

DEACONESS HEALTH SYSTEM, INC.
Evansville, Indiana

Policy and Procedure No. 40-19 S

Revised Date: September 12, 2013
Reviewed Date: September 12, 2013

RESTRAINT or SECLUSION

- I. **PURPOSE:** To provide instruction to Deaconess employees on the implementation and monitoring of behavioral or medical restraint.
- II. **SCOPE:** This policy is applicable to Deaconess Hospital, Inc. and all joint ventures in which Deaconess has 50% or more ownership with the exception of The Women's Hospital.
- III. **POLICY:** Deaconess Hospital provides an environment that promotes the rights of all patients to compassionate and dignified, age appropriate care. It strives to reduce and eliminate the use of restraints. The standard of care at Deaconess Hospital is avoidance of restraints, except under exceptional circumstances, and after less restrictive alternatives have been found to be ineffective in protecting self and others from harm. Because restraint may be necessary for certain patients, health care organizations and providers need to be able to use restraint when the restraint will improve the patient's well being or there is an imminent risk of a patient physically harming him/herself, staff, or others. The leadership of Deaconess Hospital believes in creating an environment that minimizes circumstances that give rise to restraint use and that maximizes safety when they are used. The leadership is allocating sufficient resources, providing initial and ongoing education and integrating restraint use into the performance improvement activities.
 - A. The standards for restraint are not specific to the treatment setting but to the situation the restraint is used to address. The decision is driven not by diagnosis, but by comprehensive patient assessment.
 - B. *Medical Surgical Restraint standards – surgical care are applicable when it is necessary to limit mobility or immobilize a patient who is temporarily or permanently mentally incapacitated, and receiving medical, or post-surgical. .
 - C. *Behavioral Restraint standards for management of violent or self destructive behavior are applicable when a patient behaves in a severely aggressive, assaultive, violent, or destructive manner that places the patient or others in imminent danger.
 - D. Seclusion is a method of treatment that is implemented only on the inpatient acute behavioral units. Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion only be used for the management of violent or self-destructive behavior.
- IV. **DIGNITY/RIGHTS OF PATIENTS:** The Administration, Medical Staff, and Patient Care Services Staff of Deaconess Hospital believe that patients have the right to be free from physical and chemical restraints. Restraints are indicated when less restrictive methods have been tried or would not be effective in preventing the patient from possible harm to self or others. The organization does not permit use of restraint for any other purpose, such as coercion, discipline, convenience, or retaliation by staff. The dignity of the patient is always maintained and restraints are not to be used in a manner that causes undue physical discomfort, harm, or pain to the patient. The use of restraint is not based on a patient's restraint history or solely on a history of dangerous behavior.
- V. **DEFINITIONS:**

- A. **Restraint:** 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.
- B. **Seclusion:** the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.
- C. A physical restraint as defined above differs from the use of the following devices that may limit a patient's movements:
1. **Medical Immobilization:** Medical immobilization is not considered a restraint. Medical immobilization is the usual and customary use of devices and/or mechanisms during medical, diagnostic or surgical procedures that are considered a regular part of such procedures. Examples of medical immobilization devices include; cast on a broken limb, arm board use during intravenous therapy, papoose board for pediatric patients, surgical positioning and positioning during radiotherapy procedures and protection of surgical and treatment sites in pediatric patients.
 2. **Multipurpose Medical Protection Devices:** The customary use of devices to provide routine safety or compensate for a specific deficit (i.e., safety straps on carts). Devices which serve multiple purposes such as side rails, when they have the effect of restricting a patient's movement and cannot be easily removed by the patient constitute a restraint.
 3. **Adaptive Support:** The use of supportive devices intended to permit a patient assistance in obtaining and maintaining normative bodily functioning and/or provide postural support. Examples include: postural supports and orthopedic appliances.
 4. ***Therapeutic Holding or Comforting of Patient:** The temporary restricting of specific movements to permit treatment and/or to calm the patient. Examples of therapeutic holding include, but are not limited to, holding of a child to initiate an IV or give a medication. However, the use of therapeutic holds to manage a violent or self-destructive behavior is a form of restraint.
 5. **Law Enforcement Restraints:** Patients who are in the custody of law enforcement may be restrained, i.e., shackles and handcuffs. This policy for patient restraints only applies when restraints are applied for clinical reasons.
- D. **Chemical Restraint:** A drug or 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.
- E. **Emergency:** Is an instance in which there is an imminent risk of a patient harming him/herself or others, including staff or others, when non-physical interventions have been unsuccessful or are not viable and safety issues require an immediate physical response.
- F. **Violent or Self Destructive Behavior:** The patient who exhibits a, severely aggressive, violent, destructive or assaultive behavior which places the patient or others in imminent danger.
- G. **Bed Rails:** Full bed rails should only be used after individualized patient assessment and evaluation by a RN. Bed rails are considered restraint devices when used to meet the patient's assessed needs and restrict a patient's movement from exiting the bed. Use

of raised side rails on stretchers in Emergency Department and when transporting patients are not considered a restraint and as such would not require a physician order.

