SARASOTA MEMORIAL HOSPITAL POLICY

TITLE: RESTRAINTS AND SECLUSION

POLICY #: 01.PAT.64
EFFECTIVE DATE:
REVISED DATE:
POLICY TYPE: ☐ DEPARTMENTAL ☐ INTERDEPARTMENTAL ☐ DEPARTMENTS PROVIDING NURSING CARE
PAGE: 1 of 16

Job Title of Reviewer: Geriatric Program Coordinator/CNS

PURPOSE:

To provide safety to patients and staff in cases where the patient is at risk of injuring him/herself or others, while protecting the patient's health and safety and preserving the patient's dignity, rights and well-being.

POLICY STATEMENT:

Sarasota Memorial Hospital (SMH) recognizes and respects each patient's right to be free of restraints and/or seclusion that is not necessary to prevent injury or harm to the patient or others. Restraints are to be used only when less restrictive non-physical forms of intervention have failed or cannot be safely attempted to protect the patient or others from harm.

All restraint use is initiated and continued pursuant to an order by a physician. PRN or standing orders for restraint or seclusion are prohibited.

If the patient expires while restrained or in seclusion, regardless of whether or not the patient's death is a result of restraint or seclusion, the death must be reported immediately to SMH Risk Management and an occurrence report completed.

A patient's rights, dignity, and well being shall be protected during use of restraint or seclusion.

The use of seclusion shall be limited to inpatient Psychiatric Units and the ECC shall follow the parameters established in the units' seclusion policies.

The quality improvement process shall support SMH's commitment to prevent, reduce and when possible, eliminate the use of restraint and seclusion through preventive strategies and innovative alternatives that focus on the patient's well being.

EXCEPTIONS:

This policy does not apply to the following situations:

1. Standard practices that include limitation of mobility or

temporary immobilization related to medical, dental, diagnostic, or surgical procedures and related post-procedure care processes (for example, surgical positioning, intravenous armboards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients);

2. Adaptive support in response to assessed patient need (for example, postural support, orthopedic appliances);
3. Protective devices such as helmets applied for safety reasons;
4. Therapeutic holding or comforting of children or adolescents, or pediatric behavior management methods (i.e., for time-out when the person to whom it is applied is physically prevented from leaving an unlocked room for 30 minutes or less and when its use is consistent with the behavior management standards);
5. Instances in which an individual is restricted to an unlocked room/area consistent with the unit's rules (e.g. infection control isolation);
6. The use of restraint with individuals who receive treatment through formal behavior management programs and who exhibit intractable behavior that is severely self-injurious or injurious to others; or
7. The use of handcuffs or other restrictive devices applied by law enforcement officers for custody, detention, public safety reasons and to prisoners under direction of forensic administrative restraint used for security purposes.

DEFINITIONS:

1. Physical Restraint – Any manual method of 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.
2. Chemical Restraint – A medication used to control behavior or to restrict the patient's freedom of movement that is not a standard treatment for the patient's medical or psychiatric condition.
3. Seclusion – The involuntary confinement of a patient in a room or area alone where the patient is physically prevented from leaving. Seclusion is intended to protect the patient or others from harm that might result from the patient's actions or behavior. Seclusion may be used in psychiatric units only.
4. Behavior Management – Refers to an intervention used to manage emergency situations when a patient's behavior becomes violent or destructive versus a specific behavior

treatment plan. Behavior management, for the purposes of this policy, applies to all patients residing in a psychiatric unit and those patients, regardless of location, who exhibit violent or aggressive behavior, that presents an immediate or serious danger to the patient or others and where non-physical interventions would not be effective.

5. Non-behavioral Restraint Use – Refers to the use of restraints for medical or surgical purposes when the primary reason for their use directly supports medical healing.
6. Treating Physician – For the purposes of this policy, is the physician(s) who has/have primary responsibility for the management and care of the patient.

PROCEDURE:

I. General

A. Use of physical or chemical restraint and/or seclusion shall be based on a comprehensive assessment of the patient. The use of restraint or seclusion is based on the individual patient's needs and the associated risk of restraint and/or seclusion use. The use of restraint or seclusion is not based on an individual's diagnosis, restraint or seclusion history, or solely on a history of dangerous behavior.

B. Restraints and seclusion are used in two situations:
   1. Physical and chemical restraints for Medical/Surgical reasons may be used in medical and post surgical care as an adjunct to the plan of care for protection of surgical and procedure sites and the protection of medical lines, tubes, etc.
   2. Physical and chemical restraint and seclusion may be used as an emergency intervention in Behavior Management situations where the patient presents an immediate danger to themselves or others and when non-physical interventions, would not be effective (e.g., less restrictive alternatives) and the risk of using restraint or seclusion is clinically justified.
   3. Seclusion and restraint may not be ordered simultaneously unless the adult person is continually monitored face-to-face by an assigned staff member. Seclusion and restraint may not be ordered simultaneously for children less than 18 years of age.

