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1. **PURPOSE:**
   To standardize and communicate to all Aurora Health Care (AHC) caregivers the organizational policy on the appropriate use of restraints and seclusion within all patient care areas. The goal is to ensure that the rights, well-being, and dignity of each patient is maintained at the highest level possible by creating a physical, social, and cultural environment in which use of restraints or seclusion is prevented, reduced, or the interdisciplinary team provides an alternative. This goal for restraint and seclusion use is in alignment with the provision of a safe environment for patients and caregivers.

2. **SCOPE:**
   This policy applies to inpatient facilities owned, in whole or in part, or controlled by Aurora Health Care. The following exceptions are outside the scope of this policy.
   
   a) Use of an immobilization device that is associated with medical, dental, diagnostic, or surgical procedures and is based on standard practice for the procedure. Such standard practice may or may not be described in a procedure. For example: the policy does not apply to medical immobilization in the form of surgical positioning, IV arm boards, radiotherapy procedures, ECT, medications used to promote mechanical ventilation and so on.
   
   b) When a restraint device is used to meet the assessed needs of a patient who requires adaptive support or medical protective devices (for example: postural support, orthopedic appliances, and helmets.) Such use is based on the assessed needs of the individual patient and periodic assessment assures that the device continues to meet an identified patient need.
   
   c) Comforting of children or a timeout when its use is consistent with the patient’s treatment plan.
   
   d) Protection of surgical and treatment sites in pediatric patients or when a papoose device is used to immobilize a child for a specific intervention (i.e., IV start, suturing of a laceration, blood draw, etc.).
   
   e) Use of forensic restraints. Forensic restraints are the use of handcuffs and shackles by law enforcement officers. This is considered constraint and not restraint by Aurora Health Care and is out of scope for this policy.

3. **DEFINITIONS:**
   **Non-Violent/Non-Self Destructive Restraint Management [NV/NSD]:** Restraint for medical management is used to limit mobility or temporarily immobilize a patient for a reason specifically related to a medical, post-surgical, or dental procedure and to promote medical healing. Examples of restraint include the need to ensure that a tube will not be removed or that a patient will not attempt to walk before it is medically appropriate AND the patient is not following the instructions provided by the caregiver and other safety interventions have been determined to be ineffective.
Violent/Self-Destructive Restraint Management [V/SD]: Emergency use of Restraint whenever there is an imminent risk of a patient physically harming themselves, caregivers or others and non-physical interventions would not be effective.

Adaptive Support: Mechanisms intended to permit a patient with assessed physical needs to achieve maximum normative bodily functioning, including orthopedic appliances, braces, wheelchairs, or other devices used to support the patient’s posture.

Age or Developmentally appropriate protective safety interventions (such as stroller safety belts, infant 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 would not be considered a restraint or seclusion for the purposes of regulations related to restraints.

Attending Physician/LIP: A physician or other Licensed Independent Practitioner (LIP), who is responsible for the in-hospital management and care of the patient.

Clinical Leadership: Clinical leadership for the purpose of this policy is defined as the Patient Care Manager, Clinical Nurse Specialist/Nurse Clinician, the Clinical Nurse Coordinator or designee.

Cognitive Dysfunction: The inability of an individual to process information, respond and/or act in a safe and responsible manner.

Debriefing: A meeting or conference to systematically discuss and evaluate the events leading to and during a restraint and/or seclusion episode for behavioral reasons.

Emergency Situation: An emergency situation exists when a patient’s behavior is violent and/or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient or others.

Episode: Each episode of restraint may not exceed the exact time as stated in the restraint order.

Forensic Restraint: The use of handcuffs and shackles by law enforcement officers. This is considered constraint and not restraint by Aurora Health Care and is not a part of this policy.

Licensed Independent Practitioner (LIP): Only licensed independent practitioners that are permitted by the state of Wisconsin and the hospital may order seclusion or restraint. In Wisconsin, only certain physicians may order restraints for persons receiving inpatient hospital services for mental illness, developmental disabilities, alcoholism or drug dependency. Only certain physicians may order seclusion. Under Wisconsin State Statues, Section 51.61(l)(i): The treatment/medical director shall specifically designate physicians who are authorized to order isolation or restraint. Only practitioners that are credentialed in restraint use may order restraints (CMS 482.13(e)(5)).
A resident who is authorized by State law and the hospital’s residency program to practice as a physician can carry out functions reserved for a physician or LIP by the regulation. A medical student holds no license, and his/her work is reviewed and must be countersigned by the attending physician; therefore, he or she is not licensed or independent. A medical school student is not an LIP.

