Policy & Procedure	ID No.	3012
Subject: Restraint and Seclusion	Category:	Provision of Care, Treatment & Services
Policy Scope: AtlantiCare Regional Medical Center	Department:	General

POLICY

It is the philosophy and commitment of the AtlantiCare Regional Medical Center (ARMC) to support the rights of the patient to receive care in a safe setting. The safety of the patient, staff, or others is the basis for initiating and discontinuing the use of restraint or seclusion. Each patient has the right to be free from all forms of abuse and corporal punishment. Each patient has the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may not be used unless the use of restraint or seclusion is necessary to ensure the immediate physical safety of the patient, a staff member, or others. The use of restraint or seclusion must be discontinued as soon as possible based on an individualized patient assessment and re-evaluation.

It is the policy of the ARMC to explore ways to prevent, reduce, and eliminate the use of restraint or seclusion through evidence-based process improvements and the promotion of an environment that supports only limited and appropriately justified clinical use of restraint or seclusion while preserving the safety, dignity, rights, and well-being of the patient.
Restraint or seclusion is implemented when less restrictive interventions are ineffective to protect the patient or others from harm. The use of restraint or seclusion is discontinued as soon as possible based on an individual patient assessment and re-evaluation. The use of restraint or seclusion protects the patient's health and safety and preserves the patient's right to make informed decisions regarding their medical care. Restraint or seclusion will not be used for discipline, coercion, corporal punishment, convenience, and/or retaliation.

When restraints are deemed necessary:

1. Each patient will be respected as an individual
2. Staff will monitor and meet the patient's needs while in restraints
3. Staff will reassess and encourage release from restraints
4. The patient and family will be encouraged to participate in care and receive education as appropriate
5. Safe application and discontinuation of restraints by qualified staff authorized to do so and whose competencies have been validated

ARMC leadership is responsible for creating a culture supporting a patient's right to be free from restraint or seclusion. ARMC leadership ensures systems and processes are developed, implemented, and evaluated that support the patient's rights and eliminate the inappropriate use of restraint or seclusion. ARMC Leadership:

1. Approves the restraint policy/procedure outlining risks, prevention strategies, effective alternatives, and criteria for use, education of the patient and family, and the care of the patient in restraints.
2. Provides appropriate staffing for safe and effective use of restraint alternative(s) and restraint(s).
3. Ensure emergency medical services are always available.
4. Assures staff is trained and competent in the use of safe restraint application while respecting the patient's dignity and well-being.
5. Implement actions to ensure that restraint or seclusion is used only to ensure the physical safety of the patient, staff, and

others

6. Includes the restraint reduction plan as part of the organization's performance improvement plan.
7. Ensures staff uses an assessment process to identify warning signs of escalating potentially dangerous patient behavior and use interventions to address those behaviors when appropriate.
8. Assesses and monitors the use of restraint and seclusion.
9. Assures restraints are used in compliance with all prevailing laws, regulations, and accreditation standards.

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DEFINITIONS:

A. Restraint Categories:

1. **Violent/self-destruction**
   Utilized due to an unexpected outburst of severely aggressive, destructive, or violent behavior that jeopardizes the immediate physical safety of the patient, staff member or others. Used as an emergency measure.
2. **Non-violent/non self-destructive/medical support**
   Utilized to limit mobility, avoid treatment interruptions, or enable interventions, to promote healing, and improve the patient's well-being.

B. Restraint

Direct application of any manual methods, physical or mechanical devices, or human, material, or equipment with or without the patient's permission, that immobilizes, restricts access, or reduces the ability of a patient to move his/her arm, legs, body, or head freely

C. Medication used to manage behavior

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. This is used in emergency situations only.

D. Hold

A hold is considered a restraint when the patient's movement is restricted against their will (when his/her behavior is a danger to themselves or others). Brief physical holding of a patient for the purposes of conducting routine physical examinations, tests, or treatments, or to protect the patient from falling out of bed, or to permit the patient to participate in activities is not considered a restraint.

E. Seclusion

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 management of violent or self-destructive behavior.

F. Safety Intervention

Any intervention meant to maintain the safety and well-being of the patient. Use of Medication as a part of a patients standard medical or psychiatric treatment-is not a restraint

G. Observation

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

H. Behavioral Health Timeout

An intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not prevented from leaving and is not considered seclusion.

I. Licensed Practitioner

A physician or other authorized licensed practitioner responsible for the patient's care orders the use of restraints or seclusion in accordance with hospital policy, medical bylaws, law, and regulation.

J. Restraint-Free Alternatives

Any acceptable methods or means, keeping a patient and others safe and free from injury, does not restrict freedom of movement and which the patient can easily remove, i.e., 1:1 or close staff observation, changing or eliminating troublesome treatments, environmental manipulations, or diversionary physical activities. Alternative interventions must be considered/attempted prior to the use of restraint or seclusion and found to be ineffective in protecting the patient from harm.

K. AtlantiCare

Defined as all affiliated companies of the AtlantiCare Health System, including its joint ventures operating under the AtlantiCare trademark, and captive professional services corporations such as AtlantiCare Physicians Group.

