Major Hospital A Major Health Partner	Use of Restraints and Seclusion NS-14
Does this policy meet a regulatory standard? Yes _X___No _____	Formulated by: Nursing Executive Council Approved by: Nursing Executive Council Effective Date:

PURPOSE: Major Hospital endeavors to create a culture which upholds patient rights and dignity and minimizes the use of restraints and seclusion. This policy identifies the hospital's approach for assessing the need for and the use of restraints and seclusion. Patient rights, dignity, and physical and psychological well-being will be protected throughout restraint and seclusion usage. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint and use of seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

DEFINITIONS/TERMINOLOGY/EXEMPTION

A restraint is:

(i) 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

(ii) 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.

(iii) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. If a patient is restricted to a room alone and staff is physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether the door is actually locked or not. In this situation, the patient is being secluded. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.

*Exemption: Law Enforcement Devices

Exempt from this policy are handcuffs or other restrictive devices applied by law enforcement officers (who are not employed by the hospital) for the purpose of public safety and detention. The application, monitoring, and removal of forensic devices are the responsibility of the enforcement officers. The hospital and its staff are responsible for providing safe and appropriate health and medical care to these individuals during their hospitalization.

1. The use of restraint must be:
   1.1. In accordance with a written modification to the patient's plan of care.
   1.2. Implemented in accordance with safe and appropriate restraint techniques as determined by hospital policy in accordance with state law.
   1.3. Must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint by hospital policy in accordance with state law. Only RNs, MDs and NPs specially trained in restraint and seclusion may initiate or discontinue restraint or seclusion. Only RNs specially trained in restraint and seclusion may initiate the emergency application of restraint or seclusion prior to obtaining an order from a physician or other LIP.
   1.4. Orders for the use of restraint must never be written as a standing order or on an as needed basis (PRN).
   1.5. The attending physician or the individual overseeing the patient's care who may be a health professional practicing with the delegated authority and privileges to order restraints of supervision of a doctor of medicine or osteopathic medicine as permitted by state law and hospital policy must be consulted as soon as possible if the attending physician did not order the restraint.
   1.6. Restraint may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. It is not required to attempt less restrictive alternatives prior to the use of restraint to determine that an intervention is ineffective.
      1.6.1. The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

1.7. Restraint must be discontinued at the earliest possible time, regardless of the length of time identified in the order. If the restraint is discontinued prior to the expiration of the order, a new order must be obtained prior to the re-initiation of the restraint.

1.8. The condition of the patient who is restrained or under seclusion must be monitored by a physician, other LIP or trained staff that has completed the training criteria listed in this policy.

1.9. Patient family education will be provided.

2. When restraint or the use of seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be housed in CCU/ER and the charge nurse notified and:

2.1. The patient must be seen face-to-face within one (1) hour after the initiation of the intervention by a:

2.1.1. Physician or another licensed independent practitioner; or

2.1.2. Registered nurse or physician assistant who has been trained in accordance with the requirements specified in this policy, if a Physician or other licensed independent practitioner is not present when restraints applied.

2.2. The one-hour face-to-face evaluation is to complete a comprehensive review of the patient's condition and determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior. The one (1) hour face-to-face evaluation must include:

2.2.1. The patient's immediate situation.

2.2.2. The patient's response to the intervention.

2.2.3. The patient's medical and behavioral condition.

2.2.3.1. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, medication and most recent diagnostic tests – abnormal results to be reported to the physician.

2.2.4. The need to continue or terminate restraint.

2.3. If the face-to-face evaluation is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of

the patient as soon as possible (within minutes) after the completion of the one (1) hour face-to-face evaluation.

2.4. Each order may only be renewed in accordance with the following limits for up to a total of 24 hours.

2.4.1. Four (4) hours for adults 18 years of age or older.

2.4.2. Two (2) hours for children and adolescents 9 to 17 years of age.

2.4.3. One (1) hour for children under 9 years of age; and

2.5. After 24 hours, before writing a new order for the use of restraint for the management of violent or self-destructive behavior: a physician or other licensed independent practitioner who is responsible for the care of the patient must see and assess the patient.

