# Provider Restraint and Seclusion Policy Education

## **Non-Violent Restraints** (soft limb, mitts)

Definition

**Restraint:** Any manual method, physical or mechanical device, material or equipment involuntarily attached or adjacent to the patient's body that he/she cannot easily remove that its intended use restricts freedom of movement or normal access to one's body.

Provider Orders for Non-Violent Restraint Use: Non-Violent Standards

1. A written order by a Provider is required for use of restraints
2. Restraint orders are limited to 24 hours and will expire without a renewal order within a calendar day
3. Restraint orders, initial and renewal, must include the following:
    a. Type of restraint to be used
    b. Reason restraint is needed
4. A PRN order for restraints is not permissible

## **Chemical Restraints**

Definitions

**Chemical Restraint:** A chemical/medication 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. Chemical restraint intervention orders will only be initiated as STAT or NOW orders, they cannot be ordered PRN medication orders.

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

# **Violent/Self-Destructive Restraints** (locked)

Definition

**Restraint: Violent/Self-Destructive Behavior:** Use of restraint in emergency or crisis situations when unanticipated, severely aggressive or violent/destructive behavior presents an immediate, serious danger to his/her safety or that of others.

Examples of Violent/Self-Destructive Behavior:

- Uncontrollable punching, kicking, or biting of others or self
- Extreme physical acting out that may endanger self or others

Within 1 hour of initiation of restraint:

- Staff notifies and obtains an order from the Provider
- The face to face assessment shall be completed by the provider or trained RN, documented in the medical record, including but not limited to the following observations:
    - The patient's immediate situation
    - The patient's reaction to the intervention
    - The patient's medical and behavioral condition.

Re-Evaluation of the Need for Continued Restraint

- Restraint order is limited and must be renewed every four (4) hours for adults, two (2) hours for children and adolescents ages 9-17, and one (1) hour for children under age 9, up to a total of 24 hours.
- By the time the order for restraint expires, the patient is evaluated in person by the Provider.
- Upon expiration of an order, the restraint must be removed from the patient unless a new order is obtained.

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METHODIST
HEALTH SYSTEM

METHODIST HOSPITAL
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METHODIST JENNIE EDMUNDSON HOSPITAL
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**ADMINISTRATIVE POLICY & PROCEDURES**

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|---|---|
| **TITLE:** | Restraint and Seclusion |
| **ORIGINATION DATE:** | 1969 |
| **REVIEWED DATE:** | 5/17 |
| **REVISED DATE:** | 7/03, 4/05, 9/05, 11/05, 9/07, 12/07, 3/10, 1/13, 4/13, 7/13, 4/16, 12/16, 3/17, 1/18, 2/18, 4/18, 11/18, 12/19, 5/21, 10/21, 6/22 |
| **PURPOSE:** | To establish guidelines for the safe, effective use of restraints and/or seclusion in accordance with state, Centers for Medicare & Medicaid Services (CMS) and The Joint Commission (TJC) regulations. To reduce/limit the use of physical, chemical, and/or seclusion while maintaining safety and ensuring the patient's health, safety, dignity, rights, physical and psychological well-being are protected and preserved. The use of restraints will be based on the assessed needs of the patient utilizing a multidisciplinary team approach which includes patient/family. |

**DEFINITIONS:**

- *Alternative Interventions*: Measures which modify the environment enhance interpersonal interaction or provide treatment so as to minimize or eliminate the problems/behaviors which place the patient at risk.
- *Chemical restraint*: A chemical/medication 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.
- *Emergency situation*: Patient's violent or aggressive behavior presents immediate and serious danger to the safety of the patient, other patients, visitors, or staff.
- *Face-to-Face assessment*: Includes both a physical and a behavioral assessment of the patient. It must be performed by a LP or trained Registered Nurse (RN).
- *Least Restrictive Interventions*: Measures which permit the maximum amount of freedom of movement consistent with patient safety and protection from injury.
- *Licensed Practitioner (LP):* Any practitioner permitted by both law and the hospital to provide care, treatment and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges and credentialing. Methodist Health System recognizes Physicians, Physician Assistants, and Nurse Practitioners as Licensed Practitioners.
- *Locked Restraints*: A mechanical restraint that is used to secure ankles and/or wrists by utilizing restraints that require a key to unlock.
- *Medical Immobilization*: Mechanisms usually employed during medical, diagnostic or surgical procedures that are considered routine part of such procedures. Procedural immobilization does not require a LP order.
- *Restraint*: Any manual method, physical or mechanical device, material or equipment involuntarily attached or adjacent to the patient's body that he/she cannot easily remove that its intended use restricts freedom of movement or normal access to one's body.

