DEACONESS HOSPITAL, INC.
Evansville, Indiana

Policy and Procedure No. 40-19

Medical Surgical Restraints

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

II. PURPOSE: To provide instruction to Deaconess Employees on the implementation and monitoring of medical surgical restraint.

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 determine to be ineffective to protect the patient, staff members and others from harm.

B. Non-Restraints: A physical restraint (as defined above) differs from the use of the following devices that may limit a patient's movements. 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:

a. Use of an IV arm board to stabilize an IV line is generally not considered a restraint. However, if the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access his or her body, the use of the arm board would be considered a restraint.

b. A mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint. For example, some patients lack the ability to walk without the use of leg braces, or to sit upright without neck, head, or back braces.

c. 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 is not considered a restraint.

d. 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 are not considered restraint or seclusion.

e. 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. Restraint or seclusion may only be used when less restrictive interventions have been determine to be ineffective to protect the patient,

staff members and others from harm.

J. PRN Restraint: 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. This would constitute a PRN order. For example, if a patient's assessment allows for release of restraints and walk in the hallway but then the patient becomes violent, a new order would be required. NOTE: 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 or seclusion intervention. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is serving the same purpose as the restraint or seclusion.

K. Medical Surgical 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. It is necessary to limit mobility or immobilize a patient who is temporarily or permanently mentally incapacitated, and receiving medical, or post-surgical care. Restraint or seclusion may only be used when less restrictive interventions have been determine to be ineffective to protect the patient, staff members and others from harm.

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

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, the alternative interventions listed: 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 (supportive devices, rehabilitation equipment, reduction of noise), move personal aids within reach, physiologic assessment (including hydration, pain and elimination need), check placement of invasive devices/ tubes, 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 (folding cloths, cards, TV, radio), and alternative devices (happy hands, skin sleeves, posey chair alarms).

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 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. 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 Licensed Independent Practitioners, nurses, therapy personnel and nursing personnel (PCT, LPN, MHT) should recognize the effects and consequences of restraint use and immobilization which may include: aspiration pneumonia, elimination problems, disruption skin integrity, strangulation, and/or feeling humiliated and demoralized. 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 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.

Initial application to be performed by RN. Thereafter, reapplied by trained personnel (i.e. after repositioning or other necessary care).

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 Core Care Team 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. The LIP will participate in daily reviews as related to his/her patients. The LIP will participate in performance improvement activities.

VI. PROCEDURE:

A. 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: 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 (supportive devices, rehabilitation equipment, reduction of noise), move personal aids within reach, physiologic assessment (including hydration, pain and elimination need), check placement of invasive devices/ tubes, 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 (folding cloths, cards, TV, radio), and alternative devices (happy hands, skin sleeves, posey chair alarms).

Alternative devices should be documented in the electronic medical record on the restraint flow sheet.

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

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

3. 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.

4. If the initiation of restraint is based on a significant change in the patient's condition the RN immediately notifies the physician.

5. The RN must apply the restraints initially. Thereafter, trained personnel (MHT, PCT, LPN, LIP) may re-apply restraints after range of motion or other care.

6. If the attending physician did not order the restraint or seclusion, the attending physician 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.

7. Restraint Application:

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

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

    c. Protective devices/restraints available in EPIC (list may not be inclusive): side rails up, hand mitt secured, freedom splint, torso support, soft wrist/ankle, belt

    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 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.

8. Clarification on the Use of Side Rails:

    a. A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of the bed. The use of side rails in these situations protects the patient from falling out of bed and, therefore, would not be considered restraints and subject to this policy. 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. Disoriented patients may view a raised side rail as a barrier to climb over, may slide between raised, segmented side rails, or may scoot to the end of the bed to get around a raised side rail and exit the bed. When attempting to leave the bed by any of these routes, the patient is at risk for entrapment, entanglement, or falling from a greater height posed by the raised side rail, with a possibility for sustaining greater injury or death than if the patient had fallen from the height of a lowered bed without raised side rails. In short, 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.

c. Examples:

i. When the clinician raises all four side rails in order to restrain a patient, defined in this regulation as immobilizing or reducing the ability of a patient to move his or her arms, legs, body, or head freely to ensure the immediate physical safety of the patient, then the requirements of this restraint policy apply.

ii. Raising fewer than four side rails when the bed has segmented side rails would not necessarily immobilize or reduce the ability of a patient to move freely as defined in this policy. For example, if the side rails are segmented and all but one segment are raised to allow the patient to freely exit the bed, the side rail is not acting as a restraint and the requirements of this rule would not apply.

