual. The responsibility of hospital staff is to provide safe and appropriate health care to the patient.
- Preventing a patient from falling out of bed if side rails are lowered by the patient, 3 or fewer side rails are used.
- Seizure precautions which include 4 side rails up.
- For use of an air mattress bed to improve circulation or prevent skin breakdown can have 4 side rails up and not be considered a restraint.
- Holding a cooperative patient at their request to safely administer or conduct a procedure (i.e., injection, blood draw, or initiating an IV).
- Hand mitts that are not secured to bed/bedding. (However, mitts do become a restraint when applied so tightly the patient's hands or fingers become immobilized.)
- Chemical restraint exclusions -- refer to chemical restraint definition.
- If a patient can easily remove a device, the device would not be considered a restraint. In this context, "easily remove" means the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by staff (.e.g., side rails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the patient's physical condition and ability to accomplish the objective (e.g., transfer to a chair, get to the bathroom in time).

Physical Considerations

Physical restraints are not to be applied to the following: hemiplegic limb, fractured or circulatory impaired extremity, over graft, hemodialysis fistula site, IV access site, or during a seizure.

Physical restraints are to be secured to an immovable part of a bed or chair frame closest to the desired anatomical position and using quick release ties, Velcro restraint, or four-point leather restraints.

If a patient is restrained in the supine position, ensure the head is free to rotate to the side and when possible, the head of the bed is elevated to minimize the risk of aspiration.

Restraining a patient in the prone position should be avoided. If a patient must be restrained in the prone position, ensure that the airway is always unobstructed. For example, do not cover or "bury" the patient's face. Also, ensure that expansion of the patient's lungs is not restricted by excessive pressure on the patient's back (special caution is required for children, elderly patients, and very obese patients).

Never place a towel, bag, or other obstructive cover over a patient's face as part of the therapeutic holding process.

Staffing

Staffing levels and assignments will be determined to minimize circumstances that may give rise to restraint and seclusion use and to maximize safety when restraints and seclusion are in use. Staffing levels will be based on a variety of factors that include:

- staff qualifications
- physical design of the environment
- number of patients
- acuity levels (including the number of patients who need close supervision to assist in the prevention of the use of restraint and seclusion)
- diagnoses and co-occurring conditions
- mental and physical condition of the patients present on the units

Physical Therapy, Occupational Therapy, Laboratory, Social Workers, Nurse Case Managers, and other ancillary / non-nursing staff do not apply, monitor, or remove restraints. Only nursing department staff, Respiratory Therapists, and Radiology staff that have been trained and demonstrate competency in the use of restraint and seclusion may perform these skills.

Vulnerable Patient Populations:

The effects and consequences of restraint and seclusion use, and immobilization can include aspiration, pneumonia, elimination problems, skin integrity and/or circulatory problems, physical debilitation, accidental death by strangulation or respiratory/cardiac problems, and feeling humiliated and demoralized. Certain vulnerable patient populations are at greater risk of experiencing adverse effects from restraint and seclusion use. These patient populations may include but are not limited to:

- Pediatric
- Pregnant women
- Cognitively impaired individuals, with mental status changes.
- Physically impaired: the frail, the elderly, respiratory, cardiac, other pre-existing medical conditions, and the prone positioned patients.
- Those developmentally disabled.
- Any history of sexual and/or physical abuse that would place the individual at greater psychological risk.
- Chemically impaired individuals

Restraint and seclusion use for the vulnerable populations requires special assessment and monitoring of the individual's age-appropriate needs and physical and mental condition to avoid the use of restraint and/or seclusion and/or minimize risks to the individuals. Staff will utilize assessments and techniques outlined in the guidelines "Age Specific Care Considerations (MGMC)", "Delirium, Care of Patient", "Reality Orientation" and "Substance Use, Emotional, or Behavioral Disorders in the Non-Behavioral Health Setting, Suicide Precautions (MGMC)".

Monitoring

Physicians, LPs, and APPs monitor the condition of patients in restraint or seclusion in accordance

with written orders, assessment and re-assessment as defined in this policy. RNs, PCTs, and Psych Assistants are responsible for the routine monitoring elements of the restraint/seclusion flowsheet.