- H. **Licensed Independent Practitioner (LIP):** Physicians and Nurse Practitioners that are credentialed through the Medical Staff Office that can give orders independently.

VI. PATIENT RESTRAINT AND VULNERABLE POPULATIONS: The effects and consequences of restraint use and immobilization can include: aspiration pneumonia, elimination problems, disruption skin integrity, strangulation, and/or feeling humiliated and demoralized.

- A. All patients when restrained should be considered vulnerable. Certain patient populations where this may be more evident include, but are not limited to:
1. Cognitively impaired patients, those with mental status changes
 2. Physically impaired, the frail, the elderly, prone positioned patient
 3. Sensory impaired patients
 4. Developmentally disabled patients
 5. Pediatric patients
 6. Any history of sexual or physical abuse that would place the patient at greater psychological risk.
- B. Restraint use for the vulnerable populations requires special assessment and monitoring of the patients age appropriate needs and physical and mental condition to avoid the use of restraints and minimize the degree of restriction and duration of use.
- C. Physical restraints are not to be applied to the following: paralyzed, fractured or circulatory impaired extremities; over a graft; hemodialysis fistula sites; intravenous access sites; or during seizures.
- D. Physical restraints are to be secured to an immovable part of a bed or chair frame, only closest to the desired anatomical position and using quick release tie(s) The patient's call bell or alternative call method and frequently used items are to be placed close to the patient.

VII. EDUCATION AND COMPETENCY OF STAFF:

- A. ***Appropriate hospital and medical staff members will receive training in the following subjects as it relates to duties performed under this policy. Individuals trained will exhibit their knowledge of the subject matter through the consistent implementation of the matters taught. The training programs may also include return demonstrations or post-training tests at the discretion of the trainer.**
- B. ***Physicians who order restraints or seclusion will be trained in the requirements of this policy and will demonstrate a working knowledge of this policy through ongoing compliance.** Physicians and mid-levels do not participate in applying restraints, therefore no additional training is necessary. Documentation is included in each packet on which all credentialed providers sign an agreement to abide by the hospital and Medical Staff Bylaws and by the Rules and Regulations of the Medical Staff. The Medical Staff Bylaws require credentialed providers to "abide by all of the policies and procedures of the Hospitals and Deaconess Health System as they exist and as they shall be amended." and the Medical Staff Rules and Regulations Section 5., Orders for Restraint or Seclusion refers to Hospital Policy and Procedure No. 40-19. A copy of this Policy and Procedure No. 40-19 is included as an addendum to the Medical Staff Rules and Regs which are posted on the web site and to which all new and reappointed applicants are directed in a memo included in their credentialing packets.

- C. Hospital staff members who assess patients for restraint or who apply restraint will receive training in the following: (It is acceptable to have separate training for staff who deal with Behavioral Health and Medical restraint.)
1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint.
 2. The use of nonphysical intervention skills.
 3. Choosing the least restrictive intervention based on an individualized assessment or the patient's medical or behavioral status or condition.
 4. The safe application and use of all types of restraint used by the staff member, including training in how to recognize and respond to signs of physical psychological distress (for example, positional asphyxia).
 5. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary.
 6. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, and vital signs
 7. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

VIII. PERFORMANCE IMPROVEMENT PLAN:

- * A. The Deaconess Hospital Restraint Committee consists of the ICU Core Care, Medicine Core Care, Behavioral Core Care teams and the Nursing Shared Governance Quality and Safety Council)and directs the interdisciplinary performance improvement process for restraints. Hospital wide restraint data is aggregated quarterly and analyzed. The data collection will include these items to document trends and patterns in restraint use:
1. Shift
 2. Date and time of the order
 3. Staff who initiated the process
 4. The length of each episode
 5. Date and time each episode was initiated
 6. Day of the week each episode was initiated
 7. Type of restraint used
 8. Whether injuries were sustained by the individual or staff
 9. Age of individual
 10. Gender of individual
 11. CMS reports #1,2, and 3 listed below under IX. A and B.
- * B. The analysis identifies monthly incidence, characteristics of use, alternatives and compliance. The data is used to measure the effectiveness of the PI project, identify patterns of use and areas for improvement. A major focus of the performance improvement process is the identification of opportunities to reduce restraint use through the use of alternatives and process improvement. Unit specific or department reduction initiatives are implemented and evaluated in conjunction with the interdisciplinary leadership.