iii. If a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails for this patient would not be considered restraint because the side rails have no impact on the patient's freedom of movement. In this example, the use of all four side rails would not be considered restraint. Therefore, the requirements of this rule would not apply.

iv. When a patient is on a bed that constantly moves to improve circulation or prevents skin breakdown, raised side rails are a safety intervention to prevent the patient from falling out of bed and would not be considered a restraint.

v. When a patient is placed on seizure precautions and all side rails are raised, the use of side rails would not be considered restraint. The use of padded side rails in this situation should protect the patient from harm; including falling out of bed should the patient have a seizure.

vi. Placement in a crib with raised rails is an age-appropriate standard safety practice for every infant or toddler. Therefore, placement of an infant or toddler in the crib with raised rails would not be considered restraint.

vii. If the patient is on a stretcher (a narrow, elevated, and highly mobile cart used to transport patients and to evaluate or treat patients), there is an increased risk of falling from a stretcher without raised side rails due to its narrow width, and mobility. In addition, because stretchers are elevated platforms, the risk of patient injury due to a fall is significant. Therefore, the use of raised side rails on stretchers would not be considered restraint but a prudent safety intervention.

viii. The use of a seat belt when transporting a patient in a wheelchair would not be considered restraint.

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. 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.

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.

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 and the RN will discuss the continued need for restraint and document accordingly in electronic medical record.

5. Early 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.

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 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.

3. 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.

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

F. Physician Orders

1. PRN restraint orders are not accepted.

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 licensed independent practitioner (LIP) will be completed as soon as possible but no later than 24 hours after the restraint was initiated.

4. The order for medical surgical restraints should be placed and renewed every calendar day. Orders will be placed in the EMR.

5. 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 calendar day. If reassessment indicates the need and justification of continued use of restraints, a new order must be written.

6. Upon the expiration of an order, the patient must be removed from restraints unless a new order is obtained from physician.

7. 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. Documentation Requirements

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.

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. Observations, checks and care needs

   h. Reassessments

   i. 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.

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

H. Patient Death In Restraints Or Within 24 Hours

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

2. 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).

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

   a. 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:

      i. Record the information on the death in the hospital's internal electronic log to be made available to CMS immediately upon request.

      ii. Each entry must be made no later than *seven days* after the date of the death of the patient.

      iii. The record must include the patient's name, date of birth, attending physician, primary diagnosis(es), and medical record number.

      iv. 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.

b. 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.

i. 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.

ii. 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.

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

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

I. Performance Improvement

1. ICU Core Care team, Medicine Core Care team, and Union County Quality department direct the interdisciplinary review of restraint data that is aggregated and analyzed at least quarterly. 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.

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

J. Education And Competency Of Staff

1. 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 (see Exhibit B):

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

b. The use of nonphysical intervention skills

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

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

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

f. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the hospital policy associated with the 1 hour face to face assessment.

g. The use of first aid techniques and certification in the use of CPR, including periodic recertification.

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

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

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

5. 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 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.

VII: 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.

VIII: AUTHORITY

1. **Policy Owner:** Director of Patient Care Services-Nursing Quality, Safety, Regulatory

2. **Coordinate with**: Accreditation and Regulatory Officer, Corporate Compliance Officer, Emergency Department, Risk Management, and Deaconess Cross Pointe.

VII. REFERENCES:

A. CMS Conditions of Participation for Patient's Right, €482.13 (e) Standard: Restraint or Seclusion

B. Healthcare Facilities Accreditation Program (HFAP) 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)

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. Applies and removes locking restraints with keylocks.
17. Identifies where to document use of least restrictive device on the behavioral restraint flowsheet.
18. Discuss where to document restraint order specifics on restraint behavioral flowsheet.
19. Identify where to document education provided.
20. Discuss where to document restraint type.
21. Discuss every 15 minute monitoring requirements.
22. Discuss importance of documentation every 2 hour required treatments behavioral restraints.
23. 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

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:	01/04/2023
Last Review on:	11/14/2022
Next Review on:	11/14/2024
Effective on:	08/21/2019
Creator:	Rowley, Dawn
Committee / Policy Team:	DHS Corporate Policy Team
Owner/SME:	Swearer, Jillian
Manager:	Swearer, Jillian
Approver(s):	Swearer, Jillian
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

Summary of Changes/Updates:

updating per ACHC recommendations

Linked Regulations & Standards:
HFAP
HFAP-ACUTE
- 15.02.00
- 15.02.41