Initiation of Restraints / Seclusion

Mary Greeley Medical Center staff initiate restraint or seclusion based on an individual order. Orders for the use of restraint or seclusion are not written as a standing order per protocol or on an as needed (PRN) basis. Trial release of restraint/seclusion are not permitted. If restraint/seclusion is removed and there is a need for re-initiation, the order process must start over. Protocols shall not serve as a substitute for obtaining an LP or APP order. Leaders have identified that an RN, trained in the use and application of restraint and seclusion, based on the assessment of the patient may identify an emergent need and initiate the use of restraint and/or seclusion. Specific details for ordering restraint for non-violent or non-self-destructive behavior are addressed in Section B and for restraint and/or seclusion for violent or self-destructive behavior in Section C of this guideline. The rationale and authorization for use of restraint or seclusion shall be clearly documented in the patient's medical record by a RN.

Plan of Care

Upon initiation of restraint or seclusion, the patient's plan of care is modified in the electronic medical record (EMR).

Notification of the Patient's Family:

If the patient has consented to have the family kept informed regarding his/her care and the family has agreed to be notified, staff attempts to contact the family to inform them of the restraint or seclusion episode.

B. Restraint for Non-Violent or Non-Self-Destructive Behavior

Alternatives

Less restrictive measures which can be initiated to prevent a patient from harming self by removing or tampering with a product or piece of equipment include:

- Patient education using terminology they can understand
- Provide distraction
- Encourage other activities
- Pain / symptom treatment
- Select least invasive treatment
- Eliminate invasive treatment as early as possible
- Treat reversible changes in mental status
- Attempt to minimize causes of increased agitation such as environmental changes, sensory impairments, physical discomfort, environmental over-stimulation, and anxiety.
- Untied mittens
- Conceal tubing
- IV position
- Splints

- Educate family / significant other to elicit their support and participation*
- Encourage family / significant other to sit with patient
- 1:1 monitoring by staff

The use of restraints for prevention of falls should not be considered a routine part of the fall's prevention program. Refer to the Administrative Operational policy "Fall Prevention" for an explanation of the MGMC fall risk score and a list of other measures for fall prevention such as reminding a patient not to walk or attempt to get out of the bed or chair independently.

Initiation

A restraint used for nonviolent or non-self-destructive behavior will be initiated to prevent a patient from harming self by removing or tampering with a product or piece of equipment needed for treatment e.g., pulling out a NG or IV. Examples of restraints used to prevent patient from harming self by removing or tampering with a product or piece of equipment include soft wrist and soft ankle.

A physical assessment and a set of vitals (temperature, blood pressure, respirations) should be taken before initiation as a screening tool to identify medical problems that may be causing behavioral change in the patient. Addressing these medical issues may eliminate or minimize the need for the use of restraints or seclusion.

Criteria for Application

Patient behavior / medical condition criteria which puts a patient at risk for harming self by removing or tampering with a product or piece of equipment include:

- Reaching for / pulling at equipment (e.g., ET tube, NG, IV, urinary catheter)
- Inability to understand due to developmental age (e.g., not to pull IV or NG, remove eye patches, pull off oxygen, will not remain in mist tent)
- Inability to understand, due to confusion or disease which affects cognitive abilities (e.g., not to pull out IV or NG, pull off oxygen, pull out urinary catheter)
- Hypoxia, electrolyte imbalance, or sedative medication

Patient behavior/medical condition criteria which puts a patient at risk for falling include:

- Inability to understand, due to confusion or disease which affects cognitive abilities, not to walk or get out of a bed or chair independently
- Hypoxia, electrolyte imbalance, or sedative medication.
- Impaired mobility and demonstrates wandering and/or trying to get out of bed without assistance despite other restrictive safety interventions or precautions attempted by staff to protect the patient.