***IX. DEATH REPORTING REQUIREMENTS:**

*Change

- A. ADONS will do the following:** Upon receiving a report of a patient death, complete the Hospital-approved "Patient Death Report" and send to the "Deaths" Distribution List, the appropriate Nursing Manager and the appropriate Nursing Director, as applicable. (Exhibit B)
- B. The Accreditation and Regulatory Officer will do one of the following:**
1. **A death that occurred (1) while a patient was in ONLY a two-point soft wrist restraint and without seclusion, or (2) within 24 hours of being removed from such restraints:**
 - a) Record the information of the death in the hospital's internal electronic log to be made available to CMS immediately upon request.
 - b) Each entry must be made no later than *seven days* after the date of death of the patient.
 - c) The record must include the patient's name, date of birth, attending physician, primary diagnosis(es), and medical record number.
 - d) Print the log entry on Hospital letterhead, sign, date, and send via in-house mail to Medical Records to be scanned into the patient's EMR.
 2. **A death involving ALL other types of restraints and ALL forms of seclusion,** including those deaths known to the hospital that occur within 1 week after restraint or seclusion where it is reasonable to assume (*) that use of the restraint or seclusion contributed directly or indirectly to a patient's death.
 - a) Report using the "Hospital Restraint/Seclusion Death Report Worksheet".
 - b) Fax the worksheet or call and report the information to the CMS Regional Office ***NO LATER THAN THE CLOSE OF BUSINESS ON THE NEXT BUSINESS DAY FOLLOWING KNOWLEDGE OF THE PATIENT'S DEATH.***
 - c) Make a copy of the completed "Hospital Restraint/Seclusion Death Report Worksheet", along with a copy of the Fax Result Report confirming receipt by CMS, to be delivered via in-house mail to Medical Records to be scanned into the patient's EMR.
 - d) Save the original Worksheet according to month and year. in
 - e) Include information from the Worksheet in the hospital's internal electronic log.
- C. FOLLOWING DAILY REVIEW AND REPORTING,** The Accreditation and Regulatory Officer will conduct Monthly and Quarterly Quality Review of restraint reporting and recording and submit to the appropriate Nursing Directors and the Restraint Committee.

MEDICAL SURGICAL RESTRAINTS

X. USE OF RESTRAINT IN MEDICAL NON-VIOLENT SITUATION

- A. JUSTIFICATION:** The justification for restraint use in the medical acute care settings will be as a temporary measure to allow for procedures and treatments to proceed without interruption/interference or prevent patient self harm when preventive strategies and alternatives have been unsuccessful or determined to be inappropriate.
1. In all situations of restraint use, the benefit of safety for the patient or others outweighs the risks associated with their use. The patient's age, physical and mental condition, reason for hospitalization and vulnerability of the patient will be considered when selecting the type of restraint and the least restrictive restraint shall be used.

2. Restraint use is based upon a needs assessment conducted by a physician or RN and always requires a physician order.
3. *The patient's need for the restraint is reevaluated continuously, so that it is discontinued if not clinically justified.
4. *On transport and handoff, the receiving area and primary RN/team shall be notified that the patient is restrained and the clinical justification shall be communicated. The restraint flowsheet shall be included in the patient's medical record to ensure continuous monitoring. If restraints need to be removed, they are re-applied by qualified staff according to the policy.