I. EXCEPTIONS TO RESTRAINTS:

A. 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).

B. Voluntary Mechanical Support - A voluntary mechanical support used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such support is not considered a restraint. Examples include:

Examples Voluntary Mechanical Support	
Surgical Positioning	Protective Helmets
Arm board during intravenous	Papoose boards for the insertion of
Radiotherapy procedures	Neck braces
Back braces	Leg braces
Protection of surgical and treatment sites in pediatric patients	Orthopedically prescribed devices
Surgical dressings	Dressings or bandages

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

D. 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. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint, and all the requirements would apply.

E. SIDE RAIL EXCEPTIONS:

All side rails up are not considered restraints in the following:

1. Stretcher use
2. During transport
3. Seizure precautions

4. Sedated
5. Involuntary movements
6. If one of the side-rails is down or partially down - a lower rail (the partially down rail is placed in such a way to allow room for the patient to exit the bed and hold onto the rails as support) this is not considered a restraint.
7. Certain therapeutic beds – beds that rotate to prevent skin breakdown require side-rails to be up and are not considered a restraint.
8. Recovery from anesthesia - that occurs when the patient is in a critical care or post anesthesia care unit is considered part of the surgical procedure; medically necessary restraint use in this setting would not need to meet the requirement of the regulation.

II. SPECIAL POPULATION CONSIDERATIONS

A. Age or developmentally appropriate protective safety interventions - Age or developmentally appropriate protective safety interventions that a safety-conscious childcare provider outside a health care setting would utilize to protect an infant, toddler, or preschool-age child would not be considered restraint or seclusion. Examples of these would be strollers, safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers.

B. Forensic and Correction Restrictions – 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 not governed by this rule. The use of such devices are considered law enforcement 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).

III. DECISION TO USE RESTRAINTS

A. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
B. The reason for restraint use, not the setting, determines which restraint standards apply.
C. The use of restraints is not determined by diagnosis but by a comprehensive individual patient assessment.
D. All efforts are made to prevent the use of violent restraints including using de-escalation techniques and alternatives to restraints. The patient and/or family as indicated will participate in describing effective de-escalation techniques.

E. Alternatives to restraint use must be judged ineffective or would cause a greater risk prior to restraint usage.

F. The least restrictive, yet effective method will be used based on the assessed needs of the patient.

G. A patient assessment must be completed by the Physician/ Licensed Practitioner or qualified Registered Nurse (RN) prior to restraint application to determine the justification for the restraint and select the appropriate restraint.

H. The assessment must be documented in the medical record and contain:

1. Rationale for use
2. Alternative, less restrictive interventions attempted/considered.

I. Restraint or seclusion may only be used while the unsafe situation continues.

J. **Vulnerable Patient Populations-** Specific attention is given to risks associated with vulnerable persons such as: those who are obese, frail, dually diagnosed; those who have medical co-morbidities, intellectual or developmental disabilities; those whose repeatedly challenging behaviors put them at risk for incomplete assessments, and those who are victims of trauma and/or abuse.

IV. TYPES OF RESTRAINTS

The type of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, staff member, or other individuals from harm. Selection is based on the patient behavior(s) documented in the medical record along with the rationale for the intervention selected. The following types of restraints are approved for use at AtlantiCare Regional Medical Center:

Non-Violent Restraints

A. Soft limb holder-wrist and/or ankle (1-4 extremity)

B. Cloth vest

C. Cloth vest + additional restraint (i.e., soft limb) will require 1:1 observer at all times

D. Chair with attached tray that patient is unable to remove

E. Four side rails in the up position

Use of all four (4) side-rails **in the up position are considered restraints** if staff are using side-rails to prevent the patient from getting out of bed (see exceptions above). **An order for restraints must be obtained and the patient monitored** as required for restraints.

F. Mitts

Violent Restraints

G. Violent restraints –Key Locks, Spit Guards

H. Holds

I. Any restraint method used to manage violent/self-harm behaviors

V. CRITERIA FOR RELEASE OF RESTRAINTS

The following is a guide to assist with decisions to remove restraints. Restraint or seclusion must be discontinued at the earliest

possible time, regardless of the length of time identified in the order.

A. Non-violent restraint use situations

1. Patient able to follow directions
2. Sleeping and/or not interfering with therapeutic intervention
3. Verbally and/or physically demonstrates safe behavior
4. Order expires

B. Violent restraint use situations

1. Patient no longer verbalizes threat to self or others
2. Sleeping patients
3. Verbally negotiates and physically demonstrates self-control and safe behavior
4. Order expires

VI. SAFETY MEASURES:

A. Restraints will be applied correctly and appropriately according to the manufacturer's recommendation by competent staff who have been trained prior to implementing restraints/seclusion.

B. Violent restraint uses 4 points unless clinically contraindicated (i.e., cast, shunt, amputee).

C. Pre-existing physical disabilities, medical conditions, and a history of sexual or physical abuse that would place the patient at greater risk during restraint or seclusion are identified, when possible, prior to application of restraints.

