RESTRAINTS

I. PURPOSE:

To standardize and communicate to all Aurora Health Care (AHC) facilities 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 will be 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 alternatives are provided by the interdisciplinary team. This goal for restraint and seclusion use is in alignment with the provision of a safe environment for patients and staff.

II. SCOPE:

This policy applies to Aurora Health Care, Inc. and any entity or facility owned, in whole or in part, or controlled by Aurora Health Care.

III. 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 healthcare staff 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, staff 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 posturally support the patient.

Assessment: The action of a Registered Nurse to perform an assessment and evaluation of the individual needs of the patient and to develop a plan of care and action based upon that assessment.

Attending Physician/LIP: A Licensed Independent Practitioner (LIP), or his designee or covering 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 is defined as an instance where the 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): An individual who is permitted by law and by the health care organization in which he or she practices to provide patient care services without direction or supervision, within the scope of the individual’s license, and in accordance with individually granted clinical privileges.

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 method, either physical or chemical, used with the intent to restrict a patient’s movement, including seclusion, physical activity, or normal access to his or her body that (1) is not a usual and customary part of a medical diagnostic or treatment procedure to which the patient or his or her legal representative has consented, (2) is not indicated to treat the patient’s medical condition or symptoms, or (3) does not promote the patient’s independent functions.

Chemical Restraint: Any medication used with the intent to control behavior or to restrict the patient’s freedom of movement and is not standard treatment or dosage for the patient’s diagnosed medical or psychiatric condition. The medications that comprise the patient’s regular medical regimen are not considered chemical restraints, even if their purpose is to control ongoing behavior.

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 is only permitted on Psychiatric or Behavioral Health units.
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.

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).

IV. POLICY STATEMENTS:

A. Restraints or seclusion are used only to protect the immediate physical safety of the patient, staff or others.

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

C. The staff uses restraints or seclusion based on the assessed needs of the patient and only when less restrictive interventions are ineffective.

D. The staff uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff or others.

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

F. Direct patient caregivers that may apply restraints and/or seclusion will be trained and their competency will be assessed and documented during orientation, before participating in the use of restraints/seclusion, and on a periodic basis thereafter.

G. 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.

H. The staff will document the use of restraints or seclusion in the electronic health record (e.g., Cerner or EPIC) in accordance with the guidelines established in the procedure.

I. Notification of Injury or Death

In the event of injury or death of a patient while the patient is in restraints, the unit manager or clinical coordinator/shift supervisor will immediately notify the Site Administrator, Risk Management and Quality Management.

The Site Manager/Risk Manager/Quality Manager/Designee must report the following information to:

1. CMS
   - Each death that occurs while a patient is in restraint or seclusion
   - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
   - Each death known to the hospital that occurs 1 week after restraint or seclusion where it is reasonable to assume that restraint/seclusion contributed directly or indirectly to the patient death

Each death referenced must be reported to CMS by telephone no later than the close of business the next business day following the knowledge of the patient’s death.
The individual reporting the death to CMS must document in the patient’s medical record the date and time the death was reported to CMS.

2. WI Department of Health and Social Services, Division of Quality Assurance: will be notified by the facility within 24 hours after the death of a client, or learning of a death if there is cause to believe that the death was related to:
   - The use of a physical restraint or seclusion
   - The use of one or more psychotropic medications

In addition, the Sentinel Event policy (refer to System Policy #166: Sentinel / Significant Event) would be followed any time a patient’s death is believed to be caused by the use of restraint and/or seclusion.

V. EXCEPTIONS TO THIS POLICY: This policy does not apply:

A. To restraint use 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 and identified patient need.

C. To comforting of children or to a timeout when its use is consistent with the patient’s treatment plan.

D. To the 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. To the 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 not part of this policy.

IV. PROCEDURE

| A. Use of Restraints for Acute Medical and Post-Surgical Care (Nonviolent/Non self destructive) | B. Emergency Use of Restraints to Control the Behavior of Patients Who Are In Imminent Danger of Severely Injuring Themselves or Others (Violent/Self Destructive) |
| Evaluation of Criteria for Restraints: | Evaluation of Criteria for Restraints: |
| The use of 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. | Restraints may be used 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 | 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 |
A. Use of Restraints for Acute Medical and Post-Surgical Care (Nonviolent/Non self destructive)

that patient at greater risk during restraint.

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). The risks associated with using restraints must be weighed against the risk to the patient’s safety and well being if restraints are not used.

Initiation of Restraints Prior to Obtaining an Order

If an LIP is not available to issue an order and a Registered Nurse determines that the criteria identified above have been met, the Registered Nurse may initiate the use of restraints so long as the patient’s attending LIP is contacted immediately 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 LIP.

A Registered Nurse who initiates restraints prior to obtaining a LIP order must document in the patient’s medical record the alternative interventions that were tried and the reasons that support the determination that the restraint criteria (see above) were met.