Restraint Orders for Non-Violent or Non-Self-Destructive Behavior

An order should be obtained from a LP or APP staff prior to initiation. After attempting less restrictive alternatives, if it is determined that a restraint is clinically justified in an emergent situation, an RN may initiate a restraint following the risk criteria for interfering with treatment. An order for a restraint must be obtained **within a few minutes** but no longer than **15 minutes** after the initiation of the restraint from the physician/hospitalist, clinical psychologist, other authorized LP or APP staff who is primarily responsible for the patient's ongoing care. The attending LP or APP is consulted as soon as

possible if he or she did not order the restraint (a restraint order sticker should be utilized during down time). If the initial order is given verbally, the LP or APP will examine the patient and enter a written order into the patient's medical record within the next calendar day. If restraint use continues to be clinically justified, each calendar day the LP or APP must do a face-to-face assessment and renew the restraint order (use the provider Face-to-Face and Written Order sticker during down time). If the restraint is terminated before the order expires, a new order is needed to re-apply the restraint if the patient demonstrates risk criteria for interfering with treatment.

Monitoring when restraint used for Non-Violent or Non-Self-Destructive Behavior

A registered nurse monitors the physically restrained patient every 2 hours or more frequently as condition indicates for patient behavior, circulation to restrained limb (color, movement, and sensation) and skin integrity.

WNL definition for CMS: Color pink or normal for race; temperature warm, capillary refill 1-2 seconds; sensation no numbness or tingling; movement active; pulses palpable.

Vital signs will be assessed on initiation.

Release and remove the restraint for 10 minutes every 2 hours for hydration, nutrition, elimination, range of motion and repositioning. Evaluate patient every two hours for level of consciousness, orientation, cognition, and continued need for restraint.

If the patient is asleep do not awaken to release, reposition, offer toilet or fluids. Periods of sleep may facilitate behavior change and allow for earlier release. Observe patient for adequate circulation to areas affected by restraint. Release, reposition, offer toilet and fluids, and assess for readiness for restraint discontinuation when patient wakes.

Use of restraint should be discontinued by the LP or APP, his/her designee or RN as soon as possible when the patient's ability to understand directions improves.

Patient/Family Education

Instruct patient/family on the following:

- Interventions they can participate in to reduce the need for restraint.
- Reason for restraints and potential outcome if restraint is not used.
- Less restrictive measures attempted.
- Rounds/expected care related to nourishment, personal care, and exercise.
- Restraint will be discontinued as soon as possible.
- If restraints can be removed during family/friend visitation, instruct visitor(s) to notify staff when leaving.
- Risks related to restricted mobility while restrained.
- Document teaching on Non-Violent or Non-Self-Destructive Restraint Documentation Form

Documentation

Utilize the Non-Violent or Non-Self-Destructive Restraint Documentation Flowsheet to record the following:

- Less restrictive alternatives used prior to restraint

- Behaviors exhibited by the patient and indications for restraint
- Interdisciplinary and family collaboration when appropriate, related to potential or actual use of restraint
- Patient/family education
- Monitoring of the patient's behavior
- Changes in the patient's behavior or clinical condition needed to initiate the removal of restraints
- Behavior justifying continuance/reapplication of restraints
- Attention to patient's physical and emotional needs.
- Plan for facilitation of discontinuation after prolonged use.
- Patient's rights, dignity, and safety are maintained.
- Provider communication, evaluations and obtaining of orders.
- Revisions to care plan.
- Assessments & re-assessments.
- Injuries to the patient.
- Deaths associated with restraint and seclusion use.

C. Restraint and/or Seclusion for Violent or Self-Destructive Behavior

* Attention: Italicized print applies only to the Behavioral Health Unit.

Assessment of Pre-Existing Conditions and Abuse History *(for patients in the Behavioral Health Unit)*
The Behavioral Health admission assessment includes any information regarding:

- *Techniques, methods, and tools that would help the individual control his/her behavior. When appropriate, the individual and/or family will assist in the identification of such techniques.*
- *Pre-existing medical conditions/physical disabilities that would place the patient at greater risk during an intervention.*
- *Any history of physical or sexual abuse that would compound psychological risks to the patient.*
- *Patient's prior history of restraint or seclusion.*
- *The patient and/or family will be asked whether the patient has an advanced directive with respect to behavioral health care and, if so, a copy of the directive is obtained.*

Alternatives:

The non-physical interventions, such as redirecting the individual's focus or the use of verbal de-escalation are some of the preferred interventions to control behavior. The type of interventions selected will take into consideration information learned from the individual's initial assessment. Staff will employ methods to avoid utilization of restraint or seclusion. Examples on non-physical interventions include:

- Approach the patient in a non-threatening, non-confrontational manner respecting issues of sensitivity, and need for personal space. Set clear expectations of appropriate behavior and set

limits as indicated. Let the patient know that aggressive behavior is not necessary or tolerable and that the safety of the patient and others is the first and emergent priority even if this requires isolation or seclusion of patient, restraint, or medication over objections about forced medication, seclusion, or restraint.