D. Prior to application of restraints/seclusion the patient shall be searched for possession of unsafe items that may include belts, shoestrings, and other clothing, jewelry, wallets, cigarettes, matches, lighters, medications, and sharps. These items should be removed and stored in accordance with the policy on patient belongings.

E. Ensure all smoking materials are removed from patient's access, including obtaining access from family, ~~and~~ friends, and other visitors.

F. Soft restraint straps will be secured to the bedframe not to side rails, with a quick release connection per manufacturer's instruction or a quick release knot that can be released quickly and easily in an emergency.

G. Locking Restraints - restraint keys will be readily available to enable immediate release of restraints in emergency situations.

H. Patients are restrained in a supine position, with the patient's head free to rotate and elevated whenever possible to minimize the risk of aspiration.

I. Patients on Non-invasive Positive Pressure Ventilation (NPPV) should not be restrained.

J. Do not restrain a patient in a bed with unprotected split side rails gap greater than five inches.

K. Do not cover a patient's face in a manner that would impede breathing.

L. AtlantiCare prohibits the use of restraint techniques that restrict the flow of air to the individual's lungs.

M. Clinical leaders are notified of instances where restraint use extends beyond 12 hours, or two or

more episodes are experienced within a 12-hour timeframe. Notification of clinical leadership is documented in the patient's record

N. If a patient is restrained on a stretcher, the stretcher is in low position.

VII. AUTHORIZATION AND ORDERING OF RESTRAINTS or SECLUSION

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

B. The use of restraint or seclusion must be in accordance with a written modification to the patient's plan of care.

C. The use of restraint or seclusion must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

D. The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with the medical bylaws and State law.

E. Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with 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 9 to 17 years of age
- 1 hour for children under 9 years of age

F. After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient. When the physician or licensed practitioner renews an order or writes a new order authorizing the continued use of restraint or seclusion, there must be documentation in the patient's medical record that describes the findings of the physician's or other licensed practitioners' re-evaluation supporting the continued use of restraint or seclusion.

G. When restraint or seclusion is used for the management of violent of self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others, the patient must be seen face-to-face by a licensed practitioner within 1 hour of the initiation of the intervention. Another 1-hour face-to-face patient evaluation is not required when the original order is *renewed*. A *new order* will require a face-to-face evaluation. A telephone call or telemedicine methodology is not permitted.

H. The face-to-face evaluation within 1 hour after the initiation of the intervention will include:

- The patient's immediate situation;
- The patient's reaction to the intervention;
- The patient's medical and behavioral condition; and
- The need to continue or terminate the restraint or seclusion

I. Orders for restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). Exceptions include:
   - Geri chair: If a patient requires the use of a Geri chair with the tray locked in place in order for the patient to safely be out of bed, a standing or PRN order is permitted. Given that a patient may be out of bed in a Geri chair several times a day, it is not necessary to obtain a new order each time.
   - Raised side rails: If a patient's status requires that all bedrails be raised (restraint) while the patient is in bed, a standing or PRN order is permitted. It is not necessary to obtain a new order each time the patient is returned to bed after being out of bed.
   - Repetitive self-mutilating behavior: If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyham Syndrome, and the patient engages in repetitive self-mutilating behavior, a standing or PRN order for restraint to be applied in accordance with specific parameters established in the treatment plan would be permitted. Since the use of restraints to prevent self-injury is needed for these types of rare, severe, medical and psychiatric conditions, the specific requirements (1-hour face-to-face evaluation, time-limited orders, and evaluation every 24 hours before renewal of the order) for the management of violent or self- destructive behavior do not apply.

J. The attending physician/licensed practitioner must be consulted as soon as possible if attending physician/licensed practitioner did not order the restraint or seclusion.

K. Verbal orders must be authenticated (countersigned), timed, and dated within 24 hours by the Physician/ Licensed Practitioner

L. Orders for medications used to manage behavior shall be obtained prior to the administration of the medication.

M. If a patient is removed from restraint or seclusion, a new order must be obtained prior to reapplication of restraint or seclusion. Trial releases are not permitted as the release of the patient is considered discontinuation. A temporary release that occurs to care for a patient's needs, i.e., toileting, feeding, and range of motion, is not considered a discontinuation of the intervention.

VIII. UNLICENSED ASSISTIVE PERSONNEL [Patient Care Associate (PCA), Mental Health Associate (MHA), Behavioral Health Technician (BHT), Emergency Department Technicians (EMT)] Responsibilities

Under the supervision of an RN, trained and competent unlicensed assistive personnel may be assigned the following tasks:

1. Vital signs
2. Hydration and nutrition
3. Hygiene/general care such as bathing, toileting, range of motion exercises
4. Assistance with the application or removal of restraints
5. Implementation of alternative measures
6. 1:1 observation -
   a. A PCA/Companion will be assigned to be within an arm's length of the patient and maintain direct visual sight

of patient at all times.

b. During the time that the patient is in the bathroom, the PCA/Companion will stand outside of the bathroom with the door propped open.
c. The PCA/Companion will maintain visual contact of the patient at all times.
d. The PCA/Companion will not have any other assignment during this time

