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Owner:	*Susan Leuck: Manager Patient Services*
Department:	*Patient Care Services*
References:	
Applicability:	*Columbia St. Mary's Hospital Milwaukee* *Columbia St. Mary's Hospital Ozaukee* *Sacred Heart Rehabilitation Institute*

Restraint and Seclusion

POLICY STATEMENT

Columbia St. Mary's (CSM) will provide an environment that is conducive to the delivery of patient care in a manner that protects the patient's dignity, rights, and well-being. Use of restraints/seclusion will be based on the patient's assessed needs. The least restrictive methods will be employed whenever possible.

Restraint/seclusion is never intended as punishment or as a convenience for the staff. The use of restraint/seclusion is intended to protect the patient from harm to self or others, to assist in the safe delivery of care, or to avoid interruptions in medical treatment.

CSM strives to provide a restraint/seclusion free environment through development of protocols, staff education, and continuous improvement processes.

Before restraint/seclusion is used, an assessment of the patient's behavior, medical condition, and the environment is completed. Upon completion, a plan of care is developed to ensure patient safety. Alternatives to the application of restraint/seclusion will be attempted. If restraint/seclusion use is indicated, they are applied and removed by competent staff. Competencies of staff using restraint/seclusion are documented and records are maintained.

Although patient clinical status, location within the hospital, and type of restraint device applied may vary, the approach taken to assure patient safety is consistent hospital-wide.

The placement of a patient in seclusion may only occur in the Behavior Medicine Unit.

All patient care areas are made aware of this policy and the importance of maintaining patient respect and dignity, and safety at all times.

SCOPE

This policy applies to all employees within the CSM organization who apply restraint/seclusion.

PURPOSE

To provide care for patients requiring restraint/seclusion who are demonstrating behavior that disrupts medical

treatment or is injurious to self or others.

DEFINITIONS

1. ***Violent***: Describes a patient who exhibits behavior that threatens self or others and there is need to control that behavior in order to prevent harm to the patient and/or others.
2. ***Non-Violent***: Describes confused or sedated patients who may interfere with medical devices (dressings, nasogastric tubes, intravenous or ventral lines, etc.) which could be detrimental to their care or healing process.
3. ***Adaptive Support:*** Mechanisms intended to permit a patient with assessed physical needs to achieve maximum normative bodily function, including orthopedic appliances, braces, wheelchairs, or other devices used to support the patient's posture.
4. ***Alternative Interventions:*** Any action, plan of care, or mechanism that is effective in maintaining the safety and well-being of the patient and others and that avoids the use of restraint.
5. ***Chemical Restraint:*** 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.
6. ***Medical Immobilization:*** Temporary limitation of mobility that is usually and customarily employed during medical, diagnostic, or surgical procedures/tests.
7. ***Physical Hold***: Method of restraint that temporarily restricts a patient's freedom of movement or normal access to his/her body by means of staff physically holding the patient.
8. ***Restraint*****:** The use of a manual, physical, or mechanical device, material or equipment attached or adjacent to the patient's body he or she cannot easily remove that restricts freedom of movement or normal access to one's body.
9. ***Seclusion*****:** The involuntary confinement of a person intentionally isolating them from others in a room where the patient is prevented from leaving. **Seclusion is only permitted on Behavioral Health Units.**
10. ***Time-out:*** Used to assist the patient to regain emotional control by removing the patient from his or her immediate environment and restricting the patient to a quiet area or unlocked room.

Exceptions

The standards for restraint and seclusion **do not** apply:

1. To a time-out when a patient is restricted for 30 minutes or less from leaving an unlocked room and is consistent with the treatment plan.
2. To forensic restrictions and restrictions imposed by correction authorities for security purposes (i.e., handcuffs, etc.). However, restraint or seclusion use related to clinical care of a patient under forensic or correction restrictions is surveyed under these standards.
3. To interactions with patients that are brief and focus on redirection or assistance in activities of daily living such as hygiene.

