

# Altru Health System Policies & Procedures

Number: 2002  
Policy: Restraints, Safety Mechanisms, Protective Devices, Seclusion  
Effective: September 12, 2011

## **Philosophy:**

Altru Health System is committed to preventing, reducing and striving to eliminate the use of restraint and/or seclusion. Non-physical interventions are the preferred interventions. The use of restraint and/or seclusion is limited to emergencies in which there is imminent risk of a patient physically harming himself or herself or others, including staff when less restrictive measures have been found to be ineffective in protecting the patient and/or others from harm. It is the responsibility of all staff to facilitate the discontinuation of restraint or seclusion as soon as possible. Every effort is made to maintain patient rights, dignity, and well-being. Patients have a fundamental right to be free from restraints of any form that is imposed for coercion, discipline, convenience, or retaliation by staff including drugs that are used as restraints.

## **Summary/Definitions:**

- A. **Restraint** is 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. (Refer to Attachment A for exceptions from and examples of Restraint.)
- B. **Seclusion** is the involuntary confinement of a person alone in a room from which the patient is physically prevented from leaving. (Refer to Attachment A for exceptions from and examples of Seclusion.)
- C. **Chemical restraint** is the use of a medication used to restrict the patient's freedom of movement that is **not** a standard treatment for the patient's new or continuing medical or behavioral condition. It is this hospital's policy to only use medications that are a standard treatment for the patient's ongoing or newly emerging condition. ***Chemical restraint is not practiced in this institution.***
- D. **Protective device** (for non-violent behavior): will be considered to be any device that protects the patient so that medical treatment can occur without the patient interrupting.

## **Indications:**

- A. Restraint or seclusion may be used when less restrictive means are not sufficient to protect the physical safety of patients, staff members or others.
- B. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member, or others.
- C. Protective device example would include soft wrist protective devices that could be utilized so the patient does not dislodge lines, tubes, or other medical equipment.

## **Initiation:**

Each episode of restraint/seclusion shall be initiated:

- A. Upon the order of a physician who is responsible for the patient, or
- B. By a trained registered nurse when he or she determines it is necessary to protect the patient.
- C. By an order from a physician who is responsible for the patient shall be obtained within one (1) hour.
- D. The patient is made aware of the rationale for the seclusion/restraint and the behavioral criteria to meet to discontinue the use of it.

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Each episode of a protective device shall be initiated:

- A. Upon the order of a physician who is responsible for the patient, or
- B. By a trained registered nurse who determines the need for the protective device.
- C. By an order obtained from the physician within 12 hours.

### **Orders:**

#### **Seclusion/Restraint**

- A. PRN orders are not to be used.
- B. Each order for seclusion/restraint shall
  - 1. Remain in effect until the patient's behavior or situation is assessed to no longer require restraint or seclusion, but no longer than
    - a. 4 hours for adults 18 years of age or older;
    - b. 2 hours for children and adolescents 9 to 17 years of age; or
    - c. 1 hour for children 8 years of age or younger.
  - 2. Renewal orders may be given for the above durations if the indications for restraint or seclusion persist.
  - 3. The physician has the discretion to decide that the order should be written for a shorter period of time; staff should be assessing, monitoring, and re-evaluating the patient so that he or she is released from the seclusion or restraint at the earliest possible time.
  - 4. If the seclusion or restraint is discontinued before the time-limited order expires, the original order **may not** be used to reapply the seclusion or restraint. If the patient is at imminent risk of harming self or others, and non-physical interventions are not effective, a new order for seclusion or restraints is required after assessment of the patient.

#### **Protective Devices**

- A. PRN orders are not to be used.
- B. Each order for protective devices (non-violent behavior):
  - 1. A physician order must be obtained within 12 hours after "Protective Device for Medical Treatment" is initiated. The physician's initial assessment must be completed within 24 hours of the protocol being initiated.