B. INITIAL RESTRAINT ASSESSMENT:

Provide patient all basic care needs

1. Medication review
2. Pain control

C. ALTERNATIVE INTERVENTIONS: Less restrictive interventions will be attempted prior to the initiation of restraints. Strategies and alternatives to prevent restraint use may include, but are not limited to, the alternative interventions listed below:

1. Family/Significant Other at bedside
2. Increase observation and/or movement of the patient closer to the nurse's station.
3. Use of bed exit alarm
4. Illumination of environment
5. Modification of environment (supportive devices, rehabilitation equipment, reduction of noise). Move personal aids within reach.
6. Physiologic assessment including hydration, and elimination need
7. Check placement of invasive devices, tubes
8. Exercise/up in chair/reposition/massage
9. Re-orient to activity and environment
10. Verbal intervention
11. Patient Sitter when one-on-one observation necessary (See Patient Sitter Policy 40-60)
12. Diversional activities (folding cloths, cards, TV, radio)
- * 13. Alternative devices: Happy Hands, Skin Sleeves, Posey Chair Alarms
14. Type of alternative intervention will be documented on the Restraint Flow Sheet in the Electronic Medical Record.

D. LICENSED INDEPENDENT PRACTITIONER (LIP) INVOLVEMENT:

1. The LIP is responsible for overseeing the use of restraints.
2. The LIP provides the written or verbal orders and renewals.
3. The LIP will complete a face-to-face assessment within 24 hours of the original order and each reorder/renewal.
4. The LIP will participate in daily reviews as related to his/her patients.
5. The LIP will participate in performance improvement activities.

E. EMERGENCY SITUATIONS:

1. In a situation where preventative strategies and non-physical alternatives have failed and the patient is in imminent danger to self or others and wherein the immediate application of restraints is necessary, a RN, competent in applying restraints, in the absence of a physician may initiate the use of restraints after he/she has conducted an assessment of the patient.
2. *When medical surgical restraints are used, the physician will be notified within one (1) hour of the initiation of the restraint and an order obtained. The physician will complete a face-to-face assessment of the patient within 24 hours.
3. If the initiation of restraint is based on a significant change in the patient's condition the RN immediately notifies the physician.

F. PHYSICIAN ORDERS:

1. **PRN restraint orders are not accepted.** If a physician writes an order for prn restraints the physician will be contacted for an order that will be time limited as stated in this policy.
2. A time limited physician's order must be received prior to the initiation of restraint use by the RN or within one (1) hour after in an emergency situation.
3. A face-to-face assessment by the physician will be completed as soon as possible but no later than 24 hours after the restraint was initiated.
4. The time limited order for medical surgical restraints will be for a maximum of 24 hours. Orders will be placed in the electronic medical record.
5. Telephone and verbal orders must be authenticated by the physician within 24 hours.
6. Continued daily use of restraints requires a reassessment of patient condition by the physician and nursing staff. The physician must reassess patient in a face-to-face assessment at least once every 24 hours. If reassessment indicates the need and justification of continued use of restraints, a new order must be written.
7. Upon the expiration of an order, the patient must be removed from restraints unless a new order is obtained from physician.
8. All restraint orders and renewal orders shall include the following.

- a. Date and time of the order
- b. Type of restraint
- c. Reason for the restraint
- d. Appropriate time limit
- e. Telephone orders may be taken by the nurse and will be dated, timed, read back and verified.

G. EARLY RELEASE/TRIAL RELEASE: If the patient's condition that necessitated restraint subsides, the patient may be released before the end of the period specified in the order and order must be discontinued. If the patient's behavior escalates again, if alternatives remain ineffective, a new order must be obtained.

* **H. PATIENT/FAMILY EDUCATION:** Prior to application of restraints, family members/significant others will be asked to participate in interventions that are intended to reduce the need for restraints, when appropriate. When restraints are used, the patient and family will receive an explanation regarding the need for restraint and the potential outcome should restraint not be implemented. The patient and family will be assured that the least restrictive device will be utilized and that monitoring of the patient will ensure that restraint use will be discontinued as soon as possible. The patient and family are also assured that the patient's basic needs for nourishment, personal care, elimination, and exercise will be met during the use of restraints. Documentation of this education will be completed accordingly in electronic medical record.

I. RESTRAINT APPLICATION: The RN must be present at the initial restraint application. Thereafter, trained personnel may re-apply restraints.

Restraint Application:

1. Least restrictive restraint appropriate for the patient and the intent for its use should be selected.
2. Restraint should be correct size and modified or padded as needed for patient comfort.
3. Protective devices/restraints available are:
 - a. Full side rails
 - b. Hand Mitt
 - c. Freedom Splint
 - d. Torso Support
 - e. Soft wrist/ankle
 - f. Belt
 - g. Full Body (restraint of all 4 extremities)
- * 4. Applied Restraints should:
 - a. Not interfere with flow of IV infusion or arterial line.
 - b. Never be proximal to an AV fistula or shunt.
 - c. Allow as much freedom of movement as possible while achieving desired effect.
 - d. Be comfortable and not interfere with breathing.
 - e. Be secured in a quick release knot for easy removal in emergency situations.
 - f. Be secured around portion of bed frame that moves with the patient (not the side rail).