- *Restraint Chair*: A physical restraint used to control combative, self-destructive or violent behaviors to reduce the risk of physical harm by restricting patient so he/she remains seated in one place.

- *Restraint: Violent/Self Destructive Behavior*: Use of restraint in emergency or crisis situations when unanticipated, severely aggressive or violent/destructive behavior presents an immediate, serious danger to his/her safety or that of others.
  - Examples of Violent/Self Destructive Behavior:
    - Uncontrollable punching, kicking, or biting of others or self
    - Extreme physical acting out that may endanger self or others

- *Seclusion*: is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion is limited to a highly selective population with oversight reflective of its high-risk potential. Seclusion may only be used for the management of violent or self-destructive behavior.

- *Side rails as restraints*: The determination as to whether or not side rails would be considered a restraint is based on "intent". Therefore:
  - If the intent of raising the side rails is to prevent a patient from voluntarily getting out of bed or attempting to exit the bed, the side rails would be considered a restraint.
  - If the intent of raising the rails is to prevent the patient from inadvertently falling out of bed, then it is not considered a restraint. Also, if a patient does not have the physical capacity to get out of bed regardless if side rails are raised or not, then the use of side rails is not considered a restraint.
  - Use of an enclosure bed or net bed that prevents the patient from freely exiting the bed is considered a restraint. An exception is the use of an enclosed crib for infants and/or toddlers.

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

- *Trained Registered Nurse*: RN who has completed training and competency on Face-to-Face Evaluation include:
  - NMH Critical Care Core Coordinators/Rapid Response Nurse (RRN) and Administrative Coordinators (AC)/House Supervisors
  - MWH ED nurses and Administrative Coordinators (AC)
  - MJEH Psychiatric Nurses and Administrative Coordinators (AC)
  - MFH: House Supervisor, Behavioral Health RN, 3rd Floor Lead

**PHILOSOPHY:**

- Methodist Health System's philosophy is to strive toward a practice culture that minimizes the use of restraints and/or seclusion, by limiting restraints and/or seclusion use to clinically appropriate and justified situations.
- Methodist Health System is committed to prevent, reduce, and eliminate the use of restraint/seclusion through early identification and intervention of high-risk behaviors or events.

- The rights, dignity, welfare, and safety of the patient are to be protected during the restraint process (initiation, implementation, and release).
- Every effort will be made to avoid the most restrictive treatment measures through the use of de-escalation techniques and alternative treatment measures aimed at controlling behavior without physical restraint and seclusion.
- All patients have the right to be free from restraint or seclusion imposed as a means of coercion, discipline, convenience, or retaliation by staff.

**POLICY:**

**Assessment:**

- The use of restraint/seclusion will not be based on a patient's history of restraint/seclusion or history of dangerous behavior.
- The risks and benefits will be discussed with the patient, or the patient's representative. The patient or patient's representative should be involved in the decision making process when appropriate. Patient family/significant others request for the use of restraint cannot be a determining factor in the decision to use a restraint.
- Before ordering restraint or seclusion consideration must be given to any potential medical/psychological contraindications example: physical/sexual abuse. (Seclusion only available at MJE and MFH BH unit)

**Non-Violent Restraints:**

- Restraints are used only when less restrictive protective interventions and/or devices have been tried and have failed.
- Restraints shall be used only when alternative methods are not sufficient to protect the patient from harm or unsafe mobility.
- Restraints may be used to protect life-saving tubes and lines from accidental dislodgment or removal by patient.

**Violent Restraints:**

- Use of restraint will be limited to emergency/crisis situations when unanticipated, severely aggressive or violent/self-destructive behavior presents immediate danger to the patient or others.
- Restraint and seclusion interventions are implemented only when alternative methods are not sufficient to protect the patient or others from imminent harm or injury.

**Discontinuation of Restraints:**

- Staff are educated to discontinue restraint/seclusion at the earliest time possible when the patient is able to demonstrate compliance by achieving the identified release criteria.