Alternatives to Restraint/Seclusion

Unless safety requires an immediate response, restraint and seclusion are used only after other alternative less restrictive methods have proven ineffective. **All alternatives that have been attempted must be**

documented with the patient's response, as well as the behaviors and actions leading to the use of restraint and seclusion. (See Flow Chart Restraint Use and Addendum B – Alternatives to Restraint Use.)

The initial admission assessment identifies information about the patient that could be used to minimize restraint and seclusion including:

1. Coping mechanisms to reduce stress and help the patient control his/her behavior.
2. Pre-existing medical conditions or any physical disabilities and limitations that would place the patient at greater risk during restraint or seclusion.
3. Any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint or seclusion.

PROCESS

1. The following immobilization situations may commonly occur in administering or performing routine care. These are not considered restraint situations and therefore devices **MAY BE APPLIED WITHOUT A PHYSICIAN'S ORDER:**
    A. **Routine Treatment Immobilization**
    Mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures that are considered a regular part of the procedure. Mechanisms may include arm boards, lap belts on surgical tables and carts, single limb holders, and sandbags (e.g., for use after cardiac catheterization or angioplasty).
    B. **Adaptive Support (Postural)/Safety Support**
    Mechanisms utilized to assist patients with physical and or neurological deficits to maintain normal body position and function.
2. Situations may occur when patient healthcare needs necessitate the use of restraint/seclusion. In each situation, clinical justification for application and removal of restraint/seclusion will be identified. This includes emergency use of restraints/seclusion.
    A. **Non-violent: Disruption of Medical Treatment**
    Restraint may be used to prevent disruption of care or treatment necessary to the maintenance or promotion of health or life. Individuals requiring restraint may manifest one or more of the following: restlessness, disorientation, pulling at tubes/lines, attempting to discontinue equipment, unable to comprehend directions, or compromised recall/carryover. (Refer to Flow Chart Restraint Use.)
    B. **Violent: Behaviors Injurious to Self or Others**
    Use of restraint or seclusion are primarily to protect the patient against injury to self and/or others due to an emotional or behavioral disorder. Restraint or seclusion is employed only when nonphysical interventions are ineffective or not viable and when there is an imminent risk of a patient physically harming himself/herself, staff, or others. (Refer to Flow Chart Restraint Use.)
3. **NON-VIOLENT: DISRUPTION OF MEDICAL TREATMENT**
    A. **Physician Orders**
        1. A physician's order for a physical hold is required and must address the justification for physical hold use.
        2. A physician's order for restraint is required prior to the initiation of restraints unless it is an emergency. In an emergency situation, a registered nurse may initiate restraint. If this occurs,

an order must be obtained during the application or within minutes.

3. In the event that the attending physician was not the ordering physician, the attending must be notified as soon as possible and this notification is then documented in the Progress Notes. The order must specifically address:
    a. Time limits (not to exceed 24 hours)
    b. Type of restraint device to be applied
    c. Justification for restraint use
    d. **PRN orders are not acceptable**

    If the initial order is received via a telephone order, the order must be authenticated by a physician within 24 hours.
4. Continued use of restraint beyond the first 24 hours is authorized by a physician. The physician may renew the original order or issue a new order if restraint use continues to be clinically justified. Such renewal is issued no less than once each calendar day and is based upon an examination of the patient by the physician. The order must include type of restraint device to be applied and justification for restraint use.
5. Restraints cannot be initiated upon a family member's request unless the nurse and/or physician has assessed and determined that restraint use is indicated.
6. An electronic order in the Electronic Health Record (EHR) is to be used when restraints are ordered for an individual.