IX. Violent/Self Destructive Debriefing

1. Patients in violent restraints regardless of the setting must receive a debriefing for each episode.
2. Patient and staff participate in the debriefing.
3. All involved available staff, patient, and, if appropriate, patient's family, participate in the debriefing.
4. The debriefing occurs as soon as possible but no longer than 24 hours after the episode.
   The debriefing is used to:
   a) Discuss the precipitating factors that lead to the need for restraint(s), patient's response to stressors, and alternative coping skills that could have been used.
   b) Ascertain that the physical well-being, psychological comfort, and the right to privacy were addressed.
   c) Identify what led to the incident and what could have been handled differently.
   d) Council the patient on any trauma that may have resulted from the incident.
   e) Modify the individual treatment or plan of services when indicated.
   f) Used in performance improvement activities.

X. BEHAVIORAL HEALTH UNIT ONLY - Violent/Self Destructive Restraint or seclusion after 5 p.m., during the weekend, or on a holiday

1. If the RN initiates the restraints, after 5 p.m., during the weekend, or on a holiday, the RN calls the on-call restraint resident via beeper.

XI. EQUIPMENT CLEANING PROCESS

1. After removal of restraints, use the following process:
   a. **Soft Limb Restraints:** Disposable.
   b. **Vest Restraints:** Disposable.
   c. **Locking Limb Restraints:** After each use, contact Logistics for replacement.

XII. TRAINING:

Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion
All staff that apply restraint or seclusion, monitor, assess, or otherwise provide care for patients in restraint or seclusion will have education, training, and demonstrated knowledge based on the specific needs of the patient population.

A. Training and competency assessment occurs:

1. Upon hire as part of orientation
2. Before applying restraints or seclusion for the first time
3. Annually

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

C. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
2. Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect how an individual may react to physical contact.
3. The use of nonphysical intervention skills.
4. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
5. 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).
6. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
7. 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, elimination, hygiene, and nutritional and hydration needs.
8. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
9. Understand how staff behaviors affect behaviors of patients
10. Recognition of inherent risks and untoward side effects of restraint(s) use, such as physical and psychological harm, loss of dignity, and death.
11. Release criteria.
12. Recognize when to contact a medically trained licensed practitioner or emergency medical services to

evaluate and/or treat the physical status of an individual in restraint or seclusion.

13. Emergency response system (Code Blue & MET).
14. The viewpoints of individuals who have experienced restraint or seclusion are incorporated into staff training and education to help staff better understand all aspects of restraint and seclusion. Whenever possible, individuals who have experienced restraint or seclusion contribute to the training, education curricula, and/or participate in staff training and education.

XIII. MEDICAL STAFF AND LICENSED PRACTITIONER AUTHORIZATIONS AND REQUIREMENTS

A. The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law.

B. Medical staff and Licensed Practitioners authorized to order restraint or seclusion will have a working knowledge of the restraint policy.

C. Medical staff and Licensed Practitioners will receive annual policy review and restraint education, including

1. de-escalation
2. alternatives to restraints
3. assessment requirements
4. any other pertinent information to provide safe, minimal restraint usage

XIV. PERFORMANCE IMPROVEMENT (All Restraint Settings):

The organization measures and assesses restraint or seclusion use to identify opportunities to introduce preventive strategies, investigate and implement evidence-based alternatives, and establish process improvements to reduce the risks associated with restraint or seclusion.

Episodes of restraint or seclusion are monitored at the unit/department level on an ongoing basis. Trends or performance improvement opportunities are identified and addressed through PDCA methodology.

Performance improvement is initiated at the unit/department level and reviewed by the Restraint Steering Committee and ARMC quality committees.

A. To standardize rate calculations across populations ARMC utilizes the Joint Commission Behavioral Health formula: Restraint hours/Bed day hours X 1,000. PIP and ED rates are calculated based on number of events/total patients seen x 100. These results are aggregated quarterly and used to compare usage and establish targets.

B. Particular attention shall be paid to the following:

1. Multiple instances of violent restraint or seclusion experienced by a patient within a 12-hour timeframe.
2. Number of episodes per patient.
3. Instances of restraint or seclusion that extend beyond 12 consecutive hours.

Physicians/ Licensed Practitioner's participate in measuring and assessing use of restraint and seclusion.

XV. INJURY, ADVERSE PHYSICAL IMPACT OR DEATH ASSOCIATED WITH RESTRAINT OR SECLUSION USE – REPORTING REQUIREMENTS

There are both CMS and AtlantiCare reporting requirements for any injury, adverse physical impact or death associated with the use of restraint or seclusion use.

A. Incident Reporting: It is imperative that all injuries, adverse physical impact events, and deaths associated with restraint or seclusion be entered into the AtlantiCare electronic incident reporting system. This reporting is required regardless of severity and the type of restraint used. In nursing care areas, this will be the responsibility of the primary care nurse. In other areas, it will be the responsibility of the direct care provider.

B. CMS Reporting Requirements

Hospitals must report deaths associated with the use of seclusion or restraint.

The hospital must report the following information 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 (except 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).