**Observation:** The act of physically viewing the patient to note the safety, well-being and any immediate needs of the patient.

**Protective Device:** Mechanisms intended to compensate for a specific physical deficit or to prevent any safety incidents, which are not related to any cognitive dysfunction. This may include, but is not limited to – tabletop chairs, cart/gurney rails, helmets, protective nets, or a bubble top for cribs.

**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 or a drug or medication when it is 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. Restraint definition applies to other commonly used hospital devices and other practices that could meet the definition of a restraint, such as:
   a. Tucking a patient’s bed sheets in so tightly that the patient cannot move
   b. Use of a “net bed” or enclosed bed that prevents the patient from freely exiting the bed.
      An exception to this definition is placement of a toddler in an “enclosed” or “domed crib” for safety purposes
   c. Use of “freedom” splints that immobilize a patient’s limb when the individual cannot remove the splint easily.
   d. Using side rails to prevent a patient from voluntarily getting out of bed
   e. Geri chairs or recliners, only if the patient cannot easily remove the restraint appliance and get out of the chair on his or her own.
Generally, if a patient can easily remove a device, the device would not be considered a restraint.

A restraint does not include 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) (CMS Conditions of Participation §482.13(e)(1)(i)(C)) Physical escort includes using 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. However, holding a patient in such a way that restricts the patient’s movement against the patient’s will is considered a restraint unless it is for the purpose of conducting a routine physical examination or test. (CMS Conditions of Participation, A-0159).

Recovery from anesthesia that occurs when the patient is in a critical care or postanesthesia care unit is considered part of the surgical procedure; therefore, medically necessary restraint use in this setting would not need to be met. 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.
Medication Used as Restraint: A drug or medication that is 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. (CMS Interpretive Guidelines §482.13(e)(1)(i)(B))

Differentiation of Medications Used as Restraints:

a) Drugs or medications that are used as part of a patient’s standard medical or psychiatric treatment, and are administered within the standard dosage for the patient’s condition, would not be subject to the requirements of this policy.

b) A medication(s) used outside the standard for a patient or situation, or use of a medication not medically necessary but used for patient discipline or caregiver convenience, is considered a restraint and is subject to the requirement of this policy.

c) The application of physical force to hold a patient, in order to administer a medication against the patient’s wishes, is considered restraint. The patient has a right to be free from restraints and, in accordance with 482-13(b)(2), also has a right to refuse medications, unless a court has ordered medication treatment. A court order for medication treatment only removes the patient’s right to refuse the medication.

d) Some patients may be medicated against their will in certain emergency circumstances. However, regardless if the medication is court ordered or being administered in an emergency situation, the caregiver is expected to use the least restrictive method of administering the medication to avoid or reduce the use of force when possible. The use of force in order to medicate a patient, as with other restraint, MUST HAVE a physician order prior to the application of the restraint or use of force. If physical holding for forced medication is necessary with a violent patient, the 1-hour face-to-face evaluation by the physician requirement applies.

Physical Restraint: Any manual or physical or mechanical device, material, or equipment attached or adjacent to the patient’s body that he or she cannot easily remove that restricts freedom of movement or normal access to one’s body.

Safety Intervention: Any intervention meant to maintain the safety and well-being of the patient and others.

Seclusion: The involuntary confinement of a person intentionally isolating them from others in a room or in areas where the person is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior. **Seclusion is only permitted on Psychiatric or Behavioral Health units or as otherwise permitted by law.** (See Appendix B)
**Side Rail:** A side rail is considered a restraint if it is intentionally used to restrict the patient’s freedom of movement and is not easily lowered by the patient. The use of side rails, as a sole means of restraint, will not be utilized. In beds with split rails, the top two rails may be raised to facilitate the patient’s self-movement and to use bed controls, the call light and television controls without being considered as restraint items. A limited number of ICU beds are in use where the middle bed rails, not the top rails, contain the bed controls.

When side rails are used to protect the patient from falling out of bed (e.g., side rails on a stretcher or low air loss bed) or to protect the patient from harm (e.g., use of padded side rails with seizure precautions), side rails are not considered a restraint.