LIP Orders

- 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. Consultation with the patient’s attending LIP should occur if the order was authorized by a LIP other than the patient’s attending LIP.
- Be implemented at the least restrictive level possible while maintaining the patient’s safety and well-being.
- Be accompanied by a written modification to the patient’s plan of care.
- Be renewed if necessary, each day, following an examination by the LIP.

B. Emergency Use of Restraints to Control the Behavior of Patients Who Are In Imminent Danger of Severely Injuring Themselves or Others (Violent/Self Destructive)

abuse that would place that patient at greater risk during restraint.

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 or claustrophobia) or physical disabilities and limitations that would place the patient at greater risk during restraint. The risks associated with using restraints must be weighed against the risk to the patient’s safety and well being if restraints are not used.

Seclusion is only permitted for patients on a behavioral health or psychiatric unit.

Refer to Section VIII, A through D for use of seclusion on a Behavioral Health or Psychiatric unit.

Initiation of Restraints Prior to Obtaining a LIP Order

If an LIP is not available to issue an order and a Registered Nurse determines that the criteria identified above have been met, the Registered Nurse may initiate the use of restraints so long as the patient’s attending LIP is contacted immediately 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 LIP.

A Registered Nurse who initiates restraints prior to obtaining a LIP order must document in the patient’s medical record the facts supporting his or her determination that the restraint criteria (see above) have been met.

LIP Orders

- 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. Consultation with the patient’s attending LIP should occur if the order was authorized by a LIP other than the patient’s attending LIP.
- Be implemented at the least restrictive level possible while maintaining the patient’s safety and well-being.
- Be accompanied by a written modification to the patient’s plan of care.
- Be limited in duration to:
  - 4 hours for adults
  - 2 hours for children and adolescents ages 9 years to
<table>
<thead>
<tr>
<th>A. Use of Restraints for Acute Medical and Post-Surgical Care (Nonviolent/Non self destructive)</th>
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| 17 years  
1 hour for children under the age of 9 years | An LIP order is time limited and renewal of orders is required for continuation of restraints every:  
4 hours for adults  
2 hours for children and adolescents ages 9 years to 17 years  
Every hour for children under the age of 9 years.  
**LIP orders to continue restraints may be renewed by telephone or after an LIP face-to-face meeting within the specified timeframes within the 24 hour period.**  
For example, a nurse may obtain a telephone order to continue a restraint on an adult after four hours. When the LIP does a face-to-face evaluation after 8 hours, the LIP 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. |
| The attending LIP must perform a daily face-to-face evaluation of the patient to assess the need for restraints and the patient’s physiological and psychological condition. | **LIP Evaluation**  
The attending LIP:  
• 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, to assess the need for restraints and the patient’s physiological and psychological condition.  
• The physician or LIP must see the patient and conduct a face-to-face reevaluation at least every 8 hours for patients ages 18 years and older and every 4 hours for patients ages 17 and younger.  
• The initial and the subsequent in-person evaluation by the LIP must include an evaluation 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 LIP is not the LIP who gives the order, the attending LIP is notified as soon as possible of the patient’s status if the restraint is continued. |
| **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 | **Nursing Intervention**  
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- Indicate the rationale for the initiation of or ongoing use of restraint based on the patient’s orientation and mental status |
### A. Use of Restraints for Acute Medical and Post-Surgical Care (Nonviolent/Non self-destructive)

- 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 (“For Your Well Being” information available)

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
- Patient’s family notified promptly of the initiation of restraint(s) when appropriate.

Observation

Any staff member who has received appropriate training in restraint use as determined by Aurora Health Care may observe a restrained patient.

Patients with all extremities restrained must be continuously observed.

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

- Observation

B. Emergency Use of Restraints to Control the Behavior of Patients Who Are In Imminent Danger of Severely Injuring Themselves or Others (Violent/Self Destructive)

- 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 (“For Your Well Being” information available)

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

Nursing interventions should be performed by a Registered Nurse and 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) or seclusion when appropriate.
- Ongoing observation data

Observation

Any staff member who has demonstrated competency in restraint use as determined by Aurora Health Care may observe a restrained patient.

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

If the patient is in a physical hold a second staff person is assigned to observe the patient. Specially trained staff may only use physical hold.

Canvas body wraps may be used only on child/adolescent behavior units by specially trained staff. Patients in Canvas body wraps must be continuously observed.

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:
**A. Use of Restraints for Acute Medical and Post-Surgical Care (Nonviolent/Non self destructive)**

**Every 2 hours:**
- Peripheral vascular/neurological checks including color, temperature, sensation, motion under and distal to the restraint
- **Neurovascular status (circulation, motion, and sensation) of the extremity(s)** (Cerner language)
- ROM and positioning
- Hydration, toileting, and nutritional needs of the patient while awake.
- Integument check under and distal to restraint
- **Integument check (color, temperature and integrity) of skin under and distal to restraint device(s)** (Cerner Language)
- 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.