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

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of 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 related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation

*Within 1 week after use of restraint or seclusion where the death is known to the hospital and it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death, regardless of the type(s) of restraint used on the patient during this time.

o "Reasonable to assume" applies only to those deaths that occur on days 2-7 after restraint or seclusion has been discontinued.

o This criterion applies regardless of the type of restraint that was used on the patient. In other words, it applies to all uses of restraint or seclusion where the patient has died on days 2-7 after the restraint or seclusion was discontinued, and it is reasonable to assume the use of the restraint or seclusion contributed to the patient's death. In a case where only two-point soft wrist restraints were used and there was no seclusion, it may reasonably be presumed that the patient's death was not caused by the use of restraints.
o In cases involving death within one week after use of restraint or seclusion where the intervention may have contributed to the patient's death, it is possible that the patient's death might occur outside the hospital and that the hospital might not learn of the patient's death, or that there might be a delay in the hospital's learning of the patient's death.

(iv) Patients who expire while in seclusion or were in seclusion within 24 hours prior to expiration are CMS reportable events.

Hospitals must document in the patient's medical record the date and time each reportable death associated with the use of restraint or seclusion was reported to the CMS Regional Office. Documentation should include date and time death was reported to CMS and/or date and time death was recorded in the internal restraint log

C. Restraint Log - 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 in an internal log or other system, the following information:

1. Any death that occurs while a patient is in such restraints.
2. Any death that occurs within 24 hours after a patient has been removed from such restraints.
3. The staff must document in the patient's medical record the date and time the death was recorded in the restraint log

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

1. Each entry must be made no later than seven days after the date of death of the patient.
2. Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis(es).
3. Makes the information in the log or other system available to CMS, either electronically or in writing immediately upon request

XVI. RESPONSIBILITIES

A. Direct Care Provider Responsibilities

Any injuries that occur during the restraint or seclusion episode, as well as the treatment provided for those injuries must be documented in the patient's medical record.

1. Incident Reporting - If the use of restraint or seclusion causes or is related to any injury or any adverse physical impact, an Incident Report should be entered into the incident reporting system prior to the reporting staff member going off shift. If it is unclear whether there has been an actual adverse outcome that is associated with restraint use/seclusion, a report should be entered into the incident reporting system. A subsequent review will clarify whether there was an actual injury.
   The incident report documentation will include:
   a) The patient was in restraint and/or seclusion
   b) There was an injury
   c) Description of the injury
   d) Type of restraint being used
   e) Extent of limb restraint 1-Point, 2-Point, 3 Point, 4- Point and limb restrained
2. Notification to Management
   a) Injury/adverse physical impact -The reporter should notify their manager/designee.
   b) Death associated with restraint use - The reporter will make direct and immediate contact with the Manager/Administrative Supervisor. The Manager/Administrative Supervisor will make direct
   c) Telephonic communication to the appropriate Administrator and Risk Management

B. Manager/Designee responsibilities

The manager/designee of the unit on which the restraint episode occurred is responsible to oversee/ensure staff compliance with the reporting requirements. The manager/designee is responsible to ensure Risk Management is directly notified of any death that meets the CMS reporting requirements. The Manager/Designee is also responsible to immediately report these events to the Risk Management Department, no later than the close of business on the next business day following knowledge of the patient's death

C. The Risk Management Department responsibilities

1. The Risk Management Department is responsible for receiving reports from the Manager/Designee of CMS reportable events related to patients' deaths and restraint use. Upon review of the events, the Risk Management Department will conduct all CMS reporting.
2. The Risk Management Department is also responsible for monitoring submitted incident reports of injuries or adverse outcomes associated with restraint use. The clinical course of the patients involved in these incidents will be monitored for 7 days post injury to identify any patient expiration. If there is expiration, Risk Personnel will collaborate with clinicians to determine if the event is a CMS reportable event. If Risk Personnel determines a CMS reportable event, the Risk Manager will contact the appropriate leaders and coordinate the reporting process.

3. The reports required under §482.13(g)(1) must be submitted to the CMS Regional Office electronically at https://restraintdeathreport.gov1.qualtrics.com/jfe/form/SV_5pXmjIw2WAzto8J as determined by the Regional Office no later than close of next business day following the day in which the hospital knows of the patient's death.

D. Documentation

Chart documentation - When there is a CMS reportable event, the Risk Management department will coordinate the documentation in the patient's medical record the date and time the death(s) was reported to CMS.

XVII. ALTERNATIVES TO RESTRAINT OR SECLUSION:

Before restraint(s), alternatives must be judged ineffective or would cause a greater risk. Based on the needs of the patient, the least restrictive, yet effective method will be used.