**Sitter or Observer:** A sitter/observer is a caregiver who sits with the patient and is trained and competent in observation and restraint use.

**Timeout:** A procedure used to assist the individual to regain emotional control by removing the individual to a quiet area of an unlocked quiet room. Use of time out is limited to no more than 30 minutes and is consistent with the patient’s treatment plan. Time out is not considered seclusion (JC PC 01.03.03).

### 4. POLICY:

4.1 Restraints or seclusion are used only when necessary to protect the immediate physical safety of the patient, caregivers or others.

4.2 All patients have the right to be free from restraints that are not medically necessary or that are used by caregivers as a means of coercion, discipline, convenience or retaliation.

4.3 A caregiver uses restraints or seclusion based on the assessed needs of the patient and only when less restrictive interventions are ineffective.

4.4 The caregiver uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, caregivers or others.

4.5 The caregiver discontinues restraints or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.

4.6 If a patient with restraints is transported to another area or department for treatment, monitoring and documentation of restraint use will continue. The patient’s nurse shall be notified when the patient is returned to his or her room.

4.7 The caregiver will document the use of restraints or seclusion in the electronic health record in accordance with the guidelines established in the procedure.

4.8 Hospitals must report deaths associated with the use of seclusion or restraint. Each Aurora hospital will have a consistent process for internally identifying patient deaths and evaluating whether the death is associated with the use of seclusion or restraint.
4.9 The Wisconsin Department of Health and Social Services, Division of Community Services will be notified by the facility within 24 hours after the death of a patient, or learning of a death if there is cause to believe that the death was related to:
   i. The use of a physical restraint or seclusion
   ii. The use of one or more psychotropic medications

4.10 In addition, the Incident Reporting/Sentinel Event Management policy (#166) would be followed any time a patient’s death is believed to be caused by the use of restraint and/or seclusion.

4.11 Direct patient caregivers will be trained and demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment and providing care for a patient in restraint or seclusion before performing any action. Site-specific training will be provided upon hire and on a periodic basis thereafter; training will be documented and records maintained. (See Appendix A)

5. PROCEDURE

<table>
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<tr>
<th>Use of Restraints for Acute Medical and Post-Surgical Care</th>
<th>Emergency Use of Restraints to Control the Behavior of Patients Who Are In Imminent Danger of Severely Injuring Themselves or Others</th>
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5.1 Evaluation of Criteria for Restraints:
A comprehensive assessment of the patient must determine that the risk associated with the use of the restraint is outweighed by the risk of not using the restraint. Less restrictive interventions do not always need to be tried but less restrictive interventions must be determined by the caregiver to be ineffective to protect the patient from harm prior to the introduction of more restrictive measures. Alternatives attempted or the rationale for not using alternatives must be documented in the electronic health record (EHR).

Restraints may be necessary if a patient’s treatment or regimen of care requires immobility to aid in therapy or healing. Under these circumstances, restraints may be used only if needed to improve the patient’s safety and well-being after other safety/less-restrictive interventions have been considered or tried and determined to be ineffective.

Take into consideration information learned from the initial assessment upon admission which, may identify techniques, methods, or tools that would help the patient control his or her behavior or identify any history of

5.1 Evaluation of Criteria for Restraints:
A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint or seclusion is outweighed by the risk of not using the restraint or seclusion. Less restrictive interventions do not always need to be tried but less restrictive interventions must be determined by the caregiver to be ineffective to protect the patient or others from harm prior to the introduction of more restrictive measures. Alternatives attempted or the rationale for not using alternatives must be documented in the electronic health record (EHR).

Restraints may be necessary when a patient is demonstrating aggressive or violent behavior and is in imminent danger of severely harming or injuring himself or herself or others. Under these circumstances, restraints may be used to ensure the physical safety and well-being of the patient/others only after other safety/less-restrictive interventions have been considered or tried and determined to be ineffective.

Take into consideration information learned from the initial assessment upon admission which, may identify techniques, methods, or tools that would help the patient control his or her behavior or identify any history of
physical or sexual abuse that would place that patient at greater risk during restraint. Caregivers will assess for and tailor interventions to meet the individual patient’s needs after weighting factors such as the patient’s condition, behaviors, history and environmental factors.

Contraindications to the use of restraint may include any medical or psychiatric condition that could be exacerbated by its use (e.g., fractured or burned extremities, acute confusion, delirium or claustrophobia) or physical disabilities and limitations that would place the patient at greater risk during restraint (Segaore & Adams, 2001).

