# DEACONESS HOSPITAL, INC.
# Evansville, Indiana

**Policy and Procedure No. 40-19**

**Restraints**
**Medical and Behavioral/Violent**

**I. SCOPE:** This policy and procedure applied to Deaconess Hospital, Inc.

**II. PURPOSE:** To provide instruction to Deaconess Employees on the implementation and monitoring of restraint utilization – either medical-surgical or behavioral restraint. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff members and others from harm.

**III. DEFINITIONS:**

A. **Physical 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. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff members and others from harm.

B. **Non-Restraints:** Devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).These devices and methods are typically used in medical-surgical care. Examples include:

1. Use of an IV arm board to stabilize an IV line.

2. A mechanical support used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such a mechanical support.

3. A medically necessary positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures.

4. Recovery from anesthesia that occurs when the patient is in a critical care or post anesthesia care unit is considered part of the surgical procedure; therefore, medically necessary restraint use in this setting would not need to meet the requirements of the regulation.
However, if the intervention is maintained when the patient is transferred to another unit or recovers from the effects of the anesthesia (whichever occurs first), a restraint order would be necessary and the requirements of this policy would apply.

5. Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers) that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool-aged child.

6. A physical escort would include a "light" grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint.

C. **Physical Holding ("Therapeutic Holding"):** 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.

D. **Prisoner Restraint:** The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are considered prisoner restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients. 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. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer's prisoner).

E. **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.

Criteria used to determine whether the use of a drug or medication, or combination of drugs or medications is a standard treatment or dosage for the patient's condition includes all of the following:

1. The drug or 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;

2. The use of the drug or medication follows national practice standards established or recognized by the medical community, or professional medical associations or organizations; and,

3. The use of the drug or medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's or other licensed independent practitioner's (LIP) knowledge of that patient's expected and actual response to the medication.

F. **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.

G. **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.

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

I. **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. Seclusion is a method of treatment that is implemented only on the inpatient acute behavioral units and is not utilized in conjunction with restraints.

J. **PRN Restraint:** PRN restraint orders are not accepted. If a patient was recently released from restraint or seclusion, and exhibits behavior that can only be handled through the reapplication, a new order, would be required.

K. **Medical Restraint:** Restraint use in the medical acute care settings 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.

L. **Behavioral Restraint:** Restraints necessary for management of violent or self-destructive behavior and are applicable when a patient behaves in a severely aggressive, assaultive, violent, or destructive manner that places the patient or others in imminent danger.

M. **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,: family/significant other at bedside, increased observation and/or movement of the patient closer to the nurse's station, use of bed exit alarm, illumination of environment , modification of environment, move personal aids within reach, physiologic assessment (including hydration, pain and elimination need), exercise/up in chair/massage, re-orient to activity and environment, verbal intervention, patient sitter with one-on-one observation necessary (Patient Sitter Policy 40-60), diversional activities.

**IV. 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 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.

**V. RESPONSIBILITY:**

A. All Physicians, Licensed Independent Practitioners (LIP), nurses, therapy personnel and nursing personnel (PCT, LPN, MHT) should recognize the effects and consequences of restraint use. All patients when restrained should be considered vulnerable. Certain patient populations where this may be more evident include, but are not limited to:

- Cognitively impaired patients, those with mental status changes
- Physically impaired, the frail, the elderly, prone positioned patient
- Sensory impaired patients
- Developmentally disabled patients
- Pediatric patients
- Any history of sexual or physical abuse that would place the patient at greater psychological risk.

Restraint use for the vulnerable populations requires special assessment and monitoring of the patient's age appropriate needs and physical and mental condition to avoid the use of restraints and minimize the degree of restriction and duration of use.

B. **Registered Nurses**: Responsible for initial application and removal of restraints, assessment, monitoring and documentation related to patients in restraints. The nurse is also required to attend annual education as outlined in this policy.