XVIII: TABLES

See tables 1 – 13 on the following pages:

Table 1. Evaluation Criteria and Initiation of Restraints
Table 2. Physician/Licensed Practitioner Evaluation
Table 3. Nursing Care
Table 4. Plan of Care
Table 5. Observations/Interventions
Table 6. Release Criteria
Table 7. Documentation
Table 8. Plan of Care/Safety Concerns
Table 9. Restraint Reduction: Know the Risk Factors and Warning Signs
Table 10. Non-Physical Interventions
Table 11. Things to Avoid
Table 12. Plan of Care for Agitation
Table 13. Age Specific Considerations

Table 1. Evaluation Criteria and Initiation of Restraints

A. Use of Restraints for (Nonviolent/Non self-destructive – Medical Support)	B. 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 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. Review the initial assessment, which may include techniques, methods, or tools that have been effective in managing the patient's behavior. Identify any history of physical or sexual abuse, which places the patient at greater risk during restraint. A decision guide for restraint use is provided in Section III. The use of restraint/seclusion poses an inherent risk to the vulnerable population. **Initiation of Restraints Prior to Obtaining an Order** If Physician/License Practitioner is not available to issue an order and a competent Registered Nurse determines criteria identified above has been met, the Registered Nurse may initiate the use of restraints. The Physician/Licensed Practitioner is to be contacted as soon as possible and an order obtained. The order may be a verbal order. A Registered Nurse who initiates restraints prior to obtaining an order must document in the patient's medical record which alternative interventions were tried or judged ineffective and reasons to support restraint use.	**Evaluation of Criteria for Restraints** The use of restraints may be necessary when a patient is demonstrating aggressive or violent behavior and is in imminent danger of severely harming or injuring himself/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. Review the initial assessment that may include techniques, methods, or tools that have been effective in managing the patient's behavior. Identify any history of physical or sexual abuse, which places the patient at greater risk during restraint. A decision guide for restraint use is provided in Section III. The use of restraint/seclusion poses an inherent risk to the vulnerable population. **Initiation of Restraints Prior to Obtaining an Order** If Physician/ License Practitioner is not available to issue an order and a competent Registered Nurse determines criteria identified above have been met, the Registered Nurse may initiate the use of restraints. The Physician/ License Practitioner is to be contacted as soon as possible and an order obtained. The order may be a verbal order. A Registered Nurse who initiates restraints prior to obtaining an order must document in the patient's medical record which alternative interventions were tried or judged ineffective and reasons to support restraint use.

Table 2. Physician/Licensed Practitioner Evaluation

A. Use of Restraints for (Nonviolent/Non self-destructive – Medical Support)	B. Use of Restraints to Control the Behavior of Patients Who Are in Imminent Danger of Severely Injuring Themselves or Others (Violent/Self Destructive)
Physician/License Practitioner Evaluation The Physician/ License Practitioner 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. Additionally, a new face to face assessment must be completed with each **new** order (new orders are to be obtained every 24 hours)	**Physician/License Practitioner Evaluation** Within **one (1) hour** of initiation of the intervention, the Physician/Licensed Practitioner must perform a face-to-face evaluation of the patient to assess the need for restraints and the patient's physiological and psychological condition. Additionally, a new face to face assessment must be completed within one (1) hour with each **new** order (new orders are to be obtained every 24 hours) The initial and the subsequent in-person evaluation by the Physician/License Practitioner must include: • Evaluation of the patient's immediate situation • Patient's reaction to interventions • Patient's medical and behavioral condition • Need to continue or terminate the restraint or seclusion The Physician/License Practitioner: • Reviews with the staff the physical and psychological status of the patient • Collaborates with the patient and staff to identify ways to help the patient regain control so the restraint or seclusion can be discontinued and to update the treatment plan/plan of care

Table 3. Nursing Care

A. Use of Restraints for (Nonviolent/Non self- destructive – Medical Support)	B. Use of Restraints to Control the Behavior of Patients Who Are in Imminent Danger of Severely Injuring Themselves or Others (Violent/Self Destructive)
Nursing Care Only a Registered Nurse may assess and evaluate the individual needs of the patient. Based on this assessment and regulatory requirements a plan of care will be developed Nursing assessments should be performed at initiation and designated intervals (see Table 5)	**Nursing Care** Only a Registered Nurse may assess and evaluate the individual needs of the patient. Based on this assessment and regulatory requirements a plan of care will be developed Nursing assessments should be performed at initiation and designated intervals (see Table 5)

Table 4. Plan of Care

A. Use of Restraints for (Nonviolent/Non self- destructive – Medical Support)	B. Use of Restraints to Control the Behavior of Patients Who Are in Imminent Danger of Severely Injuring Themselves or Others (Violent/Self Destructive)
Plan of Care All admitted/observation patients must have a plan of care*. The plan of care and nursing interventions/actions will be developed and implemented based upon the assessment. The Registered Nurse will: • Engage patient in plan if possible • Identify and use least restrictive safety interventions • Ensure or apply the restraint(s) properly and safely • Ensure the patient's safety, well-being and dignity are maintained while in restraints • Assess patient's physical and psychological response to the use of restraint • Monitor effectiveness of the restraint • Notify patient's family promptly of the initiation of restraint(s) when appropriate • Provide ongoing patient/family education related to the restraint experience • Provide ongoing observation data *The Emergency Department is not required to have a formalized plan of care	**Plan of Care** All admitted/observation patients must have a plan of care*. The plan of care and nursing interventions/actions will be developed and implemented based upon the assessment. The Registered Nurse will: • Engage patient in the plan if possible • Identify and use least restrictive safety interventions • Ensure or apply the restraint(s) properly and safely • Ensure the patient's safety, well-being and dignity are maintained while in restraints • Assess patient's physical and psychological response to the use of restraint • Monitor effectiveness of the restraint • Notify patient's family notified promptly of the initiation of restraint(s) when appropriate • Provide ongoing patient/family education related to the restraint experience • Provide ongoing observation data *The Emergency Department is not required to have a formalized plan of care