5.2 Initiation of Restraints Prior to Obtaining an Order
If an emergency situation exists and the LIP is not available to issue an order, the Registered Nurse may initiate the use of restraints as long as the patient’s physician or other licensed practitioner who is responsible for the care of the patient is contacted immediately (within 5 minutes after the restraint is applied) and an order is obtained. The order may be a verbal order and the LIP issuing the order need not be the patient’s attending physician.

A Registered Nurse who initiates restraints prior to obtaining a restraint order must document in the patient’s EHR any alternative interventions that were tried and the reasons that support the application of the restraints (see Evaluation of Criteria for Restraints section).

5.3 Restraint Orders
- Restraint orders shall be documented in the EHR
- Never be written as a standing order or on an “as needed basis” (prn)
- Be obtained prior to the use of restraint(s) whenever possible.
- Include the date, time of the order, the reason for the restraint(s), the type(s) of restraint(s) authorized for use and the duration of the order
- If authorized by a LIP other than the patient’s attending physician, consultation with the patient’s attending physician should occur as soon as possible

physical or sexual abuse that would place that patient at greater risk during restraint. Caregivers will assess for and tailor interventions to meet the individual patient’s needs after weighting factors such as the patient’s condition, behaviors, history and environmental factors.

Contraindications to the use of restraint may include any medical or psychiatric condition that could be exacerbated by its use (e.g., fractured or burned extremities, acute confusion, delirium or claustrophobia) or physical disabilities and limitations that would place the patient at greater risk during restraint.

Seclusion is only permitted for patients on a behavioral health or psychiatric unit. See Appendix B for use of seclusion on a Behavioral Health or Psychiatric unit.

5.2 Initiation of Restraints Prior to Obtaining an Order
If an emergency situation exists and a physician is not available to issue an order, the Registered Nurse may initiate the use of restraints as long as the patient’s physician or other licensed practitioner who is responsible for the care of the patient is contacted immediately (within 5 minutes after the restraint is applied) and an order is obtained. The order may be a verbal order and the LIP issuing the order need not be the patient’s attending physician.

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- Never be written as a standing order or on an “as needed basis” (prn)
- Be obtained prior to the use of restraint(s) whenever possible.
- Include the date, time of the order, the reason for the restraint(s), the type(s) of restraint(s) authorized for use and the duration of the order
- If authorized by a LIP other than the patient’s attending physician, consultation with the patient’s attending physician should occur as soon as possible
- Be implemented at the least restrictive level possible while maintaining the patient’s safety and well-being.
- Be accompanied by modification to the patient’s plan of care.

### 5.4 Physician/LIP Evaluation

The attending physician or other practitioner that is responsible for the patient:
- Must perform a face-to-face evaluation within one hour of restraint initiation even if the patient has been released from restraints prior to the expiration of the one-hour time period. During the evaluation the physician/LIP will assess and evaluate:
  - (A) The patient’s immediate situation
  - (B) The patient’s reaction to the intervention
  - (C) The patient’s medical and behavioral condition
  - (D) The need to continue or terminate the restraint or seclusion.

  - Face-to-face evaluation may not be completed by an eICU provider or via telemedicine venue.
  - The physician or LIP must see the patient and conduct a face-to-face reevaluation at least
    a) every 8 hours for patients ages 18 years and older
    b) every 4 hours for patients ages 17 and younger.
  - The initial and the subsequent in-person evaluation by the physician/LIP is documented in the health record and must include a reassessment of the patient’s immediate situation, the patient’s reaction to interventions, the patient’s medical and behavioral condition, and the need to continue to terminate the restraint or seclusion.
  - If the attending physician is not the LIP who gives the order, the attending physician is notified as soon as possible of the patient’s status if the restraint is continued and to complete the evaluations at the appropriate intervals.

### 5.5 Restraint Order Renewal

- The physician/LIP will renew a restraint order daily if restraints are still needed.