C. **Assistant Director of Clinical Operations (ADCO):** 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 A)

D. **Accreditation and Regulatory Officer:** Responsible for review of deaths that occur while that patient was in restraints and for review of restraint data on a regular interval with reports to Critical Care and Medical-Surgical Core Care Teams and/or Regulatory Preparedness Committee for education and performance improvement.

E. **Licensed Independent Practitioner(s):** Responsible for overseeing the use of restraints. He/she provides written or verbal orders and renewals. The LIP will complete a face-to-face assessment within 24 hours of the original order and each reorder/renewal for medical surgical restraints and complete a face-to-face assessment within 1 hour for behavioral restraints. The LIP will participate in daily reviews as related to his/her patients. The LIP will participate in performance improvement activities.

F. **Trained RN:** Trained/responsible for completing a face to face assessment of the patient placed in behavioral restraints within 1 hour when requested by RN and relaying information to the LIP.

## VI. PROCEDURE – MEDICAL-SURGICAL RESTRAINTS:

A. **Alternative Interventions:** 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.

B. **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. 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/LIP or RN and always requires a physician order.

3. The patient's need for the restraint is reevaluated continuously, so that it is discontinued at the earliest possible time.

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 part of the patient's medical record to ensure continuous monitoring.

C. **Placement of Restraints:**

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. In a situation where preventative strategies and non-physical alternatives have failed and the patient is high risk 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/LIP may initiate the use of restraints after he/she has conducted an assessment of the patient.

3. If the initiation of restraint is based on a significant change in the patient's condition the RN immediately notifies the Physician/LIP.

4. Restraint Application:

a. Should be applied initially by the RN. Restraints may be released and reapplied after ROM or ADL care by other trained personnel (MHT, PCT, LPN, RT, PT/OT) as directed by the RN.

b. Least restrictive restraint appropriate for the patient and the intent for its use should be selected.

c. Restraint should be correct size and modified or padded as needed for patient comfort. Some available restraints include soft-wrist restraints and lap belts.

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.

e. Applied Restraint should:

i. Not interfere with flow of IV infusion or arterial line.
ii. Never be proximal to an AV fistula or shunt.
iii. Allow as much freedom of movement as possible with achieving desired effect.
iv. Be comfortable and not interfere with breathing.
v. Be secured in a quick release knot for easy removal in emergency situations.
vi. Be secured around portion of bed frame that *moves* with the patient (not the side rail).
vii. Be applied according to manufacturer's recommendations.

5. **Clarification of the Use of Side Rails**:

a. A restraint does not include methods that protect the patient from falling out of bed. However, side rails are frequently not used as a method to prevent the patient from falling out of bed, but instead, used to restrict the patient's freedom to exit the bed. The use of side rails to prevent the patient from exiting the bed would be considered a restraint and would be subject to the requirements of the restraint policy.

b. The use of side rails is inherently risky, particularly if the patient is elderly or disoriented. The patient may have an increased risk for a fall or other injury by attempting to exit the bed with the side rails raised. The risk presented by side rail use should be weighed against the risk presented by the patient's behavior as ascertained through individualized assessment.

D. **Assessment, Reassessment and Care During Medical Restraint Use:**

1. When restraints are placed, provide patient all basic care needs including medication review and pain control.

2. The patient's physical and emotional needs are considered while the patient is in restraints. The basic rights of dignity and respect are maintained.

3. Every two hour observation and monitoring will include the following:

a. Visual check of patient including current psychological status, circulatory and respiratory status, range of motion, fluids and food/meal, elimination. Restraints may be released and reapplied after ROM or ADL care by other trained personnel (MHT, PCT, LPN, RT, PT/OT).

b. Patient needs for warmth, privacy, personal needs and comfort will be assessed.

c. Responses to restraint, continued clinical justification and determination if changes in patient's behavior or clinical condition allow for removal of the restraint of lessening the level of restraint.

d. 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.

4. Daily, the Physician/LIP and the RN will discuss the continued need for restraint and document accordingly in electronic medical record. A face-to-face assessment by the Physician/ LIP will be completed as soon as possible but no later than 24 hours after the restraint was initiated

5. Early Release: If the patient's condition that necessitated restraint resolves, the patient may be released from the restraints. Order is considered discontinued once restraints are discontinued. Should the patient's behavior escalate again and alternatives remain ineffective, a new order must be obtained.