Table 5. Observations/Interventions

A. Use of Restraints for (Nonviolent/Non self- destructive – Medical Support)	B. Use of Restraints to Control the Behavior of Patients Who Are in Imminent Danger of Severely Injuring Themselves or Others (Violent/Self Destructive)
Observation/Interventions Any staff member who has received training and demonstrated competency in using restraints may observe a restrained patient. Refer to UAP role at the end of this section. Observation intervals should be based on the patient's needs and regulatory requirements. **Continuous Observation** Patients with all four extremities restrained or patients with vest plus two extremities restrained must be monitored by direct, 1:1 observation. Vital signs will be monitored and documented based on patient condition and needs The following are required: **Every 2 hour:** ▪ RN/LPN – applies or ensures correct application ▪ RN/LPN - evaluates the patient's physical and psychological response to the restraint ▪ RN/LPN - evaluates readiness for discontinuation of restraint ▪ RN/LPN – evaluates signs of injury associated with application ▪ RN/LPN – assesses circulation and respiratory status. ▪ RN/LPN – assesses skin integrity ▪ RN/LPN/UAP – provides hydration/nutrition ▪ RN/LPN/ UAP – ensures hygiene/elimination needs are addressed ▪ RN/LPN/UAP – provides opportunity for exercise or perform range of motion procedures for a minimum of five minutes per limb ▪ RN/LPN/ UAP – provides comfort measures ▪ RN/LPN/ UAP - observes behaviors ▪ ADLS offered and provided per unit protocol and as needed while in restraints	**Observation/Interventions** Any staff member who has received training and demonstrated competency in using restraints may observe a restrained patient. Refer to UAP role at the end of this section. Observation intervals should be based on the patient's needs and regulatory requirements. **Continuous Observation** All restrained patients must be monitored by direct observation on a continual basis. Vital signs will be monitored and documented based on patient condition and needs The following are required: **Every 15 minutes:** ▪ RN/LPN – applies or ensures correct application ▪ RN/LPN - evaluate the patient's physical and psychological response to the restraint ▪ RN/LPN - evaluates readiness for discontinuation of restraint ▪ RN/LPN - evaluates signs of injury associated with application ▪ RN/LPN – assesses circulation and respiratory status. ▪ RN/LPN – assesses skin integrity ▪ RN/LPN/UAP – provides hydration/nutrition ▪ RN/LPN/UAP – ensures hygiene/elimination needs are addressed ▪ RN/LPN/UAP – provides opportunity for exercise or perform range of motion procedures for a minimum of five minutes per limb ▪ RN/LPN/UAP – provides comfort measures ▪ RN/LPN/UAP – observes behaviors ▪ ADLS offered and provided per unit protocol and as needed while in restraints

Table 6. Release Criteria

A. Use of Restraints for (Nonviolent/Non self- destructive – Medical Support)	B. Use of Restraints to Control the Behavior of Patients Who Are in Imminent Danger of Severely Injuring Themselves or Others (Violent/Self Destructive)
Release Criteria (as determined by Physician/ License Practitioner or Registered Nurse): • The patient must be informed of the restraint release criteria upon initiation of restraint and throughout the duration of the episode as appropriate. • Restraint(s) should be removed at the earliest possible time based on the criteria outlined in **Section V**. • A new MD/License Practitioner order must be obtained before the reapplication of restraints.	**Release Criteria (as determined by Physician/License Practitioner or Registered Nurse):** • The patient must be informed of the restraint release criteria upon initiation of restraint and throughout the duration of the episode as appropriate. • Restraint(s) should be removed at the earliest possible time based on the criteria outlined in **Section V**. • A new MD/License Practitioner order must be obtained prior to the reapplication of restraints.

Table 7. Documentation

A. Use of Restraints for (Nonviolent/Non self- destructive – Medical Support)	B. Use of Restraints to Control the Behavior of Patients Who Are in Imminent Danger of Severely Injuring Themselves or Others (Violent/Self Destructive)
Documentation The RN will document in the patient's medical record restraint initiation, assessments/interventions, and discontinuation of restraint(s). Competent UAPs may enter interventions listed on page 16. Documentation shall include at a minimum: • Reason for restraint • Patient assessment • Alternative interventions attempted or judged to be ineffective prior to application of restraint • Restraint(s) utilized • Notification of the patient's family when appropriate • Patient and/or family education as appropriate related to the restraint episode • Patient's physical and psychological response to the use of restraint • Modifications to the Plan of Care • 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	**Documentation** The RN will document in the patient's medical record restraint initiation, assessments/interventions, and discontinuation of restraint(s). Competent UAPs may enter interventions listed on page 16. Documentation shall include at a minimum: • Reason for restraint • Patient assessment • Alternative interventions attempted or judged to be Ineffective prior to application of restraint • Restraint(s) utilized • Notification of the patient's family when appropriate • Patient and/or family education as appropriate related to the restraint episode • Patient's physical and psychological response to the use of restraint • Modifications to the Plan of Care • 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