  - Each restraint order may be renewed based on the following limits for up to a total of 24 hours.
  - 4 hours for adults 18 years of age or older
  - 2 hours for children and adolescents ages 9 years to 17 years
  - 1 hour for children under the age of 9 years

  If restraints are continued for longer than 24 hours, the physician must renew the orders using the same specified timeframes.
5.6 Nursing Intervention

Only a Registered Nurse may perform an assessment and evaluation of the individual needs of the patient. The plan of care and nursing interventions/actions will be developed and implemented based upon that assessment. The Registered Nurse will:

- Indicate the rationale for the initiation of or ongoing use of restraint based on the patient's orientation and mental status
- Determine the appropriateness of the restraint type at the least restrictive level possible, based upon the patient's safety needs and well-being
- Determine the eligibility of the patient for release from restraint based on release criteria
  - Initiate patient and/or family teaching (as appropriate) as soon as possible related to the restraint experience

Nursing assessments should be performed at initiation and at intervals based upon the patient's condition and needs.

Nursing interventions shall consist of:

- Less restrictive safety interventions utilized
- Proper and safe application of the restraint(s)
- Maintenance of the patient’s safety, well-being, and dignity while in restraints
- Patient’s physical and psychological response to the use of restraint
- Effectiveness of the restraint on the patient
- Ongoing patient/family teaching related to the restraint experience

For example, a nurse may obtain a verbal order to continue a restraint on an adult after four hours. When the physician does a face-to-face evaluation after 8 hours, the physician will write new orders. When the original order is about to expire, the nurse may telephone the LIP, report the results of his or her most recent assessment, and request that the original order be renewed for another period of time in accordance with the above described time limits, based on the patient’s age.

5.6 Nursing Intervention

A face-to-face assessment of the patient evaluating the continued use of restraints must be documented at the specified intervals

a) every 8 hours for patients ages 18 years and older
b) Every 4 hours for patients ages 17 and younger.

Nursing assessments should be performed at initiation and at intervals based upon the patient’s condition and needs.

Nursing interventions shall consist of:

- Less restrictive safety interventions utilized
- Proper and safe application of the restraint(s)
- Maintenance of patients’ safety, well-being and dignity while in restraints
- Patient’s physical and psychological response to the use of restraint
- Effectiveness of the restraint on the patient
- Ongoing patient/family teaching related to the restraint experience
- Patient’s family notified promptly of the initiation of restraint(s) when appropriate.

- Ongoing observation data

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<th>5.7 Observation</th>
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<td>Any caregiver member who has received appropriate training in restraint use as determined by Aurora Health Care may observe a restrained patient.</td>
<td>Any caregiver member who has demonstrated competency in restraint use as determined by Aurora Health Care may observe a restrained patient.</td>
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Patients with all extremities restrained must be continuously observed.

The following checks and activities must be performed providing assistance to the patient as needed:

**Every 2 hours:**
- Peripheral vascular/neurological checks including color, temperature, sensation, motion under and distal to the restraint
- ROM and positioning
- Hydration, toileting, and nutritional needs of the patient while awake.
- Integument check under and distal to restraint
- Evaluate the patient’s physical and psychological response to the restraint.
- Evaluate for proper and safe application of the restraint
- Assesses for appropriateness and effectiveness of the restraint
- Evaluate readiness for discontinuation of restraint.

Observation intervals should be based on the patient’s condition and needs and may not exceed the specified time frames.

If a patient is restrained, he or she must be monitored by direct observation on a continual basis.

If the patient is in a safety hold a second caregiver person is assigned to observe the patient. Only specially trained caregiver may use a safety hold.

The following checks and activities will be performed as appropriate to the type of restraint/seclusion and patient’s condition providing assistance to the patient as needed:

**Upon Initiation of Restraints:**
- Assess circulation in the restrained extremity(s)
- Confirm the restraints are applied correctly and are secure.

**Every 15 minutes:**
- Evaluate the patient’s physical and psychological response to the restraint.
- Evaluate readiness for discontinuation of restraint.

**Every 2 hours:**
- Peripheral vascular/neurological checks including color, temperature, sensation, motion under and distal to the restraint
- ROM and positioning
- Hydration, toileting, and nutritional needs of the patient while awake.
- Integument check under and distal to restraint
- Evaluate the patient’s physical and psychological response to the restraint.
- Evaluate for proper and safe application of the restraint
- Assesses for appropriateness and effectiveness of the restraint
- Check vital signs as appropriate to patient condition and type of restraint

Observation intervals should be based on the patient’s condition and needs and may not exceed the specified time frames.
5.8 Release Criteria (as determined by a LIP or Registered Nurse):

Each restraint device should be removed at the earliest possible time while maintaining the patient’s safety and well-being.