C. Alternatives to Restraints and Seclusion
   Less restrictive, non-physical alternatives to restraints are used first, unless safety issues demand an immediate

physical response. Alternatives to the use of physical restraints or seclusion may include:
1. increased level of staff observation
2. distraction and/or redirection techniques
3. transfer to room in closer proximity to nurses' station
4. involve family in monitoring of patient.

D. When restraints or seclusion are used, they will be employed in the least restrictive and most safe and effective manner possible.

E. Persons will not be restrained in a prone position.

F. Discontinuation of restraints or seclusion shall be initiated as early as possible when the patient's behavior that necessitated the application of restraint or seclusion is no longer evident.
1. Only a RN with appropriate training or a physician shall determine when a patient may be released from restraint or seclusion.
2. Discontinuation of chemical restraint requires a physician's order.

II – III. Specific Requirements for Non-behavioral and Behavioral Restraint Use – The following table outlines the requirements for non-behavioral and behavioral use of restraints and the use of seclusion in behavior management.

NOTE: **Anytime four point restraints are used, they are to be considered behavior management use of restraint.**

II. Non-Behavioral Restraint (For medical or surgical care)	III. Behavioral Restraint (To manage violent or aggressive behavior)
NOTE: The restraint standards for medical or surgical purposes apply when the primary reason for use directly supports medical healing.	NOTE: Behavioral health care reasons for the use of restraint or seclusion are primarily to protect the patient against injury to self or others because of an emotional or behavioral disorder.
A. Medical Orders for Use of Restraints 1. Orders for restraint of patients receiving acute medical and surgical care shall be	**A. Orders for Use of Restraint or Seclusion for Behavior Management** 1. Upon placing a patient in restraint or seclusion, the RN

obtained from a physician prior to restraint placement or immediately after if an emergent situation. Note: Seclusion may not be ordered for medical-surgical purposes. 2. In emergent situations, the patient may be placed in restraints and the physician notified by the nurse and an order obtained immediately after the safety of the patient is assured. 3. If an order for restraint is by telephone, the patient must be evaluated by a physician and a written order signed in the record within 24 hours of initiation of restraint. 4. Orders for the use of restraints shall be dated and timed. Verbal orders must also be authenticated and dated in accordance with hospital policy. Orders also shall include the specific reason for restraint (i.e. patient's behavior) and the period of time that restraints are to be applied. 5. If a doctor other than the treating physician does not order the restraint, he/she must be contacted as soon as possible and notified about the order. 6. Orders for chemical restraint shall be obtained prior to the administration of the medication and only after an examination of the patient by a physician. 7. Orders for continued use of restraint beyond the first 24 hours is authorized by a physician renewing the original	shall notify the physician immediately and obtain an appropriate order for use of restraint or seclusion. If such order is not obtained, the patient must be released from restraint or seclusion. a. Behavior Management restraint or seclusion orders, whether written or verbal/ telephone shall be given only by a licensed physician. 2. PRN orders or Physician Approved Protocols may not be used for restraints or seclusion. 3. Orders, whether written or verbal/telephone, for the use of restraints or seclusion shall be dated and timed in accordance with hospital policy. 4. Any verbal or telephone orders for patients in a psychiatric unit must be authenticated and dated by the ordering physician within 24 hours of the initiation of restraint or seclusion. When LIP must examine patient face to face, orders for initiation or continuance are to be written by the MD at that time. 5. Orders for use of restraint or seclusion must include: a. Specific behavior prompting their uses b. Type of restraint ordered c. Time limit for use For inpatients admitted to a psychiatric unit, the order must also include the positioning of the patient for respiratory and other medical safety considerations, and the behavior necessary for the patient's release from restraint or

order or issuing a new order if restraint use continues to be clinically justified. Orders for the continuation of use of restraints must be issued a minimum of once each calendar day and is based upon an examination of the patient by the physician.

B. Initiation and Application of Physical Restraints

1. Use of physical restraints shall be initiated based on an assessment of patient's care needs and risks for adverse outcomes.
   a. RNs with appropriate training, or physicians may initiate the use of restraints.
   b. The type of physical restraint selected is based on information learned from the assessment of the patient.

2. Physical restraints shall be applied in the least restrictive manner in accordance with the patient's plan of care and should be removed as soon as possible.