- g. Be applied according to manufacturer's recommendations.

J. ASSESSMENT, REASSESSMENT AND CARE DURING RESTRAINT USE:

1. The patient's physical and emotional needs are considered while the patient is in restraints. The basic rights of dignity and respect are maintained. Physical and mental well being is preserved through direct observation, adequate exercise, nourishment, personal care, elimination, therapeutic interventions and vital sign monitoring. Privacy and modesty will also be protected.
2. Every hour observation and monitoring will include the following:
 - a. Patient's circulatory and respiratory status is not compromised.
 - b. The restrained extremity/area will be observed for redness, skin breakdown, sensation, and discomfort.
 - c. Patients in restraints will be observed and monitored to assure that the restraint is not too tight or restricting.
 - d. Patient needs for warmth, privacy, personal needs and comfort will be assessed.
 - e. Responses to restraint effectiveness; documentation of effectiveness on behavior will be completed.
 - f. Patients for whom sign language is their primary means of communication should be allowed to have one hand free every hour or more often for the purpose of communication.
 - g. During the entire restrained period the patient is observed face-to-face at least every hour.
 - h. Monitoring will determine if changes in the patient's behavior or clinical condition will initiate the removal of the restraint or lessening the level of restraint.
 - i. Assess patient behavior for a need to continue the restraint.
3. Every two hours:
 - a. Release restraint and assess for toilet needs, fluids, nutrition and repositioning.
 - b. Restraints are released at least every two hours and range of motion exercises are carried out at this time.
4. *Daily, the Physician and the RN will discuss the continued need for restraint and document accordingly in electronic medical record.

K. SUMMARY OF REQUIRED DOCUMENTATION:

1. Documentation for restraint in the medical acute care setting will be completed in electronic medical record. A new flow sheet will be initiated in EMR in accordance with documentation policies. All spaces on the flow sheet will be completed.
2. Documentation in the medical record will include the following:
 - a. Clinical justification
 - b. Assessments
 - c. Alternative interventions attempted
 - d. Patient and, if possible, family education
 - e. Type of restraint used
 - f. Orders or protocol in use
 - g. Observations, checks and care needs

- h. Early release/trial release
 - i. Reassessments
 - j. Discontinuation
3. Documented Plan of Care

The use of restraints should be evident on the patient's Interdisciplinary Plan of Care Form. The Plan of Care must include expected outcomes, assessment parameters, and interventions. The Plan of Care is reviewed daily. When restraints are discontinued, this is to be reflected on the Plan of Care.

BEHAVIORAL RESTRAINTS

XI. RESTRAINT OR SECLUSION FOR THE MANAGEMENT OF VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR

A. JUSTIFICATION

Non-physical techniques are the preferred interventions in the management of behavior. Therefore, restraint use will be limited to emergencies in which there is an imminent risk of a patient physically harming him/herself, staff, or others and when non-physical interventions have not been effective or are not an available option.

B. INITIAL RESTRAINT ASSESSMENT:

- 1. Provide patient all basic care needs
- 2. Medication review
- 3. Pain control

C. ALTERNATIVES

Nursing staff should consider the following alternatives for any patient at risk for loss of control:

- 1. Approach the patient in a non-threatening, non-confrontational manner respecting issues of particular sensitivity and need for personal space. Set clear expectations of appropriate behavior and set limits as indicated. Let the patient know that aggressive behavior is not necessary or tolerable and that safety of patient and others is the first and emergent priority even if this requires restraint or medication over objection including forced medication or restraint.
- 2. Encourage the use of non-physical interventions such as redirecting the patient's focus or use of verbal de-escalation.
- 3. Encourage utilization of relaxation techniques, appropriate physical activity or other methods identified by patient, which help patient to gain control.
- 4. Review medications and possibly offer medications.
- 5. Increase staffing for more frequent observations and provide 1:1.
- 6. Provide diversions such as T.V., activities, cards, snacks and exercise.

7. All efforts shall be made to make the patient as comfortable and calm as possible.
8. On a behavioral health unit, additional options may include:
 - a. Separate the patient from the group or community.
 - b. Engage in 1:1 conversation or activity to allow the patient the opportunity to safely express feelings
 - c. Accompany the patient to his/her room with staff present
 - d. Offer the patient the opportunity to use the self quieting room to decrease stimuli and regain control.