E. **Patient/Family Education:**

1. 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.

2. When restraints are used, the patient and family will receive education regarding the need for restraint, the ongoing monitoring, to include basic needs for nourishment, personal care, elimination, and exercise as well as that restraint use will be discontinued as soon as possible. Documentation of this education will be completed in electronic medical record.

F. **Physician Orders:**

1. A time limited Physician/LIP order must be received prior to the initiation of restraint use by the RN or within one (1) hour after in an emergency situation.

2. The order for medical surgical restraints should be placed and renewed every calendar day. Orders will be placed in the EMR. Upon the expiration of an order, the patient must be removed from restraints unless a new order is obtained from Physician/LIP.

3. The Physician/LIP has the discretion to write orders for shorter lengths of time based his/her patient assessment.

4. Upon the expiration of an order, the patient must be removed from restraints unless a new order is obtained from Physician/LIP.

5. 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

6. PRN restraint orders are not accepted.

G. **Documentation Requirements:**

1. Documentation for restraint in the medical acute care setting will be completed in electronic medical record, utilizing the appropriate flowsheet.

2. Documentation in the medical record will include the following:

   a. Clinical justification

   b. Assessments

   c. Alternative interventions attempted

   d. Patient and, if appropriate, family education

   e. Type of restraint used

   f. Orders

   g. Observation, checks, and care needs

   h. Reassessments

   i. Discontinuation

3. Documentation 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. When restraints are discontinued, this is to be reflected on the Plan of Care.

4. Documentation of Patient/family education that was completed related to restraint indications, use and any other relevant information.

## VII. PROCEDURE – BEHAVIORAL/VIOLENT RESTRAINTS/SECLUSION

A. **Alternative Interventions**: 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.

   **Alternatives should be documented in the electronic medical record on the restraint flow sheet.**

B. **Justification:** Non-physical techniques are the preferred interventions in the management of behavior. Therefore, restraint use will be limited to management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others when non-physical interventions have not been effective or are not an available option. The type of behavioral restraints may include, soft wrist restraints, four-way locking, seclusion and medication based upon the INTENT of device used.

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, LIP or RN and always requires a Physician/LIP order.

3. The patient's need for the restraint is reevaluated continuously, so that it is discontinued at the earliest possible time.

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.

C. **Placement of Restraints:**

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. 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/LIP may initiate the use of restraints after he/she has conducted an assessment of the patient.

3. If the initiation of restraint is based on a significant change in the patient's condition the RN immediately notifies the Physician/LIP.

4. If the attending Physician/LIP did not order the restraint or seclusion, the attending Physician/LIP must be consulted as soon as possible. This requirement may be achieved through a telephone call. The attending physician is notified to ensure continuity of care, to ensure patient safety, and to obtain other relevant information about the care of the patient. When the attending physician is not available and has delegated patient responsibility to another physician, the covering physician is considered the attending physician.

5. Restraint Application:

   a. Should be applied initially by the RN and may be reapplied after ROM or care by other trained personnel (MHT, PCT, LPN). The RN must apply the restraints initially. Thereafter, trained personnel (MHT, PCT, LPN, PT/OT) may re-apply restraints after range of motion or other care.

   b. Least restrictive restraint appropriate for the patient and the intent for its use should be selected.

   c. Restraint should be correct size and modified or padded as needed for patient comfort.

   d. Some protective devised/restraints available are soft restraints wrist/ankle, four way locking, chemical, and seclusion.

   e. 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.

   f. Applied Restraints should:

      i. Not interfere with flow of IV infusion or arterial line.
      ii. Never be proximal to an AV fistula or shunt.
      iii. Allow as much freedom of movement as possible while achieving desired effect.
      iv. Be comfortable and not interfere with breathing.
      v. Be secured in a quick release knot for easy removal in emergency situations.
      vi. Be secured around portion of bed frame that *moves* with the patient (not the side rail).
      vii. Be applied according to manufacturer's recommendations.