3. The physical application of restraints may only be performed by physicians and those staff members who are registered nurses, licensed practical nurses, nursing assistants, technicians, and other members of the health care team who have completed training on application of such restraints. A quick release knot is used for all restraints with straps.

4. Individuals who have specific care needs based on age, cognitive or physical limitations are at increased risk related to seclusion.

6. Orders for the use of restraints or seclusion will be limited to:
   - 4 hours for adults;
   - 2 hours for children and adolescents ages 9-17;
   - 1 hour for children under 9 years of age.

7. A physician must see and evaluate the patient <u>within one hour</u> after the initiation of restraint or seclusion. SMH Hospitalists may be contacted for this evaluation and order between 7 pm Sunday and 7 am Friday only between the hours of 7pm-7am. The Attending MD should be contacted during all other hours (i.e. 7 am -7 pm every day and 7 pm to 7am on Saturdays).

If the patient quickly recovers and is released before the physician arrives to perform the assessment, the physician must still see the patient face to face to perform the assessment within one hour after initiation of restraints or seclusion.

8. <u>To continue restraints or seclusion</u> after the initial order expires, the RN shall perform a face-to-face reassessment of the patient, review the findings with a physician and obtain a written or telephone order for continued use.
   a. Orders for continuation are limited to the timeframes outlined above.
   b. When restraints/seclusion are continued, a face-to-face assessment by the physician is required at least every 8 hours for patients 18 years

the use of restraint. Careful consideration should be taken with the application of restraint in this population. The frequency of monitoring also should be based on these specific needs.

5. Every effort shall be made to discuss the issue of restraint, when practical with the patient and family (if authorized by the patient) around time of its use.

C. Care and Monitoring of Patients in Restraints

1. Staff with appropriate training shall assess, monitor, and provide care for patients in restraints as appropriate for their job responsibilities.

2. Patients in restraints shall be monitored at least hourly or more frequently, based on patient need. PCS/PCA can document Q1 hour observations. RN or LPN must do Q2 hour observations. RN **MUST** do the Q4 hour assessments on all patients in restraints. Monitoring is accomplished by observation, interaction with the patient, or direct examination of the patient. Monitoring determines:
a. The physical and emotional well being of the patient;
b. That the patient's rights, dignity and safety are maintained;
c. Whether use of less restrictive measures is feasible.
d. Changes in the patient's behavior or clinical condition indicating the need to remove restraints; and
e. Whether the restraint has been appropriately applied,

and older, every 4 hours for patients less than 18 years of age.
c. The patient's plan of care shall be modified accordingly.

9. If restraints or seclusion are discontinued prior to expiration of the original order, a new order must be obtained prior to reinitiating seclusion or reapplying restraints.

B. Notification of Patient's Family and Clinical Leadership for Psychiatric Patients in Restraint/Seclusion

1. Clinical leaders (i.e. the physician in charge and the nurse manager or his/her designee) of the psychiatric unit shall be notified when a patient experiences an extended episode of restraint or seclusion of more than 12 hours duration or when 2 or more separate episodes of restraint and/or seclusion, of any duration, are experienced within 12 hours. If either of these conditions continue, clinical leadership is notified at least every 24 hours of the situation.

2. Staff make every attempt to promptly notify the individual's family of the initiation of restraint or seclusion in those cases where the patient has consented to the family being informed and the family has agreed to be notified.

C. Initiation and Application of Restraint or Seclusion

1. Use of restraints or seclusion

removed or reapplied. 3. Patients in Psychiatric Unit, who are restrained for medical-surgical purposes, shall be monitored at least every 15 minutes. Monitoring is accomplished as noted in above C.2. **D. Release from Restraints** 1. The use of restraints shall be terminated when the patient's behavior that necessitated the application of restraints is no longer evident. Only RNs who have completed the appropriate training and physician may determine when a patient may be released from physical restraints. 2. Release shall be initiated as early as possible and based on individual assessment of the patient. 3. If restraint is terminated early and needs to be replaced the restraints can be reapplied. However, a new order is required even if the original order has not expired. 4. Discontinuation of chemical restraint requires a physician's order. **E. Documentation in the Medical Record** 1. Each episode of restraint use is documented in the patient's medical record and shall include: ▪ relevant orders for use, ▪ alternatives to restraint attempted, ▪ type of restraint applied	shall be initiated based on an assessment of the patient's care needs and risks for adverse outcomes. a. RNs with appropriate training or physicians may initiate the use of restraints. b. The type of physical restraint selected is based on information learned from the assessment. 2. Physical restraints shall be applied in the least restrictive manner in accordance with the patient's plan of care and be removed as soon as possible. 3. The physical application of restraints may be performed by physicians and those staff members who are registered nurses, licensed practical nurses, nursing assistants, technicians, and other members of the health care team who have completed training on application of such restraints. 4. Individuals who have specific care needs based on age, cognitive or physical limitations are at increased risk related to the use of restraint. Careful consideration should be taken with the application of restraint in this population. The frequency of monitoring also should be based on these specific needs. **D. Patients admitted for psychiatric evaluation**: 1. Receive an initial assessment at the time of admission or intake that includes information that may help minimize the use of restraint or seclusion. a. If a patient is determined to be a risk for harming