2.6. When restraint or seclusion is used for violent or self-destructive behavior, there must be documentation in the patient's medical record of the following:

2.6.1. The one (1) hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior.

2.6.2. A description of the patient's behavior and the intervention used.

2.6.3. Alternatives or other less restrictive interventions attempted (as applicable).

2.6.4. The patient's condition or symptom(s) that warranted the use of the restraint; and

2.6.5. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

2.7. Patient monitoring and reassessments will be documented by a RN trained in restraint/ seclusion practices at least every hour and half (1.5) hours plus/minus 15 minutes and will include safety, comfort, mental status, skin integrity/circulation checks, fluids and nourishment, toileting, range of motion and systematic release, readiness for release from restraint / seclusion and the charge nurse's knowledge of restraint / seclusion use. Vital signs will be monitored per individualized plan of care and as needed.

2.7.1. When the patient is secured with locking restraints; the keys are to be kept in a secure location:

2.7.1.1. Emergency Department (ED): The ED Charge Nurse will one (1) key and the ED secretary will have one (1) key.

2.7.1.2. Inpatient Care Unit: The Inpatient Charge Nurse will carry one (1) key and the Patient Safety Monitor will have one (1) key.

2.8. While in seclusion or simultaneous restraint and seclusion, the patient will be monitored continuously by a trained person.

3. When restraint is used to ensure the physical safety of the non-violent or non-self-destructive patient (used to limit mobility or temporarily immobilize a patient because of medical, post- surgical or dental care):
   3.1. The order must be renewed at least daily and the ordering practitioner does not have to be physically present to re-evaluate the need for continuing the restraint.
   3.2. There must be documentation in the patient's individualized plan of care of the following:
      3.2.1. Description of the patient's behavior and the intervention used.
      3.2.2. Alternatives or other less restrictive interventions considered.
      3.2.3. The patient's condition or symptom(s) that warranted the use of the restraint; and
      3.2.4. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.
      3.2.5. Patient monitoring and reassessments will be documented by a RN at least every two and half (2.5) hours and will include safety, comfort, mental status, skin integrity/circulation checks, fluids and nourishment, toileting, range of motion and systematic release, readiness for release from restraint and the charge nurse's knowledge of restraint use. Vital signs will be monitored per individualized plan of care and PRN.
   3.3. Side rails.
      3.3.1. Are not a restraint when a patient is:
         3.3.1.1. On a stretcher
         3.3.1.2. Recovering from anesthesia
         3.3.1.3. Sedated
         3.3.1.4. Experiencing involuntary movement (seizure activity)
         3.3.1.5. On certain types of therapeutic beds to prevent the patient from falling out of bed.
         3.3.1.6. Not physically able to get out of bed has no impact on patient's freedom of movement.
         3.3.1.7. Prevented from falling out of bed

3.3.2. When the clinician raises all four side rails in order to restrain a patient, defined in this regulation as immobilizing or reducing the ability of a patient to move his or her arms, legs, body or head freely to ensure the immediate physical safety of the patient, then the side rails are considered a restraint.

3.3.3. Raising fewer than four side rails when the bed has more than two side rails, would not necessarily immobilize or reduce the ability of a patient to move as defined as a restraint.

3.3.4. A request from the patient or family member for the application of a restraint, which they would consider beneficial, is not enough basis for the use of a restrain intervention.

3.3.5. A patient or family member request for a restraint intervention, such as raising all for side rails, to keep the patient from getting out of bed should prompt a patient and situational assessment to determine whether such a restrain is confirmed the practitioner must then determine the type of restrain intervention that will meet the patient's needs with the least risk and most benefit to the patient. If restraint (as defined by the regulation) is used, then the requirements of the regulation must be met.

3.3.6. Rationale for four side rails as a restraint – Medicare guidelines: The use of side rails to prevent a patient from exiting a hospital bed may pose a risk to the patient's safety, particularly for the frail elderly frame. The disoriented patient may see the side rail as a barrier to be climbed over or may attempt to wiggle through split rails or to the end of the bed to exit the bed. As a result, this patient may have an increased risk for a fall or other injury by attempting to exit the bed with the side rails raised.

3.3.6.1. If a patient's status requires that all bedrails be raised (restraint) while the patient is in bed, a standing order is permitted. It is not necessary to obtain a new order each time the patient is returned to bed after being out of bed.

3.4. Pediatric population

3.4.1. Placement of an infant or toddler in the crib with raised rails would not be considered a restraint.

3.4.2. Age or developmentally appropriate protective safety interventions, such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails and crib covers that safety conscious child care providers outside a health care setting

would utilize to protect an infant, toddler or preschool aged child would not be a restraint.