D. **Assessment, Reassessment, and Care During Restraint Use**:

1. When restraints are placed, provide patient all basic care needs including medication review and pain control.

2. A staff member who is trained and competent (RN or MHT) 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 by a staff member who is trained and competent (RN, MHT, PT/OT or PCT)

3. 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.

4. **Every 15 minute observation and assessment will include the following:**

   a. Psychological/neuro, respiratory, circulatory status.

   b. Patient needs for warmth, privacy, personal/emotional needs and comfort will be assessed.

   c. Responses to restraint effectiveness and clinical justification.

   d. Determine if changes in the patient's behavior or clinical condition allow for removal of the restraint or lessening the level of restraint.

5. **Every two hours the patient is assessed for:**

   a. Range of motion, physical comfort, fluids, food/meal, and elimination needs if appropriate.

   b. 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.

6. Face to Face Assessment:

   a. A physician, 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. The assessment should evaluate the patient's immediate situation, reaction to the intervention, the patient's medical and behavioral condition and the need to continue or terminate the restraint or seclusion.

   If this evaluation is completed by a trained RN, he/she must consult the attending physician or other LIP who is responsible for the care of the patient as soon as possible after the completion of the 1 hour face to face evaluation.

E. **Patient/Family Education**

1. 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:

   a. The reason for seclusion or restraint

   b. The least restrictive techniques that were offered and utilized

c. The guidelines for early release from seclusion or restraint discontinuation

d. The patient's basic needs were met

2. Documentation of this education will be completed accordingly in electronic medical record.

F. **Physician Orders:**

1. 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

2. Orders for initial use or continuing use of restraint are time limited as followed:
- 4 hours for adults 18 years of age or older;
- 2 hours for children and adolescents 9 to 17 years of age OR
- 1 hour for children under 9 years of age

3. The physician or LIP has the discretion to write orders for shorter lengths of time based his/her patient assessment.

4. When the original order is about the expire and the patient continues to exhibit violent or self-destructive behavior, the RN must contact the physician or LIP, report the results of his/her most recent assessment and request the original order be renewed (not to exceed the time limits established above).

5. The original order may only be renewed within the required time limits for up to a total of 24 hours.

6. After the original order expires (24 hours), **before writing a new order** for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or LIP who is responsible for the care of the patient must see and assess the patient.

a. **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. PRN orders are not allowed or permitted at Deaconess Hospital, Inc. if a patient was recently released from restraint of seclusion, and exhibits behavior that can only be handled through the reapplication of restraint or seclusion, a new order, would be required. Staff cannot discontinue a restraint or seclusion intervention, and then re-start it under the same order.

G. **Release from Restraints**

1. The patient in seclusion or restraints should be assisted by staff toward gaining enough control of behavior to begin gradually removing restraints.

2. The RN should document in the patient's medical record when seclusion or restraint has been discontinued and should include the following information:

   a. Patient's level of response and compliance with criteria for terminating seclusion or restraints.

   b. Patient education regarding identification of triggers and alternative behaviors/response to triggers.

   c. 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.

   d. Documentation that behavior criteria were discussed with the patient and a list of behavior criteria met will be completed in electronic medical record.

3. 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.

H. **Documentation Requirements:**

1. All assessment and monitoring and observations will be documented every 15 minutes on the Behavioral Restraint Flowsheet or on Continuous Care and Observation Flowsheet (Deaconess Cross Pointe).

2. Documentation for restraint will be completed in electronic medical record with the exception of 15 minute monitoring at Cross Pointe (see #1). A new flow sheet will be initiated in EMR in accordance with documentation policies.

3. The 1 hour face to face medical and behavioral evaluation should include documentation of the following by the Physician/LIP or trained RN:

   a. Description of the patient's behavior and intervention used;

   b. Alternatives or other less restrictive interventions attempted (as applicable);

   c. The patient's condition or symptom(s) that warranted the use of the restraint or seclusion;

   d. The patient's response to the intervention(s) used, including the rationale for continued use for the intervention.

   e. Document all findings and physician's notification in patient chart.