- Encourage the use of non-physical interventions such as redirecting the patient's focus or the use of verbal de-escalation.
- Encourage utilization of relaxation techniques, appropriate physical activity, or other methods identified by patient, which help patient to gain control.
- Utilization of a quiet room.
- Review medications and possibly offer medications.
- Increase staffing for further, more frequent observations and consider 1:1.
- Provide diversions such as TV, activities, cards, snacks, exercise, etc.
- All efforts shall be made to make the patient as comfortable and calm as possible.

Initiation and Criteria for Application

Restraint or seclusion will be initiated when non-physical and less restrictive interventions have been ineffective or not viable and when, based on assessment of the patient, there is an imminent risk of patient physically harming himself, or herself, staff, or others.

Restraint / Seclusion Orders for Violent or Self-Destructive Behavior:

All restraint and seclusion for management of violent or self-destructive behavior are applied and continued pursuant to an order by the physician/hospitalist, clinical psychologist, other authorized LP or APP staff who is primarily responsible for the patient's ongoing care. If restraint or seclusion is initiated by an RN in an emergent situation, within a few minutes but no longer than 15 minutes after the initiation of restraint or seclusion, the RN will contact the LP or APP, review the patient's physical and psychological condition and obtain an order. A written/verbal provider order is required and must include reason for restraint / seclusion, type of restraint / seclusion, and time limit (not to exceed four hours for patients 18 years of age or older, two hours for children nine to 17 years of age and one hour for children under the age of nine) - (a "Restraint / Seclusion Order" sticker should be utilized during down time). If the attending physician/hospitalist or clinical psychologist did not provide the order, he or she is consulted within two hours of the application of the restraint or seclusion.

A physical hold may be required during the administration of a chemical restraint or placing a patient in a restraint chair. In these instances separate order for the physical hold is not needed.

The role of the physician/hospitalist, clinical psychologist, other authorized LP or APP staff giving the order will be the following:

- review with the staff physical and psychological status of the individual;
- determine whether restraint/seclusion should be continued;
- supply staff with guidance in identifying ways to help the individual regain control for the restraint or seclusion to be discontinued;
- supply a time-limited order.

A physician/hospitalist, clinical psychologist, other authorized LP or APP staff responsible for the care of the patient evaluates the patient face-to-face following the initiation and before one hour post initiation of restraint or seclusion used for the management of violent or self-destructive behavior. The face-to-face is to assess the patient's tolerance and response to the intervention. The face-to-face is required even if the patient is released within the first hour of initiation.

A special trained RN (i.e., Behavioral Health RN or lead RN in the Emergency Department), qualified by one year of experience and completion of training video and knowledge assessment and case study competency validation may conduct the face-to-face evaluation following the initiation and before one hour of initiation of restraint or seclusion. He or she consults with the attending physician / hospitalist, clinical psychologist, other LP or Independent APP responsible for the care of the patient immediately but not to exceed one hour after completing the face-to-face assessment. The face-to-face evaluation includes the following: an evaluation of the patient immediate situation, the patient's reaction to the intervention, and the patient's medical or behavioral condition, and the need to continue or discontinue the restraint / seclusion. The physician, clinical psychologist, other LP or independent APP will document the face-to-face in the order or as a progress note. The RN will document the face-to-face assessment using the Nurse Face-to-Face Flowsheet.

The physician/hospitalist, psychologist, other LP or APP staff or trained Behavioral Health Unit RN only completing the face-to-face assessment will work with the individual and staff to identify ways to help the individual gain control and provides necessary written orders, revises the patient's plan of care and services if needed and if necessary, provides a new order.

When restraint or seclusion is terminated before the time-limited order (adults: four hours; children ages 9-17: two hours; and children under 9 years old: one hour) expires, a new order is needed to re-apply the restraint or seclusion if the patient is at imminent risk of physically harming himself, herself or others and non-physical interventions have not been successful.