Registered Nurse will assess for patient behaviors to discontinue restraints against the behavioral criteria specified in the physician order.

The patient must be informed of the restraint release criteria upon initiation of restraint and throughout the duration of the episode.

If the patient was released from restraints and returns to the condition or status, which initially required restraint, a new LIP order must be obtained prior to the reapplication of restraints.

5.9 Documentation

The Registered Nurse will document in the patient’s EHR upon restraint initiation, as assessments and/or interventions are performed, and upon discontinuation of restraint(s).

Documentation shall include at a minimum:
- Factors contributing to reason for restraint
- Safety assessment which includes patient’s orientation and mental status
- Least restrictive safety interventions attempted prior to application of restraint
- Justification for or reason to apply restraints
- Restraint device(s) utilized
- Notification of the patient’s family when appropriate
- Patient and/or family teaching (as appropriate) related to the restraint episode
- Notification of the attending physician if the attending physician did not order the restraint or seclusion
- Patient’s physical and psychological response to the use of restraint.
- Modifications to the Nursing Plan of Care (Inpatient only)
- Results of patient monitoring: Assessment findings, interventions, and observations
- Significant changes in the patient’s condition
- Any assistance provided to the patient to meet the release criteria

Debriefing (if restraint or seclusion is used in a Behavioral Health or psychiatric unit, see Appendix B)
5.10 **Procedure for Death reporting requirements for CMS:**

a) The Site Manager/Risk Manager/Quality Manager or Designee must report deaths associated with the use of seclusion or restraints to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient’s death:

   i. Each death that occurs while a patient is in restraint or seclusion.

   ii. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

   iii. Each death known to the hospital that occurs within 7 days after restraint or seclusion where it is reasonable to assume that use of the restraint or placement in seclusion contributed directly or indirectly to a patient’s death, regardless of the type(s) of restraint used on the patient during this time. “Reasonable to assume” in this context includes, but is not limited to, deaths due to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

b) **Exceptions to Death Reporting to CMS** exists when no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient’s wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials. The hospital staff must record the following in an internal log or other system.

   i. Any death that occurs while a patient is in such restraints.

   ii. Any death that occurs within 24 hours after a patient has been removed from such restraints.

c) The individual reporting the death to CMS must document in the patient’s EHR the following information:

   i. Date and time the death that was reported to CMS (as described in 5.3) OR

   ii. The time the death was recorded in the internal log or other system for deaths that are determined to be an exception

d) Entries into the internal log or other system must be documented as follows:

   i. Each entry must be made no later than 7 days after the date of the patient’s death.

   ii. Each entry must document the patient’s name, date of birth, date of death, name of attending physician or other LIP who is responsible for the care of the patient, medical record number, and primary diagnosis(es).

   iii. The information must be made available in written or electronic format to CMS immediately upon request.

5.11 **Notification of Clinical Leadership of patients with Violent/Self-destructive behavior in restraints/seclusion**

a) Clinical leadership must be notified immediately of any instance in which a patient remains in restraint or seclusion for more than 12 hours or, experiences two or more episodes of any duration within 12 hours.

b) Thereafter, the leadership is notified every 24 hours if either of the above conditions continues.
5.12 Guidelines for Staff/Caregiver Education: (see Appendix A)

   a) All caregivers that provide direct patient care will participate in education and training that includes the topics required by CMS.

   b) Training and competency assessment will occur upon hire, before applying restraints or seclusion for the first time, and periodically on an as needed basis.

   c) The goal of caregiver education is to promote the minimal use of restraints and patient/caregiver safety if restraints are in use.

   d) Individuals providing caregiver training must be qualified as evidenced by education, training, and experience in techniques used to address patients’ behaviors.

   e) Physicians and other LIPs authorized to order restraints and/or seclusion must have a working knowledge of the hospital policy. All medical staff members should be educated on the restraint policy and documentation of the required training will be maintained in the medical staff member’s credentials file. Staff providing education to physicians/LIPs will document the education provided and who completed the required education.

   f) The hospital must maintain documentation in caregiver personnel records that the training and demonstration of competency were successfully completed.
## RESTRAINTS

**CROSS REFERENCES:**
- Patients Under Legal/Correctional Restrictions (ABMC PC-141)
- Care of Prisoner Patients (AMC-O Policy)
- Reportable Deaths (Metro #454)
- Incident Reporting/Sentinel Event Management (#166)
- Disclosure of Unanticipated Outcomes (#146)
- Therapeutic Holds (APH #CC-250)
- Seclusion and Restraint (APH CC-230)