Table 8. Plan of Care/Safety Concerns

Behavior/ Causative Factor	Alternatives	Interventions
General All Devices	Medicate for anxiety Hide or camouflage tubing • Guide patients' hand in gentle exploration of device begin and end • Check site condition • Use stockinet, cast socking, wrap, kling, or dressing over site	Have tubes and devices discontinued as soon as possible • Approved ARMC splint or elbow immobilizer to remind patient not to bend arm (cognitively intact patients only) • Give clean similar tubing to hold and investigate • Activity apron (or similar intervention) to provide tactile stimulation • Soft cloth dolls to keep hands occupied • Rotate site • Hide tubing • Move tubing and bags of visual field
IV Therapy	• Covert to oral or use male adapter	• Skin Sleeve
Foley	• Discontinue as soon as possible • Check for rubbing and tugging • Secure tubing	• Wear briefs over urinary catheter 1. Do not use diapers as this may cause skin breakdown 2. Place between legs, check for breakdown or irritation
NGT	• Discontinue as soon as possible • Change to smaller tube • Explore GT option with MD	• Check placement • Asses for breakdown or irritation • Medicate for comfort
GT	• Cover G tube site • Secure device to decrease movement and tugging	• Check for breakdown or irritation • Consider alternative feeding source
Oxygen Tubing	• Consider humidified oxygen • Secure cannula	• Lubricate nares • Check for irritation and breakdown • Check saturation levels

Table 9. Restraint Reduction: Know the Risk Factors and Warning Signs

Risk Factors of Disruptive Behaviors	Warning Signs
• History of violence • Substance and alcohol abuse • Diagnosis: Schizophrenia, major depression, bipolar disorder, hypoxia, confusion, disorientation • Wait times – a wait of > 45 minutes increases the likelihood for aggressive behavior • Time of day – outside normal working hours evening shifts • Cultural issues – cultural insensitivity • Patients' perception of nurse's demeanor	• Staring and eye contact • Tone and volume of voice • Anxiety • Mumbling • Pacing • Foot tapping • Handwriting • Hair pulling • Fiddling with clothes and other objects

Table 10. Non-Physical Interventions

Non-Physical Interventions – Verbal De-escalation
• Verbal de-escalation is used prior to a potentially dangerous or threatening situation to prevent a person from harming staff, themselves, or others. • Verbal de-escalation enhances patient-staff relationships, decreases likelihood of restraints(s)/seclusion, prevents extended hospitalization time, and may decrease hospital admissions.

Table 11. Things to Avoid

Things to Avoid
This list is a high-level overview of things to avoid and is not all inclusive: • Becoming emotionally involved • Allowing emotions to control behavior • Taking the situation personally • Engaging in a power struggle • Telling the patient/family that you know how they feel • Raising your voice and giving ultimatums or demands • Posing in challenging stances such as standing directly opposite someone: hands on hips or crossing your arms • Attempting to intimidate a hostile person • Belittling the patient or family

Table 12. Plan of Care for Agitation

Behavior/ Causative Factor	Alternatives	Interventions
General	Consider cause and place specific to the cause: • Hypoxia • Infection • Medication toxicity • Electrolyte imbalance • Depression • Pain • Constipation • Dehydration	• Ask patient how to best de-escalate • Review labs and discuss with MD-Licensed Practitioner • Review medications; consult Pharmacist • Address bowel regime • Explain procedure prior to initiation • Assess and treat • Arrange for consistent personnel • Consider family involvement • Provide relaxation music • Address nutritional plan
Agitation	• Readjust medication to fit agitation times • Remove stressful stimuli	• Incorporate patient's personal choice as appropriate • Prove soothing music, something warm and soft to hold
Combative (cognitively Impaired)	• Approach calmly and establish eye contact • Listen to their comments and respond • Explain intervention prior to touching • Provide access to music and/or television	• Rest periods, removal from stimuli • Structured routines with choices offered • Contracting when appropriate • Medication when appropriate

Table 13. Age Specific Considerations

Age Specific Considerations	
Infants	Place a rolled towel as a barrier to the device. Swaddle infant.
Children	Place a stuffed animal as a barrier to the device, divert children with videos, games, television, music, family members, puzzles, books, and/or magazines
Adolescents	Family member, companion, music, videos/DVDs, book/magazines, verbal de-escalation, and/or medication
Adult	Family member, companion, music, videos/DVDs, book/magazines, verbal de-escalation, and/or activity apron
Geriatric	Family member, companion, music, videos/DVDs, toys, hand-held games, book/magazines, verbal de-escalation, and/or activity apron

REFERENCES

APA, APNA, National Association of Psych Health Systems; APNA Position Statement on the Use of Seclusion & Restraint/ Seclusion and Restraint Standard of Practice (2022)

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