Assessment and Monitoring when Restraint / Seclusion Used for Violent or Self-Destructive Behavior:

A registered nurse who is trained and competent, will assess the patient at the initiation of restraint or seclusion and prior to contacting the provider for an order to continue the restraint or seclusion (4 hours for adult; 2 hours for adolescent; 1 hour for child). Patients will be continually monitored by an RN, Psych Assistant, or Patient Care Technician (PCT) every 15 minutes. This monitoring is appropriate to the type of restraint or seclusion employed and will include the following as appropriate:

- Hydration
- Hygiene
- Elimination
- Skin Integrity
- CMS: Definition for WNL CMS:
 - Color = pink or normal for race
 - temperature = warm
 - capillary refill = 2 seconds
 - sensation = no numbness or tingling

- movement = active
- pulses = palpable
- Behavioral observation
- Level of consciousness
- Cognitive function
- Orientation
- Level of stress and agitation
- Continued need for restraint / seclusion and readiness for discontinuation of the intervention

Violent nutrition assessment and monitoring will be documented every 2 hours.

Vital signs will be attempted on initiation and used as a screening tool to identify physical causes of behavior change.

Assessments and monitoring will be documented on the Violent or Self-Destructive Restraint/Seclusion Form.

Monitoring of the Patient Who is Simultaneously Restrained and Secluded:

Monitoring of the patient who is simultaneously restrained and secluded is accomplished through continuous in-person face-to-face observation (in a room, through a doorway, or through a window) by an assigned staff member who is competent and trained or by simultaneous video and audio equipment if it is determined to meet the patient's needs. Secluded patients may be monitored through continuous video equipment.

Monitoring Physical Hold:

If a staff member is engaging in a physical hold, a separate staff member will be assigned to observe the individual being held.

Use of Restraint Chair

If using restraint chair, continuous use can only be for two hours maximum per incident/episode. Patient must be released every two hours for 15 minutes. Must obtain new order to put patient back in restraint chair.

Renewal and Re-Assessment:

If restraint or seclusion is to continue, a verbal or written order is required to renew the order every 4 hours for adults, 2 hours for those age 9 to 17, and every hour for children age 8 and under. A face-to-face re-assessment must be completed every calendar day by the physician / hospitalist, clinical psychologist, or other LP or APP. If attending provider or designee did not complete the face-to-face assessment, he/she will be contacted within 2 hours of the order.

Release Criteria:

Restrictive interventions will be discontinued by the LP or APP, his or her designee or registered nurse as soon as the patient meets established criteria. As soon as possible, the patient is made aware of the rationale for the intervention and the criteria for release. Some examples of criteria for release might include:

- An individual's ability to convincingly contract for safety has been established;

- An individual, previously agitated and a threat to self/others due to confusion, is now oriented to the environment (and therefore less likely to act out in fear);
- Verbal and physical threats have ceased, and the patient can convincingly ensure staff that his/her ability to remain in control has been established;
- A patient previously secluded for behaviors related to intoxication (from any substance) is no longer intoxicated (and therefore less likely to act out again due to the continuing effects of intoxication). For alcoholic intoxication, blood/alcohol level (BAL) measurement with BAL <100mg%, would be a reasonable guide of intoxication, otherwise behavioral indicators coupled with a firm knowledge of the clearance of the intoxicating agent should be used to determine duration of restraint/seclusion. To predict when a patient's BAL is less than 100mg%, use the equation: $(\text{INITIAL BAL} - 100)/15 = \text{number of hours before a BAL of 100 is possible}$. Thus, a patient with an initial BAL of 320 will not be at or below 100mg% until almost 15 hours.
- Professional judgment should guide criteria. Restraint/seclusion is clearly not for the convenience of staff but are techniques to prevent injury to the patient/others.
- In all cases, document that behavioral and any other criteria discussed with the patient. A list, showing that those criteria have been met, should be completed before the patient is moved to a less secure setting. Less secure setting should be interpreted to mean release from a secure room into a less secure area or into the general patient area on one-to-one observation. In no cases should patients be moved from a high secure setting to a low secure setting without reasonable monitoring in place to assess risk of a return to behaviors that necessitated restraint/seclusion. A patient moved from a secure room to a less secure area will be monitored for a minimum of 30 minutes before release from that secure area and then must be on one-to-one observation until staff are reasonably certain the patient can be returned to more usual observation levels. Behavioral criteria should also be developed to move the patient from one security level to another. The patient should once again be given the criteria used to determine release to the next lower security level. Reasonable exceptions to these guidelines may be made if a situation requires flexibility of decision making. However, staff must document the rationale for using steps other than these guidelines.