D. EMERGENCY SITUATIONS

1. The RN will be called when a patient's behavior is escalating. The RN must approve any physical hold of a patient **UNLESS** in an emergency when the patient is an imminent risk of physically harming self and/or others. The RN will respond as soon as possible.
2. As soon as possible, but no longer than one hour after the initiation of the restraint, the RN will:
 - a. Notify the physician and obtain an order.
 - b. Consult with the physician about the patient's physical and psychological condition.

E. PHYSICIAN INVOLVEMENT

The role of the physician will be to:

1. Review with the staff the physical and psychological status of the patient.
2. Determine whether restraint should be continued.
3. Supply the staff with guidance in identifying ways to help the patient regain control in order for the restraint to be discontinued.
4. Provide a time limited order.

F. PHYSICIAN ORDERS

1. Orders for initial use or continuing use of restraint are time limited as follows:
 - a. 4 hours for ages 18 and over
 - b. 2 hours for children and adolescents ages 9-17 years, or more frequently as designated by physician.
 - c. 1 hour for children under age 9
 - d. A physical hold may be no longer than 30 minutes.

If restraint needs to be continued **beyond the expiration** of the time limited order, a new order for the restraint is obtained from the physician who is primarily responsible for the patient's ongoing care, or his/her designee or other physician.

The use of PRN orders or the use of protocols **is prohibited**.

2. Physician orders will be obtained within one hour and will include the following:
 - a. Date and time
 - b. Type of restraint or seclusion
 - c. Rationale for the restraint or seclusion
 - d. Time limit for restraint or seclusion

3. Telephone orders must be authenticated by the physician within 24 hours. Telephone orders may be taken by the nurse and will be dated, timed, read back and verified.
4. If the patient's physician is **not** the physician who gives the order, the patient's physician will be notified of the patient's status as soon as possible.
5. If a patient has been in a seclusion or restraint for 24 hours, the physician or LIP will complete a face-to-face evaluation. The assessment is required before issuing a new seclusion or restraint order.

G. ASSESSMENT, REASSESSMENT AND CARE

1. A staff member who is trained and competent will complete this assessment and assisting of care every 15 minutes. A 1:1 constant in-person observation and monitoring will be provided for the duration of the restraint episode.
2. All assessment and monitoring and observations will be documented every 15 minutes on the Behavioral Restraint Flowsheet.
3. **Monitoring and Assessing Patient During Use of Restraint**
The patient in restraints is to be assessed and assisted every 15 minutes. The purposes of these assessments are the following:
 - a. To assess if the appropriate type of restraint is employed.
 - b. To assess signs of any injury associated with the application of restraint.
 - c. To assess physical and psychological status and comfort.
 - d. To provide assistance to the patient in meeting the behavior criteria for the discontinuation of restraint.
 - e. To ensure the patient's physical and emotional safety.
4. In addition, the patient in restraints is assessed every two hours for the following:
 - a. Nutrition and hydration
 - b. Circulation and provide range of motion
 - c. Hygiene and elimination
5. **Face To Face Assessment:**
A physician, physician's assistant, nurse practitioner, Advance Practice Nurse with privileges to do so (LIP) or trained RN must evaluate the patient on a face-to-face basis within one (1) hour of the time the patient was placed in seclusion or restraints. Report all findings to physician within an hour of face to face.
 - a. The patient's immediate situation;
 - b. The patient's reaction to the intervention;
 - c. The patient's medical and behavioral condition; and
 - d. The need to continue or terminate the restraint or seclusion.
 - e. Document all findings and physicians notification in pt. chart.
6. **PROCEDURE FOR CONTINUING**
 - a. If a decision has been reached to continue seclusion or restraints, the Charge Nurse or RN will conduct an assessment and notify the physician for new orders. The order may be continued every four (4) hours for adults and every two (2) hours for youth ages 9-17 and one (1) hour for youth ages under 9 and under by a physician.
 - 1) If seclusion or restraint is to continue beyond the expiration of the time-limited order, a new order for restraint is obtained from the physician.

- 2) An face-to face reevaluation is required by a trained RN or a Licensed Independent Practitioner (LIP) every four (4) hours for adults and every two (2) hours for youth ages 9-17 and one (1) hour for youth ages under.
- b. If a patient has been in seclusion or restraint for 24 hours, the physician or LIP will complete a face-to-face evaluation. The assessment is required before issuing a new seclusion or restraint order.