**RESTRAINT PROCEDURE FOR ALL TYPES OF RESTRAINTS AND SECLUSION:**

**Assessment Criteria:**

A. Assessment of the patient considers source of behavior and alternative measures to restraint use. Alternate measures are to be considered prior to application of restraint devices. Risks associated with any interventions must be considered in the context of a repetitive cycle of assessment, intervention, evaluation and re-evaluation.

B. A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint outweigh the risk of not using it. Least restrictive methods and interventions should always be attempted first.

C. The criteria for use of restraints are:
   1. Patient's behavior exhibits danger to self or others
   2. Alternative measures are ineffective

## ALTERNATIVES TO RESTRAINT/SECLUSION

A. Implement alternatives to physical restraints and document effectiveness of the attempts. Alternatives may include but are not limited to:
   1. Modify the environment (alter lighting, fall precautions, personal items close, etc.).
   2. Repositioning, mobility, or exercise.
   3. Address toileting and hydration needs.
   4. Active listening.
   5. Presence of family/visitors.
   6. Allow patient to verbalize feelings; calming techniques.

## NON-VIOLENT RESTRAINTS

**Non-Violent Restraint Orders:**

A. The treating LP's time-limited order, written for a specific episode must be obtained for use of any type of restraint.

B. Written and/or verbal orders must be documented in the EMR.

C. The use of PRN or standing restraint orders is prohibited.

D. The treating LP's time limited order cannot exceed a calendar day, and will specify the reason for the restraint use and the type of restraint.

E. If the treating LP is not available to issue an order, physical restraint use may be initiated by a RN based on appropriate assessment of the patient. In this situation:
   1. If restraint was necessary due to a significant change in the patient's condition, the LP will be contacted immediately for an order.
   2. When a significant change in behavior is not the reason for initiation of a restraint, the LP must be notified and order obtained within 12 hours of initiation of restraints.
      i. If a restraint order expires or restraints are discontinued and it is deemed they need to be reapplied, a new written order must be obtained from the LP. Staff cannot discontinue a restraint intervention, and then re-start it under the same order. This would constitute a PRN order. A "trial release" constitutes a PRN use of restraint, and, therefore, is not permitted by this regulation. A temporary, directly,-supervised release, however, that occurs for the purpose of caring for a patient's needs (e.g. toileting, feeding, or range of motion exercises) is not considered a discontinuation of the restraint intervention.
      ii. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint.

F. Upon expiration of an order, the restraint must be removed from the patient unless a new order is obtained.

**Non-Violent Restraint Monitoring and Documentation Guidelines:**

A. The RN is responsible for assessing and monitoring the patient in restraints. Monitoring is accomplished by observation, interaction with the patient, or related direct examination of the patient by nursing staff practicing within their scope of practice or licensure.
   1. The RN may delegate components of monitoring to other staff members within the scope of their practice or licensure.
   2. The RN will be notified immediately upon any change in patient status.
   3. The RN is responsible for supervising all delegated monitoring components.
   4. The RN will insure safe application of the restraint; e.g. if soft limb restraints, ensure that two fingers (e.g. index & middle), can be fit between the patient's limb and the restraint to insure that they are not too tight.

B. All episodes of restraints have the following documented by the RN.
   1. Date and time of initiation (one time documentation)
   2. Restraint type and location
   3. Alternative interventions
   4. Reason for restraint
   5. Criteria for restraint release
   6. Discontinuation of restraints (one time documentation)

C. Monitor and Document the following q2H. Staff members within the scope of their practice or licensure may assist with the data collection and documentation of these components:
   1. Restraint status/evaluation of continued need
   2. Restraint site assessment (Circulation/Skin Integrity)
   3. Behavioral status
   4. Orientation/Level of Consciousness (LOC)/RASS
   5. Pulse, respirations and blood pressure
   6. Hydration/Nutrition
   7. Activity/Positioning
   8. Toileting
   9. Positioning/ROM to restrained limbs
   10. Respiratory Status

D. Patient and/or family education regarding restraint use should occur upon initiation of restraints.

E. The patient's plan of care must include the use of restraints.

F. Any patient in restraints being transported off the nursing unit must have a RN, LPN or LP accompany the patient.

**VIOLENT/SELF-DESTRUCTIVE BEHAVIOR RESTRAINTS**

**Violent/Self-Destructive Restraint Orders:**

A. The treating LP's time-limited order, written for a specific episode must be obtained for use of restraints for violent/self-destructive behavior.