A patient will be immediately removed from the intervention if the health status assessment indicates a significant risk to the health and safety of the patient.

Should a patient's behavior escalate again to a point of imminent danger to self or others after an early release, a new order must be obtained prior to re-initiating the intervention and the requirements restarted.

Patient/Family Education:

Prior to the application of restraints and/or placement of the patient in seclusion, he/she will be asked to participate in interventions that are intended to reduce the need for restraint and seclusion. The patient and family, if appropriate, will be educated about these interventions. Patients will be given an explanation of the behavior criteria that they will have to demonstrate and will be assured that restraints and seclusion will be discontinued as soon as possible. Information on Mary Greeley Medical Center's restraint and seclude philosophy and policy will be given to the patient and family, as appropriate, with an explanation.

Documentation

All restraint/seclusion episodes will be documented in the medical record. Documentation includes the following:

1. a time limited order
2. justification for use including description of patient's behavior and intervention used
3. assessments and reassessments (face-to-face, in person medical and behavioral assessments); monitoring activities
4. that the individual and/or family was informed of the organizational philosophy regarding restraint and seclusion use
5. any pre-existing medical conditions
6. any history of sexual and/or physical abuse
7. *techniques and tools which assist the individual to control his/her behavior (for Behavioral Health Unit only)*
8. the circumstance that leads to use including condition or symptoms that warranted use
9. non-physical interventions, alternatives and least restrictive interventions used
10. patient's response to interventions used
11. rationale for the type of physical intervention selected
12. notification of the family, when appropriate
13. patient and family education, as appropriate
14. consent for the notification of the family
15. *behavior criteria education for the patient (For Behavioral Health Unit only)*
16. behavior criteria met and rationale for continuation
17. timely, in-person re-evaluations by the physician
18. timely re-evaluations by the nursing staff
19. 15-minute observations and monitoring
20. 1:1 continuous observation for restraint use
21. *1:1 continual observation through seclusion room window for one hour and then camera monitoring (for Behavioral Health Unit and Emergency Department only)*
22. assistance and care given
23. any injuries that are sustained and treatment
24. the reporting of injuries and deaths to the organizational leadership and to the appropriate external agencies consistent with applicable law and regulation
25. plan for facilitation of discontinuation for prolonged use
26. discontinuation of restraint and seclusion

D. Staff Training and Education:

Identified trainers will receive initial and ongoing training to provide instructional training to clinical staff in the application, assessment, and monitoring of the restrained or secluded patient. Training will occur before performing these applications as part of orientation and on a subsequent and periodic,

ongoing basis. Staff that initiate, monitor, and discontinue restraint/seclusion and care for patients in restraint/seclusion will be trained and demonstrate competency. Training shall be comprehensive with some skills requiring demonstrations and return demonstration. The content will be reviewed annually with review of this policy. Training includes:

- Underlying causes of threatening behaviors exhibited by the patients they serve
- Events and environmental factors that may trigger circumstances that lead to restraint and seclusion.
- Aggressive behavior that is related to a patient's medical condition and not related to his / her emotional conditions.
- How their own behaviors can affect the behaviors of the patients they serve.
- The use of de-escalation, mediation, self-protection, non-physical intervention skills, and methods for choosing least restrictive intervention based on assessment of the patient.
- How to recognize signs of physical and psychological distress in the patient who is restrained or secluded.
- Recognize how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a patient reacts to physical contact.
- Behavior criteria for readiness for discontinuation of restraint/seclusion.
- Assessment, monitoring and care of the restrained/secluded patient.
- How the use of restraint may be experienced by the patient.
- The safe application and removal of all types of restraints and for applicable areas the implementation of seclusion.
- Taking vital signs and interpreting their relevance to the physical safety of the patient in restraint and seclusion.
- Recognizing nutritional and hydration needs.
- Checking circulation and range of motion in the extremities.
- Addressing physical and psychological status and comfort including respiratory status and skin integrity
- Addressing patients in meeting behavioral criteria for discontinuing restraint or seclusion.
- Recognizing signs of any incorrect application of restraints.
- Recognizing when to contact medically trained personnel or licensed, independent practitioner to evaluate and/or treat the patient's medical status.
- Recognizing clinical identification of behavior changes that indicate readiness for discontinuing restraints or seclusion.
- Use of first aid techniques including Basic Cardiac Life Support certification and periodic re-certification.
- *Physical hold techniques and take down (for Behavioral Health Unit and Emergency Department only).*

- *Other techniques such as time out (for Behavioral Health Unit only).*

Training and education will be accomplished using the following methods:

- At Mary Greeley, restraint education will be provided or determined by individuals who have been determined to be subject matter experts (SMEs) as identified by their role on the unit such as Clinical Resource Nurse (CRN), manager, director identified as such by department leaders. These identified individuals will be educated on the CMS requirements that have been identified for restraint and seclusion training of clinical staff by completing the Restraint and Seclusion Train the Trainer CBL.
- Orientation and before participating in the use of restraint or seclusion
 - CBL's completed before Nursing Department employees including RNs, LPNs, PCTs and Psych Assistants provide patient care.
 - Nursing Department employees including RNs, LPNs, PCTs, and Psych Assistants will demonstrate competency in application of restraints, implementation of seclusion (ED and BH only), monitoring, assessment, or care of patient in restraint or seclusion prior to participating in the care of a restrained or secluded patient. Respiratory Therapists and designated Radiology staff will demonstrate competence of safe and secure retying a soft, non-violent restraint using a quick release knot secured to a solid structure and first aid techniques and response to patients experiencing distress/injury from use or restraint prior to participating in care of a restrained patient.
 - De-escalation training within 90 days of hire.
 - Complete additional orientation competency skills as outlined in unit specific orientation competency checklist.
 - All clinical staff that work in the Emergency Department, Behavioral Health Services, Nursing Support Team, House Supervisors, Intensive Coronary Care Unit (ICCU), Mobile Intensive Care Services (MICS), Acute Rehabilitation Center (ARC), Medical Telemetry Unit, Medical Surgical Unit, and clinical staff routinely working between the hours of 2300-0700 that work on Oncology, Birthways, Neonatal Intensive Care Unit (NICU), Pediatric Unit will complete combative response team training within 90 days of hire or transfer.
*Staff under the age of 18 are exempt from this requirement.
- Ongoing education/competency
 - Emergency Department, Behavioral Health (Inpatient), Nursing Support Team (NST), Intensive Coronary Care Unit (ICCU), nursing department staff, Respiratory Therapists and Radiology staff will complete annual restraint/seclusion competency assessment as outlined in unit specific position competencies. All other inpatient nursing units will complete these competencies every other year in unit specific position competencies.
 - All clinical staff that work in the Emergency Department, Behavioral Health Services, Nursing Support Team, House Supervisors, Intensive Coronary Care Unit (ICCU), Mobile Intensive Care Services (MICS), Acute Rehabilitation Center (ARC), Medical Telemetry Unit, Medical Surgical Unit, and clinical staff routinely working between the hours of 2300-0700 that work on Oncology, Birthways, Neonatal Intensive Care Unit (NICU), Pediatric Unit will complete combative response team training within 90 days of hire or transfer.
*Staff under the age of 18 are exempt from this requirement.

- CBL's related to restraints/seclusion are completed every other year or earlier if major content changes for nursing, Respiratory Therapists, and designated Radiology Department staff (including RNs, LPNs, PCTs, and Psych Assistants).
- Training for physician / hospitalist, psychologist, other LP or APP training includes provision of policy overview provided in orientation resource guide and review in medical staff newsletter every two years.

E. Quality Monitoring

Use of restraint and seclusion is monitored through on-going hospital performance improvement processes overseen by the Quality Management System (i.e., the Patient Care Review/UM Committee, Administration, and the Board of Trustees). The focus of these processes is to measure and assess restraint and seclusion use to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the risks associated with restraint use and seclusion.

