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<th>Policy and Procedure</th>
<th>Restraint/Seclusion, Medical Center Patient Care</th>
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<td>Issuing Department: Patient Care Services</td>
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<td>Behavioral Health</td>
<td>David W. Cress, President/CEO</td>
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<td>Clinical Practice</td>
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<td>Reviewed by:</td>
<td>Medical Executive Committee 2/23/10</td>
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<td>Patient Care Practice &amp; Outcomes</td>
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RESTRAINT/SECLUSION, MEDICAL CENTER

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*Indicates addition/change
A. DEFINITIONS:

* **Restraint** – Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of the patient to move his/her arms, legs, body or head freely. Devices which are considered restraint include, but are not limited to: padded mitts, vest, soft extremity, 4 siderails, GeriChair, Twice-As-Tough cuffs.

* **Non-violent or non-self-destructive Restraint Use (medical-surgical)**- Restraint use to control behaviors which interfere with medical/surgical healing. For example, the patient may be trying to pull out lines or tubes and less-restrictive methods or alternative measures have not worked.

* **Violent or Self destructive Restraint Use (Behavioral)**- Restraint use to control behaviors which are unanticipated, severely aggressive or destructive behavior placing the patient or others in imminent risk of harming themselves or others, and non-physical intervention has not been effective.

* **Chemical Restraint** – A medication when used as a restriction to manage the behavior or to restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

  **Alternative measures** – Interventions taken to modify the environment, enhance interpersonal interactions or provide treatment in efforts to minimize or eliminate the behaviors/problems which place the patient at risk. (See Appendix A.)

* **Episode** – An episode is defined as every time an order is written or the length of the restraint order. Patient's total time in restraint may or may not equal one (1) episode.

* **Application** - it is time when the restraint is initially applied until the time all restraints are discontinued. The period from START to DISCONTINUED in Epic documentation. Multiple episodes can be within an application.

* **Seclusion** – Involuntary confinement of a person alone in a room or area from which the patient is physically prevented from leaving. Does not include confinement to a locked unit with others. *Used in the Emergency Department and Crisis Intervention Unit.*

* **Time Out** – An intervention in which the patient consents to be alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. *Applicable on Crisis Intervention Unit only.*

B. POLICY:

Restraints pose a risk to the physical safety and psychological well-being of the patient and staff. Physical restraints are used only after alternative strategies and lesser restrictive interventions fail or are not possible and the situation is considered an emergency. Chemical restraints are prohibited. When restraints

*Indicates addition/change*
are used, staff maximizes patient’s and other’s safety. The patient's physical and psychological well-being, rights and dignity will be protected at all times. North Memorial will have an environment which promotes restraint reduction.

1. Non-physical techniques are the preferred intervention in the management of behaviors and restraint is employed only when non-physical interactions are ineffective or not viable.

* 2. Alternatives to restraints are always considered before restraints are used. Because of the risks and consequences of use, staff will use the least restrictive, safe and effective method(s) to protect the patient, staff member, or others from harm. At all times staff will protect the patient and preserve their rights, dignity and well-being. Staff will address the unique needs/risks of vulnerable patients such as pediatric and cognitively or physically impaired.

* 3. The behavior of the patient triggers the restraint type not the location of use. (i.e., non-violent or non-self destructive versus violent or self-destructive.)

* 4. Generally, restraints used outside of CIU are considered non-violent. However, when the Code Green Team is activated and restraints are used, the Code Green Team RN will assist in determining violent or self-destructive or non-violent.

* 5. All restraints used in CIU are used for violent or self-destructive behaviors.

* 6. Every restraint use is documented in the EHR Non-violent, non-self-destructive restraint use (med/surg) is reflected in "Restraints M/S" flowsheet. Violent, self-destructive restraint use is reflected in "Restraints Behavior" flowsheet.

7. Physician orders are required with every restraint use. Standing Orders or PRN orders are not acceptable.

* 8. The following physician group MD’s can order restraints: Trauma, emergency department, psychiatry, hospitalist, intensivist, CV surgeons, Primary care physicians, and Neuro surgeons.