### **Assessment and Monitoring:**

- A. Documentation of the assessments shall include a minimum of the elements indicated in the electronic medical record.
- B. **One-hour Face-to-face Assessment:** Physician or trained registered nurse shall perform a face-to-face assessment of the patient's physical and psychological status within one (1) hour of the initiation of restraint or seclusion. If completed by an RN, this assessment is communicated to the physician as soon as possible after the assessment is completed.
- C. **Monitoring:** Patients shall be subject to monitoring by individuals trained to do so.
  - 1. **Restraint or Seclusion:** Patients shall be monitored on an ongoing basis by staff members who are responsible for the patient's assessment and evaluation. The observations and data collected during such monitoring shall be documented every 15 minutes at a minimum.

\* Note for patients in seclusion: The first hour is direct observation. Subsequent observation may include simultaneous audio and video monitoring.

This assessment includes as appropriate to the type of restraint or seclusion, the following:

- a. Signs of any injury associated with applying restraint or seclusion
- b. Nutrition and hydration

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- c. Circulation and range of motion in the extremities
  - d. Vital signs
  - e. Hygiene and elimination
  - f. Physical and psychological status and comfort
  - g. Readiness for discontinuation of restraint or seclusion
  - h. Positioning
2. **Protective Devices:** Patients shall be monitored on an ongoing basis by staff members responsible for the patient's assessment and evaluation. The observations and data collected during such monitoring shall be documented every two (2) hours.

The assessment of the patient in a Protective Device for Medical Treatment includes the following:

- a. Signs of any injury associated with applying the protective device
  - b. Nutrition and hydration
  - c. Circulation and range of motion in the extremities
  - d. Vital signs
  - e. Hygiene and elimination
  - f. Physical and psychological status and comfort
  - g. Readiness for discontinuation of the protective device
  - h. Positioning
- D. **Assessment:** In fulfilling their responsibility for safeguarding the patient and preventing injury, personnel must be observant of the patient's behavior, document behavior and care, and report patient's behavior to the physician.
1. RN assessment: Assessment of patients in seclusion or restraints must be completed by a registered nurse every 15 minutes. For patients in protective devices (nonviolent behavior) the RN assessment must be completed every two (2) hours.
- \* PHP (Partial Hospitalization Program – Psych) initial assessment must occur within four (4) hours for patients 18 years and older, and within two (2) hours for patients 17 years and younger.
- E. **Reassessment:** Reassessment of the patient by the physician for continuation of seclusion/restraint must occur every eight (8) hours for patients 18 years and older, and every four (4) hours for patients 17 years old and younger.
1. Reassessment by a physician for continuation of protective device must occur daily.
- \* PHP reassessment must occur with each new order if seclusion or restraint needs to continue beyond the initial order.
- F. **Discontinuation:** Restraints, seclusion, and protective devices shall be discontinued by a physician or registered nurse as soon as the behavioral criteria are met.
- G. **Debriefing:** Debriefing occurs with the staff involved and the patient/family as appropriate.
- H. **Care Plan:** The patient's written plan of care shall be modified to address the appropriate interventions implemented to assure the patient's safety and encourage the least restrictive form of restraint as well as the prompt discontinuation of its use.
- I. **Reporting Restraint-related Deaths:** Hospital personnel shall promptly contact hospital administration whenever a patient dies:
1. While restrained or within 24 hours after being released from restraint; or
  2. As the result of a restraint-related condition within seven (7) days after restraint removal.
- Designated hospital administration staff shall notify the Centers for Medicare and Medicaid Services of such deaths within one (1) business day of their discovery. Such notification shall be documented in the patient's medical record.

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- J. **Training/Education:** Designated hospital staff shall receive training as appropriate to perform assigned duties. Such training shall take place prior to staff being asked to implement the provisions of this policy and shall be assessed for competency periodically. (Refer to Attachment B.)
- K. **Documentation:** All documentation pertaining to the use of seclusion/restraint and protective devices will be completed in the electronic medical record under the Seclusion/Restraint document flow sheet and/or the one (1) hour face-to-face assessment and/or protective devices document flow sheet.
- L. **Communication to Family/Significant Other:** Significant other/family is notified of the need for protective devices and/or episodes of seclusion/restraint for patients 18 years and older if a release of information is signed. Parents/guardians of patients 17 years and younger are notified of seclusion/restraint or protective devices.
- M. **Clinical Leadership Notification:** Clinical leadership is notified of two (2) or more episodes of seclusion/restraint in 12 hours or seclusion/restraint for more than 12 hours.