The nurse manager or designee reviews patient chart and tabulates monthly data. Data on all restraint and seclusion episodes are collected from and classified for all settings/units/locations by the following: Data is collected on all restraint and seclusion episodes related to:

- Shift initiated
- Date, start time of order
- Staff who initiated the process
- Length of each episode
- Date and time each episode was initiated
- Day of the week each episode was initiated
- The type of restraint or seclusion used
- Compliance with requirements defined in standards
- Whether injuries were sustained by the patient or staff
- Age of the patient

This is forwarded to the Quality Management Department for quarterly aggregation and identification of patterns and trends. Particular attention is paid to: patterns of excessive use such as multiple instances of restraint or seclusion experienced by a patient within a 24-hour time frame, number of episodes per patient, instances of restraint and seclusion extending beyond 24 consecutive hours or a violent restraint or seclusion and 72 hour consecutive hours for a non-violent restraint; use of physical restraint or drugs used as a restraint for inadequate staffing; monitoring, assessment, or investigations of reasons behind patient behavior such as wandering or getting up in the night which may indicate unmet care needs; and opportunities for improving compliance with requirements of these standards.

Intensive analysis will be done in any event where a patient or staff is injured through the restraint /seclusion process. Such events will be entered into the hospital variance systems which will initiate the review process.

An intense analysis will also be conducted on events of prolonged use of restraints or seclusion.

F. Required Reporting of Deaths Associated with Restraint or Seclusion

Mary Greeley Medical Center is required to report to CMS patient deaths associated with the use of restraint or seclusion, including the following criteria:

Each death that has occurred while a patient is in restraints or seclusion.

Each death has occurred within 24 hours after the patient has been removed from a 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 the use of the 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, death related to restrictions of movement for prolonged periods of time, or death related to chest compressions, restriction of breathing, or asphyxiation.

If any patient death associated with restraints or seclusion occurs, the department/unit representative or House Supervisor will call 515/239-2078 (Case Management --- this extension is answered each business day). Case Management will refer all patient deaths associated with restraints or seclusion, as outlined above, to the Director of Quality Management.

The Director of Quality Management, or their designee, will review any death that occurred within one week of the restraint or seclusion to determine if it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death. The Director of Quality Management, or their designee, is responsible for reporting patient deaths associated with the use of restraints or seclusion as outlined in the criteria above. **Reporting to the CMS Regional Office must occur no later than close of the next business day following the day in which the hospital knows of the patient's death.** This reporting process will involve contacting CMS by telephone, facsimile, or electronically by completing the electronic Form CMS-10455. The electronic Form CMS-10455 can be accessed by using the URL link below:

https://restraintdeathreport.gov1.qualtrics.com/jfe/form/SV_5pXmjIw2WAzto8J

The hospital must complete sections A-D of the electronic Form CMS-10455.

The Director of Quality Management, or their designee, will document in the patient's medical record the date and time the death was reported to CMS.

Exceptions to Reporting Restraint or Seclusion Associated Patient Deaths to CMS:

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 are composed solely of soft, non-rigid, cloth-like materials Case Management staff shall record the following information in Mary Greeley Medical Center's Internal Restraint Death Log:

- Any death that occurs while a patient is in these restraints.
- Any death that occurs within 24 hours after a patient has been removed from such a restraint.

Entries into Mary Greeley Medical Center's Internal Restraint Death Log shall be documented by Case Management staff as follows:

Each entry shall be made not later than 7 days after the date of death of the patient.

Each entry shall document the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis(es).

The information shall be made available in either written or electronic form to CMS immediately upon request.

Case Management staff shall also document in the patient's medical record the date and time the death (as described above as Exceptions to Reporting Restraint or Seclusion Associated Patient Deaths to CMS) was recorded in Mary Greeley Medical Center's Internal Restraint Death Log.

■ References

NIAHO Rev 25-0 April 28, 2025

■ Facility Review

Mary Greeley Medical Center reviewed procedure on 09/06/2025. Procedure was approved by Callie Ayers MHA, BSN, RN CMSRN CHC.