**REFERENCES:**

- Joint Commission on Accreditation of Hospitals and Organizations 2015:
  - Standards PC.03.05.01, PC.03.05.03, PC.03.05.05, PC.03.05.07, PC.03.05.09, PC.03.05.11, PC.03.05.15, PC.03.05.17, and PC.03.05.19; CTS 05.05.17, 05.05.19, CTS 05.06.31.
  - andRC.02.01.05
Appendix A

Training Topics Required by CMS Regulations

1. Techniques for Nonphysical Interventions
2. Tailoring interventions to patient’s condition, behaviors, history, and environmental factors
3. Identification and implementation of applicable Least Restrictive interventions
4. Safe use of all types of restraints or seclusion
5. Recognition of and response to patient physical and psychological distress
6. Ability to recognize patient behavioral changes that signal when use of restraints or seclusion can be discontinued
7. Competency of caregiver to monitor the physical and psychological well-being of the patient
8. Caregiver’s competency to recognize changes in respiratory and circulatory status, skin integrity, vital signs due to restraint or seclusion use
9. Required components of a face-to-face evaluation
10. Use of first aid techniques and CPR certification tailored to scenarios associated with use of restraints or seclusion
11. Competency assessment of the caregiver and documentation of education completion
Appendix B
Behavioral Health Procedures: Seclusion, Safety Holds, and Debriefing

THIS APPENDIX APPLIES ONLY TO PATIENTS ON A BEHAVIORAL HEALTH OR PSYCHIATRIC UNIT WHO ARE RECEIVING TREATMENT FOR A MENTAL HEALTH CONDITION, ALCOHOL OR DRUG ABUSE, OR A DEVELOPMENTAL DISABILITY.

1. Seclusion is only permitted for patients on a behavioral health or psychiatric unit. Additional guidelines apply to the use seclusion on a Behavioral Health or Psychiatric Unit.
   a) Seclusion Guidelines:
      i. Seclusion should be removed at the earliest possible time while maintaining the patient’s safety and well-being.
      ii. Patients may be released from seclusion when the initial behavior or condition, which led to the seclusion, has subsided to a degree where seclusion is no longer needed.
      iii. The patient must be informed of the seclusion release criteria upon initiation and throughout the duration of the episode.
      iv. If a patient is released from seclusion prior to the expiration of the order and he or she then returns to the condition or status, which initially required the use of seclusion, a new order must be obtained prior to the reapplication of seclusion.
      v. Documentation to support the decision for seclusion release or reduction must be noted in the patient’s EHR.
      vi. Direct observation shall involve face-to-face monitoring or continuous ongoing observation by audio or video equipment, which is in close proximity to the patient.
   b) Monitoring of the Secluded patient:
      i. Seclusion will only be permitted on a psychiatric or behavioral health unit that has caregiver qualified to assess, monitor, and manage a secluded patient.
      ii. Any caregiver member who has demonstrated competency in restraints or as applicable, seclusion use as defined by Aurora Health Care may observe a restrained or secluded patient.
      iii. If restraints are used simultaneously with seclusion, the patient must be continuously observed face-to-face by an assigned, trained, and competent caregiver.
      iv. After the first hour of observation, a patient in seclusion only may be continuously monitored by trained caregiver using simultaneous video and audio equipment.

2. Safety Hold with Pediatrics patient:
   i. Qualified caregivers will initiate a safety hold and use for no more than 15 minutes. After 15 minutes, the hold is discontinued or restraints are applied.
   ii. See also Therapeutic Holds Policy (APH #CC-250) for guidance on the use of safety holds.

3. Debriefing following Restraint/Seclusion Use
   a) Debriefing is used to:
      i. Identify what led to the incident
      ii. Ascertained that the patient’s physical and psychological well-being, comfort, and right to privacy were addressed
iii. Counsel the patient involved for any trauma that may have resulted from the incident
iv. Modify the patient’s treatment plan when indicated

b) Debriefing, if indicated, is important in reducing the use of restraints or seclusion. It should occur as soon as possible, but no longer than 24 hours following the episode.

c) Debriefing should include (as appropriate) the patient, the patient’s family, and any caregiver who was involved in the episode.