B. Written and verbal orders must be documented in the EMR.

C. The use of PRN or standing restraint orders is prohibited.

D. The initial and renewal order for patients restrained because of violent or self-destructive behavior will be for a maximum of four hours for adults, two hours for children/adolescents (age 9-17) and one hour for children under age nine and will specify the reason for the restraint use and the type of restraint.

E. The LP or Trained RN will perform a face-to-face assessment on the patient's physical and psychological status within one hour of the initiation of the restraint. The face-to-face assessment is performed even in those situations where the person is released early (prior to one hour). The assessment shall include and be documented in the medical record:
   1. The patient's immediate situation
   2. The patient's reaction to the intervention
   3. The patient's medical and behavioral condition

F. If the patient's attending LP is not the LP who gives the order, the patient's LP will be notified of the patient's status as soon as possible if the restraint is continued.

G. Renewal orders for violent/self-destructive behavior must occur every 4 hours for patients age 18 and older, every 2 hours for patients age 9-17, and every 1 hour for children under 9 years of age for up to a total of 24 hours.

H. A renewal order may be obtained by an RN, following a reassessment.

I. Renewals may be obtained via phone or verbal order.

J. At a minimum, if a patient remains in restraints for the management of violent or self- destructive behavior 24 hours after the original order, the LP must see the patient and conduct a face-to face re-evaluation before writing a new order for the continued use of restraint.

K. If restraint/seclusion is terminated prior to the expiration of the original order, and an unsafe condition reoccurs, and alternatives are ineffective, the LP must be notified and a new order obtained.

**Violent/Self-Destructive Restraint Monitoring and Documentation Guidelines:**

A. The RN is responsible for assessing and monitoring the patient in restraints. Monitoring is accomplished by observation, interaction with the patient, or related direct examination of the patient by nursing staff practicing within their scope of practice or licensure.
   1. The RN may delegate components of monitoring to other staff members within the scope of their practice or licensure.
   2. The RN will be notified immediately upon any change in patient status.
   3. The RN is responsible for supervising all delegated monitoring components.
   4. The RN will ensure safe application of the restraint; e.g. if limb restraints used, ensure that two fingers (e.g. index & middle) can be fit between the patient's limb and the restraint to ensure they are not too tight.

B. All episodes of restraints have the following documented by the RN.
   1. Date and time of initiation (one time documentation)
   2. Restraint type and location
   3. Alternative interventions
   4. Reason for restraint

5. Criteria for restraint release
6. Discontinuation of restraints (one time documentation)

C. Monitor and Document the following q15 minutes. Staff members within the scope of their practice or licensure may assist with the data collection and documentation of these components:
   1. Restraint status/evaluation of continued need
   2. Restraint site assessment (Circulation/Skin Integrity)
   3. Behavioral status
   4. Respiratory Status

D. Monitor and Document the following q2 hours unless clinically indicated otherwise. Staff members within the scope of their practice or licensure may assist with data collection and documentation of these components:
   1. Hydration/Nutrition
   2. Toileting
   3. Positioning/ROM to restrained limbs
   4. Pulse, respirations and blood pressure

E. Patient and/or family education regarding restraint use should occur with each episode of locked restraints.

F. Any patient in restraints being transported off the nursing unit must have a RN, LPN or LP accompany the patient.

G. Simultaneous use of restraint and seclusion is monitored through continuous in-person (face-to-face) observation by staff members within the scope of their practice or licensure, for the duration of the restraint episode.

H. The patient's plan of care must include the use of restraints.

**Locked Restraints:**

A. Security personnel should be notified of any patient who would require locked restraints, physical holding techniques, and/or takedown techniques.
   1. At MH/MWH, locked restraints are brought to the patient by security personnel.
   2. At MFH, locked restraints are kept on the unit.
   3. At MJE, locked restraints are kept on the ED, ICU, and Behavioral Health units.

B. When applying locked restraints, remove any clothing, i.e. sleeves or pant legs away from the area restraints are placed.

C. Thread straps through the cuffs and lock straps to bed frame out of the patient's reach. Allow the patient some movement. Assure that raising side rail or lowering the bed will not tighten the strap.

D. Ensure that two fingers (e.g. index & middle) can be fit between the patient's limb and the restraint to insure they are not too tight.