and/or medication given,
- the plan of care
- patient and/or family education
- results of patient monitoring and assessment, reassessment, and
- significant changes in the patient's condition.

2. The plan of care includes the identified problem, outcome oriented goals, the planned intervention including the time limit for restraints, and persons responsible for implementation and discontinuation of restraints. The plan may be documented in the treatment plan, flowsheets, physician orders, and/or working documents.

3. Discontinuation of restraints and the patient's behavior reflecting improvement which supports the discontinuation, shall be documented and the plan of care revised accordingly.

F. Patient and Family Education

The patient, and when appropriate the family/significant other, receives education related to the organization's philosophy as reflected in the Patient's Rights and Responsibilities regarding the use of restraints and the reason for this episode of restraint application.

G. Training and Education of Staff

Staff applying and/or providing care to patients in restraint, whether chemical or physical, are trained and receive ongoing

himself/herself or others, he/she assists when possible in identifying techniques, methods, or tools that would help control his/her behavior.
b. Pre-existing medical conditions, physical disabilities and limitations, and a history of sexual or physical abuse that would place a patient at greater risk during restraint or seclusion are identified.
2. When appropriate to the patient's condition, information regarding an advance directive with respect to behavioral health care is obtained.

E. Patient and Family Education

1. The patient, and when appropriate the family/ significant other, receives education related to the organizations' philosophy as reflected in the Patient's Rights and Responsibilities regarding the use of restraints and seclusion, and the reason for this episode of restraint and/or seclusion use.

2. As early as feasible in the restraint or seclusion process, patients shall be informed of the behavior that caused their restraint, and the behavior and conditions necessary for their release.

F. Care and Monitoring of Patients in Restraints and/or Seclusion

1. Patients restrained or placed in seclusion for Behavior Management reasons are assessed at the initiation of restraint or seclusion by a RN.
a. The patient shall be

education regarding the organization's philosophy as reflected in the Patient's Right and Responsibilities on restraint use and on the proper and safe use of restraint, medications and devices .	searched for possession of unsafe items that may include belts, shoestrings, and other clothing, jewelry, wallets, cigarettes, matches/lighters, medications, and sharps. These items shall be removed and stored in accordance with facility guidelines. 2. Staff with appropriate training shall assess, monitor, and provide care for patients in restraint or seclusion as appropriate for their job responsibilities. a. Patients placed in restraints or seclusion are continually observed by a staff member with approved training. b. <u>For seclusion without restraints (Psychiatric Unit)</u>: After the first hour, a patient in seclusion without restraints may be continuously monitored using simultaneous video and audio equipment, if consistent with the patient's condition or wishes. c. Monitoring for physical use of restrains includes a face to face interaction with the patient at least every 15 minutes, to check and document: ▪ Respiratory rate ▪ Potential injury ▪ Skin integrity ▪ Circulation (i.e., extremity color/ warmth) <u>Note</u>: If the patient is sleeping, the person monitoring may substitute an appropriate assessment parameter, and document such actions and findings in the medical record. d. Documentation of monitoring and the staff person's name shall be recorded at the time the monitoring takes place. e. At least once every hour,

	monitoring shall be conducted by a RN and include an evaluation of the patient's mental status. f. At least every two hours, as appropriate, the patient has nourishment, toileting, and range of motion needs met. If physical restraints are applied, they may be removed or adjusted for range of motion exercises unless determined by the RN as not appropriate. 3. When a patient is being physically restrained by another staff member for the purposes of controlling his/her behavior, a second staff person must be present to monitor the patient particularly noting respiration. **G. Discontinuation of Restraints or Seclusion** 1. The use of restrains or seclusion shall be terminated when the patient behavior that necessitated the application of restraints is no longer evident. Only RNs who have completed the appropriate training and physicians may determine when a patient may be released from physical restraints or seclusion. 2. Release shall be initiated as early as possible and based on an individual assessment that the patient is no longer at a risk for harm to him/herself or others. In seclusion, visual assessment includes: ▪ Description of patient's verbal and nonverbal behavior ▪ Patient's level of agitation/ calmness/readiness for discontinuation