B. **Monitoring/Documentation**

1. The assessment, implementation, maintenance, and decision for early release of restraint is directed by the registered nurse who has knowledge and training of alternative (less restrictive) interventions as well as care specific to patients in restraints.
2. Restraint application will be explained to the patient and/or significant other as appropriate. If a responsible adult refuses restraints, the physician will be contacted and asked to speak to the responsible adult about the risks of refusal of restraints. The refusal will be documented in the medical record along with a specific description of the patient's mental status and physical condition and a "REFUSAL TO PERMIT TREATMENT/PROCEDURE" form (CSM Patients Services P&P, Discharge Against Medical Advice-Refusal to Permit Medical Treatment-Procedure") will be completed. Patient/family education will occur regarding the need for restraint and the option of family participation will be discussed and assessed. Patients whose behavior puts others at risk to injury will not be allowed to refuse restraints.
3. A patient in restraints will be monitored at least every 2 hours. Monitoring will include:
    a. Assessing continued need for restraint
    b. General clinical condition
    c. Circulation
    d. Condition of limbs and skin
    e. Basic needs of hydration, elimination, and nutrition

    These assessments will be documented in the EHR .
4. Patients are to be released from restraint when the unsafe situation passes regardless of the time limit on the order. Restraints are not considered discontinued if removal occurs during

therapeutic interventions or under the direct supervision of a staff member.

a. Family members and other visitors cannot serve as the direct supervisor.

5. If restraint is discontinued and the patient's unsafe behavior resumes or escalates, a new order will need to be obtained prior to initiation of the restraint unless it is an emergency. If emergent, the new order would need to be obtained within minutes of the initiation of the restraints.
6. Failure to complete documentation included in this policy may lead to immediate corrective action up to termination.

4. **VIOLENT: BEHAVIORS INJURIOUS TO SELF OR OTHERS**

A. **Physician Orders**

1. Physical Hold: A physician's order for a physical hold is required and must address the justification for physical hold use. In the event a physical hold is required for initiation of restraint or seclusion, it is understood the physical hold may be required and does not require a separate physical hold order.
2. Restraint: A physician's order for a restraint is required and must address the justification for restraint use.
3. Seclusion: **Seclusion is only permitted on Behavioral Health Units.** A physician's order for seclusion is required and must address the justification for seclusion use.
4. A physician's order for restraint/seclusion is required and must specifically address time limits, type of restraint device to be applied, and justification for restraint/seclusion use. The order for restraint/seclusion is limited to:
   a. 4 hours for patients ages 18 and older
   b. 2 hours for children and adolescents ages 9-17
   c. 1 hour for children under age 9
5. In an emergency situation, a registered nurse may initiate a physical hold, restraint, and/or seclusion. If this occurs, an order must be obtained during the application or within minutes. A physician needs to complete a face to face evaluation within one hour of initiation of a physical hold, restraint, and/or seclusion.
6. Order for the use of physical hold, restraint, and/or seclusion may not be entered as standing orders or on an as needed basis. **PRN ORDERS ARE NOT ACCEPTABLE.**
7. The order for a physical hold, restraint, and/or seclusion must be entered into the patient's EHR.
8. If restraint or seclusion needs to continue beyond the expiration of the time-limited order, a new order is obtained from the physician.
9. Security staff is authorized to assist with physical hold and/or restraint application, but only at the direction of and in the presence of a physician or an RN.

B. **Monitoring**

1. Monitoring a patient in a physical hold, restraint, or seclusion is to ensure the patient's physical safety. An assigned staff member who is trained accomplishes monitoring through continuous in-person observation.
2. Patients in a physical hold, restraint, and/or seclusion are monitored and assessed. A staff member who is trained assesses the patient at the initiation of a physical hold, restraint and/or

seclusion and every 15 minutes thereafter. This assessment includes:

a. Signs of any injury associated with application of a physical hold, restraint, or seclusion
b. Nutrition/hydration
c. Circulation and range of motion in extremities
d. Vital signs
e. Hygiene and elimination
f. Physical and psychological status and comfort staff provide assistance to the patient in meeting the behavior criteria for the discontinuation of restraint or seclusion

3. A physician conducts a face to face evaluation of the patient within one hour of the initiation of physical hold, restraint, or seclusion. At the time of the face to face evaluation, the physician works with the patient and staff to:
   a. Identify ways to help the patient regain control
   b. Make necessary revisions to the patient's treatment plan
   c. Provide a new written order if necessary
4. By the time an order for restraint or seclusion expires, the patient receives an in person re-evaluation by a physician or registered nurse. This re-evaluation takes place every:
   a. 4 hours for adults ages 18 and older
   b. 2 hours for children ages 9-17
   c. 1 hour for children under the age of 9