9. MD orders for non-violent, non-self-destructive restraint use:
   a) After a RN implements emergency initiation of restraint, an individual physician time-limited order must be obtained. Individual physician orders for medical-surgical restraint is immediately obtained and a continuing order is written every calendar day.

* 10. MD orders for violent, self-destructive restraint use is as follows:
   a) A MD order is immediately obtained and a MD face-face evaluation is completed.
   b) Orders are time-limited. Maximum length of order is age-dependent:

<table>
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<tr>
<th>Age</th>
<th>Time Limit</th>
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<tr>
<td>18 years - older</td>
<td>4 hours</td>
</tr>
<tr>
<td>Age 9 - 17 years</td>
<td>2 hours</td>
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<tr>
<td>Age 0 - 8 years</td>
<td>1 hour</td>
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</table>
11. Physicians conduct face-face assessment of all patients in restraints.
   * a) The physician conducts face-face assessment for non-violent (medical) restraint within 24 hours of initiation.
   * b) The face-face assessment for violent, self-destructive (behavioral) restraint use is as follows:
      1) Patient receives face-to-face evaluation by MD or RN-qualified designee prior to every order being written. Purpose of evaluation is to determine if restraint/seclusion is to be continued. If continued, an order is obtained and reevaluation personnel works with patient to regain behavior and modified the plan of care.
      * 2) Patient receives face-to-face evaluation by MD within one (1) hour of initial restraint application. MD responsibility includes: an evaluation of the patient's immediate situation; patient's reaction to the intervention, patient's medical and behavioral condition; need to continue or terminate the restraint or seclusion.
      3) Face-to-face evaluations are conducted based on age-dependent timeframes
         
         | Age            | Timeframe |
         |----------------|-----------|
         | 18 years - older | 4 hours   |
         | Age 9 - 17 years | 2 hours   |
         | Age 0 - 8 years  | 1 hour    |

      4) Patients require face-to-face reevaluation by MD dependent on age (cannot be delegated to RN designee):
         
         | Age            | Timeframe    |
         |----------------|--------------|
         | 18 years - older | Every 8 hours|
         | 17 years and under | Every 4 hours |

      5) If the face-to-face evaluation is completed by non-MD (that is, RN-qualified designee), the MD is notified of face-to-face assessment outcome by the RN. MD input is sought regarding review of psychological status of patient and to identify ways for patient to regain control.

12. RN is responsible for patient assessment, implementing alternatives, monitoring patient safety and modifying the Plan of Care.

13. Restraints are applied, monitored and removed by qualified staff.
   * 14. Patients are monitored frequently for non-violent restraint use (med-surg) or continuously for violent, self-destructive restraint use.

*Indicates addition/change
15. It is practice to end restraint use at the earliest possible time. Patient may be released before the order expires based on RN or MD assessment.

16. Patient and family involvement and education is critical to prevention of restraint use. Discussions regarding restraint prevention and use are held with patient, and/or family, as appropriate. Family is notified of restraint use as patient permits.

17. When conflict develops with staff and/or family in the management of patient behavior and restraints any staff member should consult with any resources: Nurse Manager, Clinical Nurse Specialist, administrative designee, Patient Representative, or Ethics Committee (Biomedical Ethics or Nursing Ethics).

18. Patients who die while in restraints are reported to Risk Management immediately so required reports can be made to regulatory agencies.

EXCLUSIONS:

This policy does not apply to:

1. Devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for:
   a) purpose of conducting routine physical examination or tests, or
   b) protect the patient from falling out of bed, or
   c) permit the patient to participate in activities without the risk of physical harm.

2. Age or developmentally appropriate protective safety intervention (e.g. raised crib rails, crib covers).

3. Side rails which protect the patient from falling out of bed (vs patient exiting the bed) (e.g. stretcher, recovering from anesthesia, certain types of therapeutic beds).

4. Picking up, redirecting or holding an infant, toddler or pre-school aged child to comfort them.

5. Forensic restrictions imposed by correction authorities for security purposes. (See Care of Patient Under Forensic Restrictions Policy.)