4. Documentation in the medical record will include the following:

   a. Description of the patient's behavior and the intervention used.

   b. Alternatives/less restrictive intervention attempted, as applicable.

c. Condition or symptoms that warranted use of restraint or seclusion.

d. Patient response to interventions used, including rationale for continued use.

e. Discontinuation of restraint.

5. 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.

6. 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.

I. **Chemical Restraints:**

1. A drug or medication used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

2. Are only used in response to an immediate threat to safety to protect patient, staff, or others from injury.

3. IV/IM antipsychotics can only be ordered as once order.

4. EMR chemical restraint order panel should be used for administration and post-administration monitoring guidelines. Monitoring and assessment every 15 minute x 4 hours post chemical restraint administration

5. May need to transfer to ICU post-chemical administration for monitoring

## VIII. PROCEDURE: PATIENT DEATH IN RESTRAINTS OR WITHIN 24 HOURS

A. RN will notify the ADCO of patient death while restrained.

B. ADCO will complete the hospital approved "patient death report" and send to the "Deaths" distribution list, the appropriate Nurse Manager and the appropriate Nursing Director, as applicable (Exhibit A).

C. The Accreditation and Regulatory Officer will do one of the following:

1. If the death occurred (1) while the patient was ONLY in a two-point soft wrist restraint and without seclusion, or (2) within 24 hours of being removed from such restraints:

a. Record the information on 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 the 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, data 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". 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.

b. 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.

c. Save the original Worksheet according to month and year in cabinet provided for that purpose.

d. Include information from the Worksheet in the hospital's internal electronic log.

## IX. PERFORMANCE IMPROVEMENT:

A. Interdisciplinary review of restraint data is aggregated and analyzed at least twice a year. Data is used to monitor trends of use, compliance with policy and procedure, types of restraints used, and other demographic indicators (gender, age, location, etc.).The data is used to measure the effectiveness of the PI project, identify patterns of use and areas for improvement. A 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.

B. Deaths in restraints or within 24 hours as defined above are also monitored (see above section for more information).

## X. EDUCATION AND COMPETENCY OF STAFF

A. All staff designated by the hospital as having direct patient care responsibilities, including contract or agency personnel, must demonstrate the competencies prior to participating in the application of restraints, implementation of seclusion, monitoring, assessment, or care of a patient in restraint or seclusion. The competency completed in orientation and annually includes:

1. Techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

2. The use of nonphysical intervention skills.

3. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition.

4. The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).

5. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

6. 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, vital signs, and any special requirements specified by the hospital policy associated with the 1 hour face to face assessment.

B. Training of staff is based upon population being served and the competency level of the staff.

C. Individuals providing staff training must be qualified as evidenced by education, training and experience in techniques used to address patients' behaviors.

D. Documentation of training will be kept in hospital personnel files to show that competency was successfully completed.

E. Training for an RN or PA to conduct the 1 hour face to face evaluation must include all (1) a-g and the following:

1. Evaluate the patient's immediate situation,

2. The patient's reaction to the intervention,

3. The patient's medical and behavioral condition. An evaluation of the patient's medical condition would include:
   a. Complete review of systems assessment,
   b. Behavioral assessment,
   c. Review and assessment of the patient's history, medications, most recent lab results, etc.

4. The need to continue or terminate the restraint or seclusion.

F. Physicians and other LIPs authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint and seclusion. 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 Regulations 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.

**XI. 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.

**XII. AUTHORITY:**

1. **Policy Owner:** Director of Nursing Quality, Safety, Regulatory
2. **Coordinate with:** Accreditation and Regulatory Officer, Corporate Compliance Officer, Emergency Department, Risk Management, and Deaconess Cross Pointe.
3. This P&P revises and rescinds Deaconess Hospital P&P 40-19 issues June 11, 2017.