4. Staff Training Requirements. The patient has the right to safe implementation of restraint by trained staff. Physician and other licensed independent practitioners will maintain a working knowledge of the hospital policy regarding restraints. This will be accomplished via the credentialing process on appointment and reappointment. Staff must be trained and able to demonstrate competency in the application of restraints, monitoring, assessment, and providing care for a patient in restraint.
   4.1. Before performing any of the actions specified in this policy.
   4.2. As part of orientation; and
   4.3. Annual credentialing/competency assessment.
5. Staff Training Content. Appropriate staff will have education and demonstrated knowledge based on the specifics of the patient population in at least the following:
   5.1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
   5.2. The use of nonphysical intervention skills.
   5.3. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical / behavioral status or condition.
      5.3.1. At Major Hospital we believe the following algorithm is a move from least restrictive to more restrictive environment. However, the nurse does not need to follow the algorithm if safety of the patient or staff warrants a more restrictive plan.
         5.3.1.1. Ask the patient to volunteer what techniques help them to decrease stress and offer those techniques when available.
         5.3.1.2. For those who cannot provide what techniques work best for them, offer least restrict diversion techniques, such as reorientation, adjust lighting in room, diversional activities & positioning.
         5.3.1.3. Ask patient if a time-out away from stressors will help and provide to them.
         5.3.1.4. Use de-escalation techniques & therapeutic use of self.
         5.3.1.5. When staff or other patients may be at risk for injury of the patient in hallways, seclusion may be needed which allows the patient to freely roam about their room but prevents them from leaving the room by stationing security outside of room.
         5.3.1.6. When the patient is physically threatening staff or self-harm, restraints may be used.

5.4. The safe application and use of all types of restraints used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example: positional asphyxia).

5.5. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary.

5.6. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the one-hour face-to-face evaluation.

5.7. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

6. Trainer Qualifications. Individuals providing staff training will be qualified through advanced training in the content listed above.
7. Staff personnel records that care for a patient population where restraints and seclusion may be used will include required documentation for the use of restraints and seclusion.
8. The utilization of restraints and the use of seclusion will be reviewed in the Quality Improvement Program at least annually. The data collected will be aggregated and utilized to reduce the incidence of restraint use and incidents related to restraint use.
9. Deaths associated with the use of restraint and/or seclusion is required to be reported to CMS (Medicare).

9.1. The hospital must report the following information to CMS:

9.1.1. Each death that occurs while a patient is in restraint.

9.1.2. Each death that occurs within 24 hours after the patient has been removed from restraint.

9.1.3. Each death known to the hospital that occurs within one (1) week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

9.2. Each death referenced above must be reported to CMS no later than the close of business the next business day following knowledge of the patient's death by using FORM-10455 electronically with link provided in the internal Death Restraint Log.

9.2.1. Staff will document in the patient's medical record the date and time the death was reported to CMS.

10. Deaths associated with the exclusive use of soft-2-point wrist restraints without seclusion are to be entered in an internal log which must be immediately available for CMS upon request. The name of the practitioner responsible for the care of the patient may be used in the log in lieu of the name of the attending physician if the patient was under the care of a non-physician practitioner and not a physician.
    - 10.1. Deaths to be entered in the internal log include:
        - 10.1.1. Any death that occurs while a patient is only soft 2point wrist restraints when no seclusion is used.
        - 10.1.2. Any death that occurs within 24 hours after a patient has been removed from only soft 2-point wrist restraints.
    - 10.2. Each entry must be made not later than seven days after the date of death of the patient.
    - 10.3. Each entry must include:
        - 10.3.1. Patient name.
        - 10.3.2. Date of birth.
        - 10.3.3. Date of death.
        - 10.3.4. Name of attending physician or other licensed independent practitioner who is responsible for the care of the patient.
        - 10.3.5. Medical record number.
        - 10.3.6. Primary diagnosis (es).
    - 10.4. Staff will document in the patient's medical record the date and the time the death recorded in the internal log.
11. Reviewed & Revised

Reviewed	Revised
7/01	10/07
5/16	12/10
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	11/16
	8/18
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	2/19
	6/20
	2/22

Federal Register: November 29, 2019, 84FR 51732, Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Part 482.13, Medicare and Medicaid Programs, Hospital Conditions of Participation: Patient's Right: Final Rule.
HFAP Chapter 15 Patient Rights and Discharge Planning 2021 HFAP Chapter 15.02.03 Non-Restraints 2021.
HFAP Chapter 15.02.04 Definition of Seclusion 2021.