7. RELEASE FROM RESTRAINT

- a. The patient in seclusion or restraints should be assisted by staff toward gaining enough control of behavior to begin gradually removing restraints.
- b. The RN should document in the patient's medical record when seclusion or restraint has been discontinued and should include the following information:
- 1) Patient's level of response and compliance with criteria for terminating seclusion or restraints,
 - 2) Patient education regarding identification of triggers and alternative behaviors/response to triggers.
 - 3) The RN should communicate with the patient during the application of restraints explaining or patient being place in seclusion the rationale and the criteria for release from seclusion or removal of restraints
 - 4) *Documentation that behavior criteria were discussed with the patient and a list of behavior criteria met will be completed in electronic medical record
- c. **Early Release From Restraint**
Discontinuing restraint before the time limit of the order expires is encouraged as soon as the patient meets the behavior criteria for discontinuation. When the restraint is terminated before the time limited order expires, a new order is required to reapply the restraint if the patient is an imminent risk of physically harming him/herself or others, and non-physical interventions are not effective.

8. NOTIFICATIONS

- a. The RN will notify and educate the parent/guardian or family member (exception is when an adult patient has not consented release of information to the family and/or family of adult patient has indicated the desire not to be notified) concerning:
- 1) The reason for seclusion or restraint
 - 2) The least restrictive techniques that were offered and utilized
 - 3) The guidelines for early release from seclusion or restraint discontinuation
 - 4) The patient's basic needs were met
- b. The RN will contact and consult with the patient's attending physician of the seclusion or restraint if the order was obtained by an on-call and/or non-attending physician as soon as possible. When attending physician is not available and has delegated patient responsibility to another physician, the covering physician is considered the attending physician.

- c. Within twenty-four (24) hours of the seclusion or restraint episode, the physician should:
 - 1) Authenticate any verbal/telephone order, including the date and time of signature, and
 - 2) Assess the patient and document a progress note including any changes in the treatment program as a result of the behaviors precipitating the use of seclusion or restraints.
- d. On a behavioral health unit, all instances of seclusion or restraints (physical and/or chemical) should be discussed at the next scheduled treatment team meeting and should be addressed in the patient's treatment plan.

H. DOCUMENTATION

Documentation will be completed in the medical record. The following documentation will be included in the medical record:

- 1. Description of the patient's behavior and the intervention used
- 2. Alternatives/ less restrictive interventions attempted, as applicable.
- 3. Condition or symptoms that warranted use of restraint or seclusion.
- 4. Patient response to interventions used, including rationale for continued use
- 5. The one hour face to face medical and behavioral evaluation
- 6. A time limited order
- 7. 15 minute observations and monitoring
- * 8. Update to Plan of Care/debriefing handoff
- 9. Discontinuation of restraint