**XIII. REFERENCES:**

A. CMS Conditions of Participation for Patient's Right, €482.13 (e) Standard: Restraint or Seclusion
B. Accreditation Commission for Healthcare (ACHC) regulations,15.02.00-15.02.41

Shawn McCoy
Deaconess Health System CEO

**Exhibit A**
**Patient Death Report: New Form**
*(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) |
|---|---|---|---|---|---|---|---|---|---|---|
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Email ***all* deaths** to Deaths Distribution List
For **Gateway** deaths, please add Cathy Murphy
**ADCO's:** May add appropriate Unit Nurse Managers as necessary

# Exhibit B

Deaconess Hospital, Inc.
Evansville, Indiana

**Restraints**
**Competency Skills Checklist**
Resource: Hospital P&P Restraint P & P No. 40-19 & P& P _____

Name _____ Department/Care Center_____

| Competency |
|---|
| **Medical Restraints** |
| 1. Identify reasons for applying medical restraints, risks of restraints (i.e. asphyxiation) and requirements of care while patient in restraints (see P&P). |
| 2. Describe how to enter a medical restraint order in Epic. |
| 3. Identify where to document restraints. |
| 4. Discuss where to document initial restraint assessment and justification for medical restraints and identify how often these must be documented. |
| 5. Discuss where to document use of less restrictive device on the restraint medical flowsheet and how often these must be documented. |
| 6. Discuss documentation on education provided and how often these must be documented. |
| 7. Identify where to document restraint type. |
| 8. Identify where to document every 2 hour required assessments for medical restraints. |
| 9. Discuss how often plan of care must be documented on. |
| 10. Identify process for discontinuation of restraints. |
| 11. Distinguish the difference in Medical and Behavioral restraints. |
| 12. Identify different types of restraints and the appropriate situation to use each. |
| 13. Applies and removes soft limb restraints correctly using quick release method. |
| 14. Describes or demonstrates appropriate documentation in EPIC. |
| **Behavioral Restraints** |
| 15. Identify a need for behavioral restraints risks of restraints (i.e. asphyxiation) and requirements of care while patient in restraints (see P&P). |
| 16. Describe how to enter a behavioral/seclusion restraint order in Epic. |
| 17. Applies and removes locking restraints with keylocks. |
| 18. Identifies where to document use of least restrictive device on the behavioral restraint flowsheet. |
| 19. Discuss where to document restraint order specifics on restraint behavioral flowsheet. |
| 20. Identify where to document education provided. |
| 21. Discuss where to document restraint type. |
| 22. Discuss every 15 minute monitoring requirements. |
| 23. Discuss importance of documentation every 2 hour required treatments behavioral restraints. |
| 24. Describes or demonstrates appropriate documentation in EPIC. |

Circle Competency Status: Meets / Below - report plan of action
**Checked off by:**
Signature _____ Date _____

Plan of action if task not completed...
_____
_____

| Document Metadata | **In Project Mode** |
|---|---|
| Document Name: | 40-19 Restraints: Medical Surgical and Behavioral/ Violent.docx |
| Policy Number: | 40-19 |
| Original Location: | /Deaconess Hospital/Hospital Policies/Patient Care/Nursing |
| Created on: | 08/27/1996 |
| Published on: | 01/22/2025 |
| Last Review on: | 12/11/2024 |
| Next Review on: | 12/11/2027 |
| Effective on: | 08/21/2019 |
| Creator: | Clodfelter, Kathy<br>*Administrative Staff* |
| Committee / Policy Team: | DHS Corporate Policy Team |
| Owner/SME: | Clodfelter, Kathy<br>*Administrative Staff* |
| Manager: | Clodfelter, Kathy<br>*Administrative Staff* |
| Approver(s): | Chiusano, Jennifer<br>*Chief Nursing Officer* |
| Description: | To provide instruction to Deaconess Employees on the implementation and monitoring of restraint utilization- either medical-surgical or behavioral restraint. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff members and others from harm |

Linked Regulations & Standards:

HFAP

HFAP-ACUTE

- 15.02.00
- 15.02.41