C. **Documentation**

1. Physician completes the following:
   a. Face to face examination of patient by a physician **within one hour** and initial assessment progress note section completed with the EHR form "Restraint/Seclusion-Violent Behavior Progress Note".
   b. If restraint continues uninterupted (every 8 hours for adults or every 4 hours for adolescents), physician completes face to face re-evaluation and documents on the reassessment section of the "Restraint/Seclusion-Violent Behavior Progress Note".
2. RN completes the following:
   a. Upon initiation of physical hold, restraint, or seclusion, RN completes the EHR PowerForm "Restraint/Seclusion for Violent Behavior Initiation".
   b. When physical hold, restraint, or seclusion is discontinued, RN completes the EHR PowerForm "Restraint/Seclusion for Violent Behavior Discontinuation".
   c. Debriefing session with patient, staff and family occurs within 24 hours and is documented in EHR PowerForm "Restraint/Seclusion for Violent Behavior Debriefing".
   d. RN updates plan of care to include Restraint/Seclusion/Physical Hold.
   e. If restraint/seclusion continues beyond the original order, RN performs face to face re-evaluation (after 4 hours for adults, 2 hours for adolescents) and documents the reassessment in the EHR PowerForm "Restraint/Seclusion Re-Evaluation Behavioral".

3. 1:1 continuous monitoring required and documented on the "Behavioral Health Restraint/ Seclusion Flowsheet"
    a. Assessment documented every 15 minutes.
    b. Nursing care documented every two hours. If nursing care is not performed every two hours due to patient's behavior, this must be documented in a nursing progress note
4. Failure to complete documentation included in this policy may lead to immediate corrective action up to termination.

5. **DISCONTINUING OF RESTRAINT/SECLUSION**

A. Staff will provide assistance to patient's in meeting the behavioral criteria for release from restraint and/or seclusion. Restraint and seclusion use is discontinued as soon as possible and when the patient meets the behavioral criteria. Behavior criteria may include, but are not limited to:
    1. The patient is able to contract for safety.
    2. The patient is oriented to the environment.
    3. Cessation of verbal threats.

B. Nursing documentation is required every 15 minutes for continued use of restraint and/or seclusion. If nursing documentation does not reflect the need for continued restraint and/or seclusion, the patient should be released from restraint and/or seclusion.

C. A debriefing with the patient, family (if appropriate), and staff occurs no longer than 24 hours after violent restraint or seclusion episodes. Debriefing is used to:
    1. Identify what led to the incident and what could have been handled differently.
    2. Ascertain that the patient's physical well-being, psychological comfort, and right to privacy were addressed.
    3. Counsel the patient involved of any trauma that may have resulted from the incident.
    4. When indicated, modify the patient's treatment plan.

6. **EDUCATION**

A. Education of staff will occur during orientation and at regular intervals thereafter.

B. Education of physicians will occur through Medical Staff Services in partnership with Behavioral Health Services.

C. The use of restraints may be interpreted by the patient and family as an unnecessary procedure. Prior to the use of restraint, whenever possible, the patient/family/significant others should be given a complete explanation of:
    1. All patients are assessed before restraints are applied.
    2. Availability of alternatives to restraint including the availability of the family to participate in the delivery of care to limit the use of restraint.
    3. What behaviors might cause restraints to be incorporated into the plan of care.
    4. Discussion of patient and family preferences and insights related to prevention, alternatives that can be incorporated into the plan of care.

D. For application of restraint, the staff attempts to contact the family promptly to inform them of the restraint or seclusion episode in those cases in which the patient has consented to have the family

kept informed and the family has agreed to be notified.