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**ATTACHMENT A**

<b>Device</b>	<b>Not Restraint</b>	<b>Restraint</b>
<b>Medication</b>	Standard use of a medication to treat the patient's behavioral or medical condition, even if given on a PRN basis.	Not a standard use of the medication to treat the patient's medical or behavioral condition.
<b>Side Rails</b>	Seizure precautions – Specialty beds (i.e., V-QUE) bed will not work unless all 4 side rails are up.	Completely surrounds the patient and cannot be lowered by the patient, patient <u>not</u> on seizure precautions or in a specialty bed.
<b>Mittens</b>	Not tied down	Patient can flex fingers and has access to his/her body. If tied down or if so tight or big as to prevent use of the hands.
<b>Arm Boards</b>	To protect intravenous access	If tied down or the entire arm immobilized preventing the patient from having access to his or her body.
<b>Standard Practices During a Procedure</b>	Used to maintain position, limit mobility, or temporarily immobilize the patient during a medical, dental, diagnostic, or surgical procedure.	Not used in association with a procedure.
<b>Adaptive Devices: Seat belts, waist belts, Geri chairs, etc.</b>	The patient can remove the device (or remove themselves from the device) in the same manner in which it was applied (e.g., unlatching a seat belt, untying a knot, letting the side rail down).	The patient cannot easily remove the device.
<b>Protective interventions for infants, toddlers and pre-school children</b>	Stroller safety belts, seat belts for high chairs, etc.	
<b>Holding the patient</b>	Therapeutic holding or light touching during escort or when a staff member(s) physically redirects or holds a child without the child's permission for 30 minutes or less, or for medical care, i.e., blood draw, sutures, etc.	A physical hold that restricts the patient's movements or is used to carry the patient against their will.
<b>Holding to give medications or treatments</b>	Voluntary	Forced
<b>Forensic Devices (hand cuffs, shackles)</b>	Used for patients in custody – applied by law enforcement.	May not be used as a device for restraint.

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**ATTACHMENT A (Continued)**

**Definition of Seclusion 42 CFR 482.13(e)(1)(ii)**

<b>Seclusion</b>	<b>Not Seclusion</b>
Confinement in a locked room apart from other patients	Assigned to a designated area on a locked unit or ward as a part of the therapeutic environment.
Physically preventing a patient from leaving an unlocked room	Having the patient agree to confine their movement to a room with an open door (time out) and the time out is consistent with the patient's treatment plan.
Preventing a patient from leaving an unlocked room through intimidation.	A "time out" in a secluded (unlocked) location.

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## ATTACHMENT B Restraint and Seclusion Training Plan

The restraint and seclusion training plan shall be based on the results of quality monitoring activities. Minimum training shall include:

1. The policy requirements and education for physicians who order restraint or seclusion.
2. The instruction and competency requirements of hospital staff who assess patients for restraint/seclusion, determine that restraint/seclusion is indicated, or who applies restraint/seclusion including:
  - a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
  - b. The use of nonphysical intervention skills.
  - c. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
  - d. The safe application and use of all types of restraint or seclusion used by the staff member, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).
  - e. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
  - f. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, and vital signs.
  - g. The use of cardiopulmonary resuscitation, including required periodic re-certification.
  - h. Recognition of signs of physical and psychological distress for hospital staff that monitor restrained patients.
3. Registered nurses who perform face-to-face assessments as required shall demonstrate competence in the management of violent or self-destructive behavior.

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References:     CMS  
                  The Joint Commission: TX 7.1

ESTABLISHED DATE: March 2, 1998

Approved by: Chief Nurse Executive, Altru Health System

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10/1/98

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