E. Nursing staff/competent staff members will keep the key to the locked restraints on their physical person at all times while maintaining visual observation of the patient until locked restraints are removed.

F. Locked restraints must be returned to security personnel upon removal from patient at MH/MWH.

G. Specific to seclusion: MJE/MFH staff will maintain key on person at all times while maintaining constant visual observation of the patient until locked seclusion door is opened.

**Restraint Chair** (MFH only):
A. Requires a LP order. Order must specify reason for restraint.
B. Chair must be placed in locked position in seclusion room.
C. Lap belt must be applied and secured first.
D. Adequate circulation checks to all sites secured must occur.

## CHEMICAL RESTRAINTS:

A. Medications that are used to restrict a patient's freedom of movement are being used as a restraint. If the medications used are a standard part of treatment for the patient's medical condition or psychiatric condition, they are not considered a chemical restraint.

B. Chemical restraint intervention orders will only be initiated as STAT or NOW orders, they cannot be ordered PRN medication orders.
   1. These medications or doses of a medications would not be a standard treatment for the patient's condition.

C. Monitoring
   1. Describe the specific behaviors necessitating the chemical restraint
   2. Monitor vital signs (HR, BP, RR, $SpO_2$), sedation, behavior each time a chemical restraint is administered, and follow up assessments of each as indicated per medication protocols timeframes.

## SPECIAL CONSIDERATION AREAS

A. **Pediatric Considerations**:
   1. The reason for applying a restraint must always be explained to both the parent and the child. A doll or stuffed animal may be used for demonstration.
   2. During application of the restraint, stimulation and diversion should be provided to relieve the sense of helplessness and loneliness.

B. **Law Enforcement Considerations:**
   1. The use of handcuffs and other restrictive devices applied by law enforcement officials used for custody, detention, and public safety reasons is not governed by the restraint policy and procedures.
   2. Notify security personnel when law enforcement officials are involved.
   3. A law enforcement official must remain with the patient at all times while the patient is handcuffed or detained by other restrictive devices applied by law enforcement officials. The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law.

## RESTRAINT TERMINATION

Restraint may only be used while the unsafe situation continues. RNs that have the education and the competency to recognize when the patient is no longer a threat may terminate restraint use earlier than the order indicates based on individualized patient assessment/condition. Termination of the restraint should be based on

the determination, before the order expires, that the patient's behavior is no longer a threat to self, staff members, or others.

If a patient was recently released from restraint or seclusion, and exhibits behavior that can only be handled through the reapplication of restraint or seclusion, a new order is required. Staff cannot discontinue a restraint or seclusion intervention, and then re-start it under the same order. This would constitute a PRN order. When a staff member ends an ordered restraint or seclusion intervention, the staff member has no authority to reinstitute the intervention without a new order. For example, a patient is released from restraint or seclusion based on the staff's assessment of the patient's condition. If this patient later exhibits behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, that can only be handled through the use of restraint or seclusion, a new order is required.

## DEATH REPORTING REQUIREMENTS

A. Soft Two-point Restraints: Methodist Health System will maintain a log for the Centers for Medicare and Medicaid of any patient death that occurs when a patient has soft two-point restraints on. Each entry in the log will be made within seven days after the date of the death of the patient. The log will contain name, date of birth, date of death, attending physician, primary diagnosis(es), and medical record number.

B. Other Restraints: For deaths involving all other types of restraints and all forms of seclusion, Methodist Health System will report to the Centers for Medicare and Medicaid by telephone/facsimile/electronically no later than the close of business on the next business day following the knowledge of the patient's death.

## STAFF TRAINING AND COMPETENCY

A. The hospital trains staff who apply restraints within their scope of practice on the use of restraints and/or seclusion, and assesses their competence at the following intervals:
   1. At orientation
   2. Before participating in the use of restraint and/or seclusion
   3. On a periodic basis thereafter

## REFERENCES:


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## Expert Reviewers:

- MHS Restraint Workgroup

## DISCLAIMER:

This policy provides guidance and information for the healthcare professional, but cannot cover all circumstances that might occur during a patient's care and treatment. This policy is intended to serve as guidance and, since it may not be universally applied to all patients in all situations, healthcare professionals should use the content along with independent judgment and on a case by case basis. Nothing contained herein establishes or shall be used to establish the legal definition of the standard of care.