E. Training content includes, but is not limited to:
    1. Techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of restraint/seclusion.
    2. The use of nonphysical intervention skills.
    3. Choosing the least restrictive intervention based on patient condition.
    4. The safe application and use of all types of restraint used in the hospital. When all limbs are restrained, a vest or waist restraint must also be applied.
    5. Training to recognize and respond to signs of physical or psychological distress.
    6. Clinical identification of specific behavioral changes that indicate that restrain is no longer necessary.
    7. Monitoring the well-being of the patient in restraints including but not limited to: respiratory and circulatory status, skin integrity, vital signs, and any special requirements.

F. When the patient is in the Behavior Medicine Unit, the Behavioral Medicine Medical Director or designee is notified immediately by the RN for:
    1. Patient in restraint/seclusion for greater than or equal to 12 hours
    2. Two or more separate episodes within 12 hours
    3. Every 24 hours if above conditions continue
    4. Notification is documented on the EHR Restraint/Seclusion Progress Note.

7. **PERFORMANCE IMPROVEMENT BEHAVIORAL MEDICINE UNIT**
    A. The Restraint and Seclusion Concurrent CQI Audit Tool will be completed for each episode of restraint and/or seclusion.
    B. The clinical nurse leader, unit manager, director, and/or medical director should be notified of any restraint and/or seclusion episode.
8. **REPORTABLE DEATHS**
    A. Any death that occurs while a patient is in restraints or seclusion is reportable. See Corporate Responsibility Policy "Reportable Deaths".

REFERENCES

Joint Commission Hospital Accreditation Manual, July 2009.

CMS Publication 100-7, State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, October 17, 2008, §482.13(e).

Title 42 Code of Federal Regulations, Condition of Participation: Patient rights, § 482.13(e), Standard: Restraint or Seclusion.

Reducing Restraint Use In The Acute Care Environment, Joint Commission Accreditation of Healthcare Organization, 1-42, 1998.

Sentinel Event Alert, Joint Commission on Accreditation of Healthcare Organizations, November, 1998.

Reith, K., Bennett, C., Restraint-Free Care, Nursing Management, May, 1998.

Wisconsin Statutes, Mental Health Act, Chapter 51 – Patient Rights, 51.61.

Wisconsin Administrative Code HFS 94, Patient Rights and Resolution of Grievances.

CSM EHR FORMS

- Restraint/Seclusion Flowsheet - Behavior Injurious to Self or Others
- Restraint/Seclusion Progress Notes - Initiating and Reassessing
- Discontinuing Restraint/Seclusion Progress Note
- Restraint/Seclusion Physician Order-Behavioral Health
- Nursing Assessment and Care Flowsheet
- Patient Information Handout - Provide a Safe Environment