STAFF OUTCOME:

1. Use of proactive non-physical interventions to manage behaviors that put patients or others at risk for harm.

2. Knowledgeably determine when to use least restrictive restraints and how to safely apply them while preserving patient dignity, rights and well-being.

SUPPORTIVE DATA:

1. JCAHO Accreditation Manual for Hospitals
2. Patient Bill of Rights
3. Safety Patient Management Policy
4. Aggressive Behavior Protocol

*Indicates addition/change
6. Workplace Violence Prevention and Intervention Program Policy
7. Vulnerable Adult Policy
9. Search Policy
10. Home Health Restraints Policy
11. Close Observational Care Policy
12. Care of the Patient Under Forensic Restrictions
13. Acute Confusion (Delirium) Protocol
14. Falls Prevention Protocol
15. Patient Rights CMS Conditions of Participation for Hospitals

C. Non-violent, non-self-destructive Restraint Procedures

**STEPS:**
1. RN determine the individual patient’s needs for safety interventions.
2. Attempt interventions to modify behavior.

**KEY POINTS:**
1. a. Initial screening or database (cognitive/perceptual) triggers need for plan to minimize restraints.
   b. Obtain data from family/patient regarding alternatives and preferences.
   c. Use Safety Protocols.
2. a. Interventions may include but are not limited to: (See Appendix A)
   b. If interventions fail or are not possible due to seriousness of behavior, RN may directly authorize restraint use.
   c. Activate Code Green Team to assist with assistance, if needed. Code Green RN will assist in determining if behavior of restraint violent, self-destructive or non-violent use.
   1) If restraint use is determined to be violent, self-destructive, CIU staff will provide on-the-spot staff coaching for documentation.
   2) Follow procedures under behavioral use.
POLICY AND PROCEDURE
RERAINT/SECLUSION, MEDICAL CENTER PATIENT CARE
Effective Date: March 2010

STEPS:

3. If attempts fail, restraint device is placed under the direction of the RN.
   a. Explain to patient/family reason for use and release criteria.

   3. a. Restraint devices used only when alternative methods are not sufficient to protect patient from interference with medical-surgical healing.
   b. Patient condition is considered when selecting devices, e.g. use of roll belt for pregnant patient is discouraged.
   c. Staff to determine one team member to provide directives to patient during restraint episode.
   d. Refer family to Patient Information Handbook for more information or handout available in Physical Restraint care plan.
   e. Request assistance from other staff as needed.
   f. RN verifies proper placement of device(s) after the device(s) is applied.
   g. Physician order for use of restraint is immediately obtained.

4. Patient care plan is updated and individualized.

   *4. Physical restraint care plan initiated.

5. Patient care needs are attended to on a regular basis.

   5. a. Directly observed every hour by direct care staff (RN, LPN, NA or MHA) for ensuring safety and dignity, including restraint correct application.
   b. Offered fluids, food and toileting at least every two hours while in restraint. Exercise needs (ROM) and CMS checks are completed every two hours.
   c. Vital signs (T, P, R, BP and pain) are monitored at least every four hours and skin care every eight hours.

6. RN reassess at least every two hours and may be more frequent based on assessment of individualized patient needs.

   6. RN assessment every two hours is completed to determine patient’s physical and emotional safety; changes in patient behavior or clinical condition needed to initiate the removal of restraints; whether less restrictive methods are possible; and whether the restraint is appropriately applied or removed.

7. Remove restraints at earliest opportunity.

   7. a. Based on assessment and re-evaluation of the patient’s condition, remove restraints and discontinue application.

   *Indicates addition/change
D. Violent, Self-destructive (behavioral) Restraint/Seclusion Use Procedures

**STEPS:**

1. Restraint prevention assessment data is included in patient plan.

2. Staff use non-physical techniques as the preferred interventions at all times.

3. Staff seek manager or administrative assistance to adjust staffing levels which maximize safety and minimize restraint/seclusion use.

4. Restraint/Seclusion implementation.

5. RN directs team to apply specific device or intervention.

**KEY POINTS:**

1. a. Admission database reflects patient (and family when appropriate) description of tools, techniques or methods to provide comfort when distressed.

   b. Seek patient direction on family notification.

   c. The following are considered in developing plan: medical condition/physical disabilities and history of sexual or physical abuse.