	3. If restraint or seclusion has been terminated early (prior to the expiration of the order's time limit), a new order is required. 4. Staff provide assistance to patients in meeting behavior criteria to discontinue the use of restraint or seclusion. 5. Upon release from restraint, the patient's condition shall be observed and evaluated. **H. For Patients Admitted for Psychiatric Treatment Who Are Post Restraint and Seclusion** The staff and the patient, as able, and the patient's family as appropriate (with patient authorization) participate in a debriefing about the restraint or seclusion episode. This debriefing occurs as soon as possible and as appropriate after the episode but no longer than 24 hours. Information gained from the debriefing is used in performance improvement initiatives and in staff training and education. **I. Documentation in the Medical Record** 1. Each episode of restraint or seclusion use is documented in the patient's medical record and shall include: ▪ That the patient and/or family was told of the hospital's policy on restraint ▪ Any pre-existing medical conditions or any physical disabilities that would place the patient at greater risk during restraint and seclusion;

	▪ Each episode of use; ▪ The circumstances that led to restraint or seclusion; ▪ Consideration or failure of nonphysical interventions ▪ The rationale for the type of physical intervention selected ▪ Notification of the patient's family, as appropriate; ▪ Written orders for use ▪ Behavior criteria for discontinuing restraint or seclusion ▪ Informing the patient of behavior criteria for discontinuing restraint or seclusion ▪ Each verbal order received from a licensed independent practitioner ▪ Each in-person evaluation and reevaluation of the patient ▪ 15-minute assessment of the patient's status ▪ Assistance provided to the patient to help him or her meet the behavior criteria for discontinuing restraint or seclusion ▪ Continuous monitoring ▪ Debriefing of the patient with staff ▪ Any injuries and treatment for these injuries ▪ Any deaths 2. Documentation of monitoring shall include the staff person's name performing the monitoring, and shall be recorded at the time the monitoring takes place. 3. The plan of care includes the identified problem, outcome oriented goals, the planned intervention including the time limit for restraints, and persons responsible for implementation

	and discontinuation of restraints. The plan may be documented in the treatment plan, flow sheets, physician orders, and other working documents. Notification of the patient's family regarding restraint or seclusion use is documented, as is the education of the patient, and as appropriate the family. 4. The physician's face to face evaluation of the patient within one hour of initiating restraints shall be documented in the medical record by the ordering physician. 5. Consultation with a patient's treating physician regarding orders for restraint shall be noted in the medical record by the ordering physician. 6. Discontinuation of restraints or seclusion and the patient's behavior reflecting improvement which supports discontinuation of restraints/seclusion shall be documented, and the plan of care revised accordingly. Initiatives to assist the patient in meeting the criteria for discontinuation of restraints or seclusion also are documented for psychiatric patients. 7. Debriefing activities for psychiatric patients are noted in the patient's medical record and include the patient's involvement or inability to participate. **J. Training and Education of Staff** 1. Staff applying and/or providing care to patients in restraint or seclusion are trained and receive ongoing education

	regarding the organization's philosophy on restraint and seclusion and the proper and safe use of restraints and seclusion. 2. Training for staff who are authorized to initiate restraint or seclusion, and/or perform evaluations/reevaluations of individuals who are in restraint or seclusion in order to assess their readiness for discontinuation or establish the need to secure a new order, receive the training and demonstrate competence. 3. Training and education shall involve individuals who have experienced restraint or seclusion by including their viewpoints and, where possible, their participation.

IV. Process Improvement – The data abstraction, measurement and analysis of restraint and seclusion utilization is a collaborative effort of leadership, physicians and patient care personnel and an integral component of system wide performance improvement initiatives.

The goal of the measurement and analysis is the ongoing reduction of the use of restraints/seclusion at Sarasota Memorial Healthcare System.

RESPONSIBILITY:

REFERENCES:

AUTHOR(S): Lynne Grief, director, ECC
Al Castrucci, Clinical Practice Specialist, ECC
Rae Daprato, director, Risk Management
Susan Kommuck, Quality Improvement
Pat McManus, Clinical Manager, Bayside

ATTACHMENT(S):

APPROVALS:

Signatures indicate approval of the new or reviewed/revised policy	**Date**
Signature: **Title:**	
Signature: **Title:**	
Signature: **Title:**	
Signature: **Title:**	
Committee/Sections (*if applicable*):	
Vice President/Administrative Director (*if applicable*): **Signature:** **Name and Title:**	
Signature: **Name and Title:**	