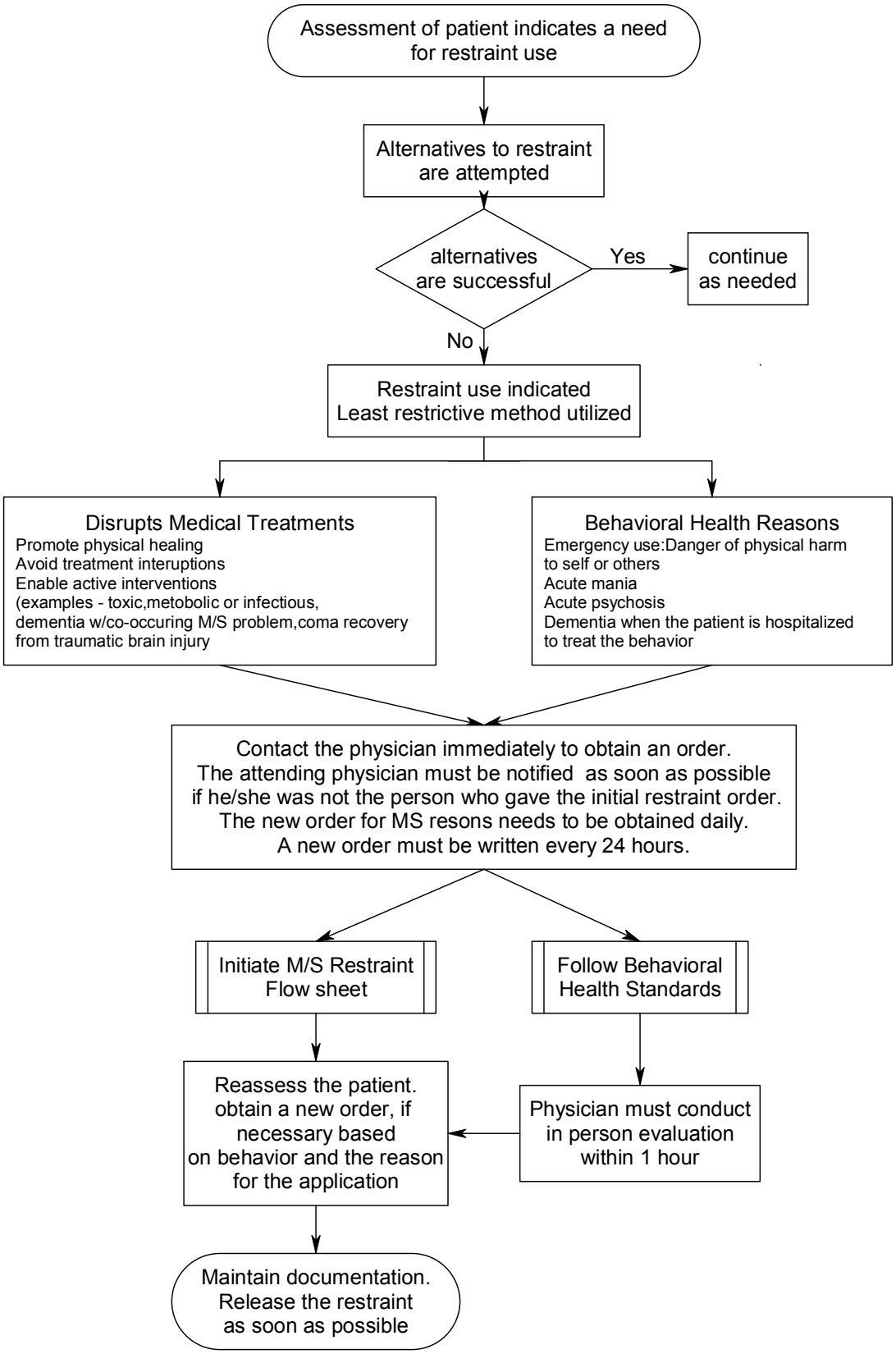
Attachments:

A - Restraint Use Flow Chart
B - Alternatives to Restraint Use
C - Procedure for Application of Soft Restraints

Approval Signatures

Step Description	Approver	Date
	Gloria Rawski: Policy/Clinical Database Coordinator	05/2017
	William Fry: Manager Patient Services	05/2017

RESTRAINT USE



ADDENDUM B

Alternatives To Restraint Use

1. Providing companionship and supervision:
   - Ask family, friends, or volunteers to stay with the patient.
   - Determine when the patient needs one-to-one attention (typically at night) and intervene accordingly.
2. Changing or eliminating bothersome treatments:
   - Initiate oral (as opposed to IV or NG) feedings
   - Remove catheters and drains as soon as possible
3. Modifying the environment:
   - Increase or decrease the amount of light in the room, depending on glare and the patient's preference or needs.
   - Position the bedside commode so that the patient can use it easily.
   - Arrange for patient to be near the nurses station, unless the stimulation triggers agitation or worsens condition.
   - Place the mattress on the floor, so the patient can move about freely without falling.
   - Leave the bed rails down if the patient tends to climb over them, or use half rails to prevent rolling out of bed.
   - Reduce environmental noise.
   - Keep the call button accessible.
   - Use special furniture accordingly (a lower bed, a reclining chair).
4. Reality orientation and psychosocial interventions:
   - Involve the patient in conversation. Don't talk over the patient.
   - Explain procedures to reduce fear and convey a sense of calm.
   - Provide reality links when appropriate (TV, radio, calendar, clock).
   - Use relaxation techniques (therapeutic touch, massage, warm baths).
   - Use active listening to elicit the patient's feelings.
5. Offer diversionary and physical activities:
   - Use TV, radio, or music for diversion (depending on patient's cognitive capacity and individual preferences).
   - Provide exercise and ambulation whenever possible.
   - Initiate training in activities of daily living.
   - Use physical and occupational therapists to help the patient increase their strength and endurance and feel a sense of accomplishment.
6. Designing creative alternatives:
   - Use music chosen specifically for the patient to reduce agitation or to provide diversion.
   - Use a pressure – sensitive bed or chair pads with alarms for altering staff to an unsteady patient standing without help.
   - Develop toileting routines to facilitate elimination and reduce falls related to elimination.
   - Consult with other disciplines about appropriate interventions.