2. a. All CIU staff have ongoing training in restraint prevention.

3. a. Population mix of unit is considered when adjusting daily staffing, i.e. diagnosis, age, developmental levels, forensic patients, etc.

4. a. When non-physical techniques have failed and other alternatives above failed or are not appropriate due to safety factors, restraint(s) or seclusion may be used.

   b. When an MD is unavailable, a RN may authorize restraint or seclusion based on individualized assessment.

   c. RN staff receive specific training and demonstrate competency of initiating restraint.

5. a. Single designated staff provide verbal direction to patient.

   b. RN verifies proper placement of device(s) after device(s) applied.

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<table>
<thead>
<tr>
<th>STEPS</th>
<th>KEY POINTS</th>
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<tr>
<td>7. Family is contacted, as per patient</td>
<td>7. a. Based on patient direction and authorization to contact.</td>
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<tr>
<td>direction.</td>
<td>b. Patient may change directive when restraint/seclusion is implemented.</td>
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<tr>
<td>8. Patient is continuously monitored by</td>
<td>8. a. At the earliest appropriate time, staff inform patient of rationale</td>
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<td>staff.</td>
<td>for restraint or seclusion and the behavioral criteria for its discontinuation</td>
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<td></td>
<td>(as defined on order).</td>
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<td>b. If seclusion is used, staff stand immediately outside room door and</td>
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<td></td>
<td>monitor via window and sound.</td>
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<tr>
<td>9. Patients are assessed upon initiation</td>
<td>9. a. Staff receive ongoing training and demonstrate competency.</td>
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<td>and every 15 minutes to meet behavioral</td>
<td>b. Safety considerations include:</td>
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<td>criteria for discontinuation.</td>
<td>- vital sign (at least every 2 hours)</td>
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<td></td>
<td>- nutrition/hydration needs (at least every 2 hours)</td>
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<td>- Check circulation</td>
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<td>- CMS (at least every two hours)</td>
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<td>- hygiene/elimination needs (at least every 2 hours)</td>
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<td></td>
<td>- physical and psychological status; comfort</td>
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<td></td>
<td>- what is needed for patient to meet criteria for discharge from</td>
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<tr>
<td></td>
<td>restraint</td>
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<td></td>
<td>- when medical help is needed</td>
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<td></td>
<td>- readiness for discharge from restraint</td>
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<td></td>
<td>* c. Staff assist patient in meeting behavioral criteria for release as</td>
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<td></td>
<td>identified in order.</td>
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<tr>
<td>10. Patients are released from restraint/</td>
<td>10. Staff use a systematic release of limbs, e.g. release one (1) leg</td>
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<tr>
<td>seclusion when behavioral criteria are met.</td>
<td>first then one (1) arm, then remainder of devices.</td>
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*Indicates addition/change
STEPS:
11. Debriefing occurs within 24 hours after each episode. Included: staff involved (as available), patient and family (if appropriate).

12. Clinical Leadership (Nurse Manager) is immediately notified when:
   a) An individual patient exceeds 12 hours in restraint or seclusion.
   b) Individual patient has 2 or more different initiations of restraint or seclusion within 12 hours.

   Thereafter, leadership is notified every 24 hours if either of the above conditions continue.

KEY POINTS:
11. a. If patient is CIU patient or is in restraints while in ED and then admitted to CIU, the CIU staff provide the debriefing.
   1) Charge RN collaborates with staff to facilitate schedule.
   * 2) Staff complete Debriefing in "Restraints Behavior" flowsheet.
   * 3) Place a note on staff-staff communication and in care plan when debriefing is due.
   4) Modify patient plan of care based on information from Debriefing.

12. a. Charge RN notifies the Nurse Manager (or Administrative Designee) when either condition occurs. Manager will contact Medical Consultant, Director and/or CNS to assist in clinical review.

ATTACHMENTS:
Attachment A - Alternative Measures to Restraints
Attachment B - Restraint Algorithm
Attachment C - Face-Face Evaluation, Violence Behavior Restraint Use