**Cerner specific documentation language**

**B. Emergency Use of Restraints to Control the Behavior of Patients Who Are In Imminent Danger of Severely Injuring Themselves or Others (Violent/Self Destructive)**

**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
- **Neurovascular status (circulation, motion, and sensation) of the extremity(s)** (Cerner Language)
- ROM and positioning
- Hydration, toileting, and nutritional needs of the patient while awake.
- Integument check under and distal to restraint
- **Integument check (color, temperature, and skin integrity) of skin under and distal to restraint device(s)** (Cerner Language)
- 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.

**Cerner specific documentation language**

**Release Criteria (as determined by an 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.

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<tr>
<td>Documentation</td>
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<td>➢ Notification of the patient’s family when appropriate</td>
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<td>➢ Patient and/or family teaching (as appropriate) related to the restraint episode</td>
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<td>➢ Obtain physician orders for restraint.</td>
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<td>➢ Patient’s physical and psychological response to the use of restraint.</td>
<td>➢ Patient’s physical and psychological response to the use of restraint and seclusion.</td>
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<tr>
<td>➢ Modifications to the Nursing Plan of Care</td>
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<td>➢ Results of patient monitoring: Assessment findings, interventions, and observations</td>
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<td>➢ Debriefing (if applicable)</td>
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VII. THIS SECTION 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.

A. 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.

B. Monitoring of the Secluded patient:
1. Seclusion will only be permitted on a psychiatric or behavioral health unit that has staff qualified to assess, monitor, and manage a secluded patient.
2. Any staff 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.
3. If a patient is in seclusion, he or she must be continuously observed by a competent staff member. After the first hour, a patient in seclusion only may be continuously monitored using simultaneous video and audio equipment.
4. 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.

C. Seclusion Guidelines:
1. Seclusion should be removed at the earliest possible time while maintaining the patient’s safety and well-being.
2. 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.

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

4. 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.

5. Documentation to support the decision for seclusion release or reduction must be noted in the patient’s medical record.

VIII. Debriefing

A. Debriefing is used to:
   1. Identify what led to the incident
   2. Ascertain that the patient’s physical and psychological well-being, comfort, and right to privacy were addressed
   3. Counsel the patient involved for any trauma that may have resulted from the incident
   4. 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 staff who was involved in the episode.

IX. Notification of Clinical Leadership of patients with Violent/Self-destructive behavior in restraints/seclusion

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. Thereafter, the leadership is notified every 24 hours if either of the above conditions continues.

X. Guidelines for Staff Education:

A. Staff education and training will be provided to all caregivers that provide direct patient care to patients in restraints/seclusion including initiation of restraints, assessment of use, and ongoing patient evaluation/reevaluation during restraint use.

B. The goal of staff education is to promote the minimal use of restraints and patient/staff safety if restraints are in use.

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

D. Physicians and other LIPs authorized to order restraints and/or seclusion must have a working knowledge of the hospital policy.

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

Centers for Medicare & Medicaid. (October 2008). CMS Standard 482.13 (e), 482.13 (f), and 482.13 (g) December 2006


Joint Commission on Accreditation of Hospitals and Organizations 2011: Standards PC.03.05.01 through PC.03.05.19.


Patient assessment indicates potential for use of restraint and/or seclusion.

Continue safety intervention until no longer needed.

Implement safety interventions if possible.

Continue safety intervention until no longer needed.

Safety interventions effective?

Yes

No

[NV/NSD] Interference with or jeopardizing medical management and/or treatment.

Obtain order prior to initiation

Face-to-face assessment by attending/designee within 24 hours.

Nursing assessment and observations.

Continued restraint needed?

Yes

Renew order each calendar day.

No

Reason for restraint and/or seclusion assessed.

[V/SD] Behavior placing patient and/or others in imminent danger of severe injury (emergency situation).

Obtain order prior to initiation

Face-to-face assessment by LIP within one hour

Conduct debriefing for restraint and/or seclusion episode. [For Behavioral Health only]

Notification of clinical leadership if episode lasts >12 hours or if 2 or more episodes within 12 hours and every 24 hours thereafter until restraint and/or seclusion discontinued or death of patient.

Continued restraint and/or seclusion needed?

Yes

No

Nursing assessment and continuous observation required

Renew original order by telephone X 1. Further orders require face-to-face assessment by LIP. Time limited orders:

4 hours – age >17
2 hours – age 9 to 17
1 hour – age <9

In the event of injury or death of a patient while the patient is in restraints, or has been in restraints the previous 7 days, the unit manager or clinical coordinator/shift supervisor will immediately notify the Site Administrator, Risk Management and Quality Management.

RERAINTS #2004