Adapted from Evans, L., et al. limiting use of physical restraints: a prerequisite for independent functioning, In Practice of Geriatrics, 2nd edition, edited by E. Calkins, et al., Philadelphia, PA., W.B. Saunders Co., 1992 Strumpt, N.E., et al, Physical Restraint of the Elderly, In Clinical Gerontological Nursing, edited by C. Chenitz, et al., Philadelphia, PA., W.B. Saunders, 1992, pp. 329-344 Strumpt, N., et al., Reducing Restraints: Individualized Approaches to Behavior, Huntingdon Valley, PA., The Whitman Group, 1994.

ADDENDUM C

Procedure for Application of Soft Restraints

Equipment: Vest, waist, pelvic, wrist/ankle devices, Wheelchair belts, Geri-chairs and lapboard on wheelchairs

1. Explain the rationale, procedure, and duration of restraint use to the patient and/or family.
2. Select size and type of restraint(s) appropriate for patient.
3. Assist the patient to a comfortable position in bed, chair, or wheelchair.
4. Apply restraint(s) assuring for security and safety:
   - Attach ties to bed frame (not side rails), back legs of chairs, frame of wheel/specialized chairs, not side arms.
   - Secure vest/waist restraints to upper portion of bed frame (moveable part).
   - Quick release clip should be beyond patient reach, but readily accessible and easily released by staff in case of emergency.
   - Vest/waist restraints should be secure enough that the patient cannot slide up or down, but permit two fingers between patient and device and allow turning by the patient.
   - Wrist/ankle restraints and mittens should permit two fingers between the patient and device. When all limbs are restrained, a waist or vest restraint will also be used for safety purposes. It is unsafe to restraint one limb alone.
5. Call light within reach when possible, side rails up, and bed in low position.
6. Behavior criteria for removal explained to patient and/or family, if appropriate.

Procedure for Application of Locked Restraints

Equipment: Waist belt (select appropriate size) Twice as Tough (T-A-T) connected ankle and wrist cuffs

1. One person, the assigned registered nurse, or designee will direct the procedure.
2. Prepare room and equipment, removing potentially hazardous furniture or equipment.
3. Assemble appropriate number of nursing staff or security personnel and review procedure and assignments.
4. Explain to the patient exactly what is to happen, soliciting cooperation to the degree possible.
5. Assist the patient to bed as necessary, using non-violent crisis intervention techniques:
   - Two staff approach from either side, hold patient's arms in extended position. Third and fourth staff may be needed to carry the lower extremities.
   - Protect against biting, kicking, or hitting by strategic positioning and holds.
6. Remove clothing/accessories and place patient in a hospital gown.
   - Remove all jewelry, belts, strings, and shoelaces.
   - Check hair for hairpins, clips, barrettes, etc.
   - Remove glasses, contacts too if possible.
7. Lay patient on the bed over waist restraint. Apply waist restraint.
   - Insert loops through belt.
   - Insert a belt into each set of loops.
   - Fasten belt to bed frame.
8. Apply ankle and wrist restraints to all four extremities: (Twice as Tough cuffs.)
   - Wrap ankle and wrist cuffs around all four extremities.
   - Fasten to bed frame and secure lock.
   - One staff secures each cuff sequentially while the other maintains patient security.
   - Locks on restraints and belts should be easily accessible to staff caring for the patient.
   - Behavior criteria for release explained to patient.