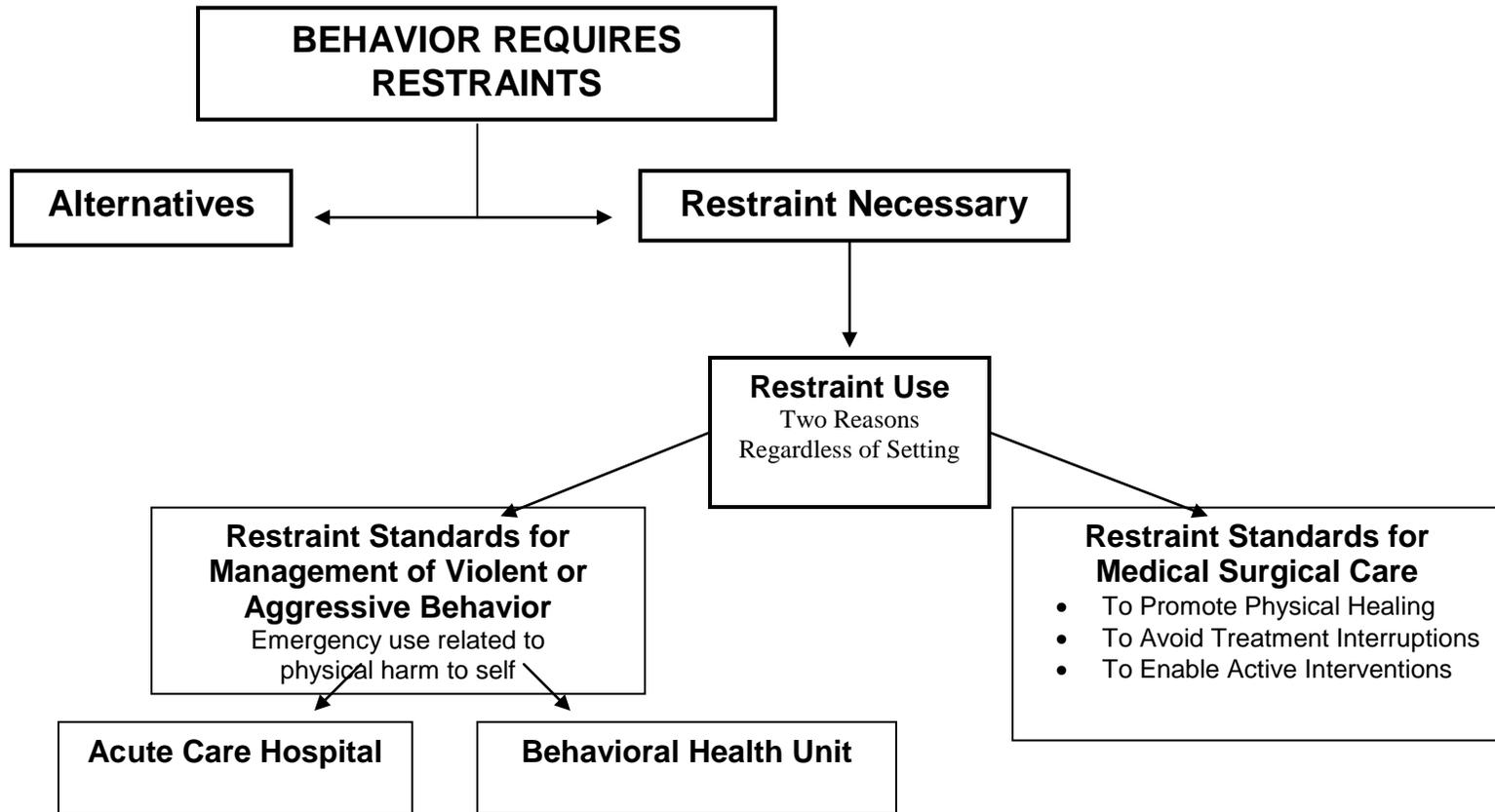
XII. REFERENCES

- A. CMS Conditions of Participation for Patient's Right.
- * B. This policy and procedure has been approved by the Deaconess Hospital Restraint Committee consisting of the ICU Core Care, Medicine Core Care, Behavioral Core Care teams and the Nursing Shared Governance Quality and Safety Council.
- * C. This policy and procedure is owned by the Director of Nursing Intensive Care Unit and is coordinated with the Accreditation & Regulatory \ Officer and the System P&P Committee.
- D. This policy revises and rescinds Policy & Procedure No. 40-19 S dated August 25, 2011.
- * E. Cross Pointe Policy - PC.081 Behavioral Management Program.
- * F. Cross Pointe Policy - PC.124 Guidelines for the Use of Humane Restraint.
- * G. Cross Pointe Policy – PC.176 Guidelines for the Use of Transport Board.
- * H. Healthcare Facilities Accreditation Program (HFAP) regulations.



Linda E. White
President and CEO

*** RESTRAINT ALGORHYTHM**



The reason for the restraint use is driven by a primary behavioral health problem; i.e., Acute Mania, Acute Psychosis, Dementia when the patient is hospitalized to treat the behavior.

The reason for the restraint is driven by an acute medical problem, i.e., toxic, metabolic, or infectious condition.

- dementia w/co-occurring medical surgical problem
- coma recovery from traumatic brain injury

Patient Death Report

Exhibit B

(For your convenience, please include all deaths occurring on your shift on this form.)

Patient Name:	Medical Record Number:	Room #:	Date of Birth:	Date of Death:	Time of Death:	Coroner notified? (Y/N)	Coroner's Case? (Y/N)	IOPO Notified? (Y/N)	IOPO Accepted? (Y/N)	In-patient Fall? (Y/N)	Restraint(s) within 24 hours prior to death? (Y/N)

Email **all deaths** to Deaths Distribution List.

For **Gateway** deaths, please add Kathy Clodfelter.

ADONs: May add appropriate Unit Nurse Managers as necessary.