CHRISTUS Southeast Texas Health System

ADMINISTRATIVE POLICY

TITLE: SETHS STANDARDIZED USE OF RESTRAINT AND/OR SECLUSION

Date Adopted: 07/09 **Date Revised: 03/18**
Supersedes: **Date Reviewed: 03/18**

I. KEY WORDS: Restraint, Chemical Restraint, Seclusion, Non-Violent/Non-Self Destructive Restraints, Violent/Self-Destructive Restraints

II. PURPOSE:

This policy standardizes the indications and methods for restraint and/or seclusion to comply with ethical, regulatory, and patient-focused considerations in order to promote safety and dignity of the restrained/secluded patient and prevent the use of restraint and/or seclusion whenever possible, *with the goal of being restraint/seclusion-free.*

III. POLICY:

A. **Hospital leadership** is responsible for creating a culture that supports a patient's right to be free from restraint or seclusion. Leadership must ensure that systems and processes are developed, implemented, and evaluated that support the patients' rights addressed in this standard, and that eliminate the inappropriate use of restraint or seclusion. Through their Quality Assurance Performance Improvement (QAPI) program, hospital leadership should:
   1. Assess and monitor the use of restraint or seclusion in their facility;
   2. Implement actions to ensure that restraint or seclusion is used only to ensure the physical safety of the patient, staff and others; and
   3. Ensure that the hospital complies with the requirements set forth in this standard as well as those set forth by State law and hospital policy when the use of restraint or seclusion is necessary.

B. The immediate physical safety of the patient, staff, or others is the basis for initiating and discontinuing the use of restraint and/or seclusion, where applicable. *Restraint and seclusion episodes will always be discontinued as soon as possible for the safety and well-being of the patient, regardless of the scheduled expiration of the order.*

C. *Patient protections, related to the use of restraint/seclusion, apply to all hospital patients (inpatients and outpatients) regardless of patient location.*

D. The decision to use a restraint and/or seclusion is not driven by diagnosis, but by a comprehensive, individual patient assessment, including a physical assessment to identify medical problems that may be causing behavior changes in the patient.

E. The use of restraints for the prevention of falls should not be considered a routine part of fall prevention.

F. A request from a patient or family member for the application of a restraint and/or seclusion, which they would consider beneficial, is not a sufficient basis for the use of a restraint or seclusion intervention.

G. Restraint and/or seclusion are not used as a means of coercion, discipline, or staff convenience or retaliation.

H. Restraint or seclusion is only used when less restrictive interventions are ineffective or determined to be ineffective for the situation. Moreover, the hospital will use the least

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

I. Weapons including but not limited to pepper spray, mace, nightsticks, handcuffs, and tazers will not be used in the application of restraint/seclusion. Use of weapons may only be used by law enforcement personnel when it is related to managing official custody, detention, and public safety issues. The use of weapons by law enforcement personnel is not governed/monitored by the hospital/medical team members.

IV. DEFINITIONS:

A. ***Restraint***: Any method (physical or chemical) of restricting a patient's freedom of 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 functioning.
4. Cannot be intentionally easily removed by the patient in the same manner that it was applied

a) Types of restraints:

i. ***Non-Violent/Non-Self Destructive Restraint***: Restraint use in any care setting for medical and post-surgical care which is used to promote medical treatment and healing, e.g. protection of airway, prevention of tube removal (IV lines, feeding tubes, endotracheal tubes, etc.). Documented clinical justification is required for such use.

ii. ***Violent/Self Destructive Restraint***: Emergency restraint use in any care setting to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

iii. ***Chemical Restraint:*** The use of a drug as a restraint requires two fundamental criteria:

a. It is used to restrict the patient's behavior and freedom of movement, and
b. It is not a standard treatment or dosage for the patient's condition.

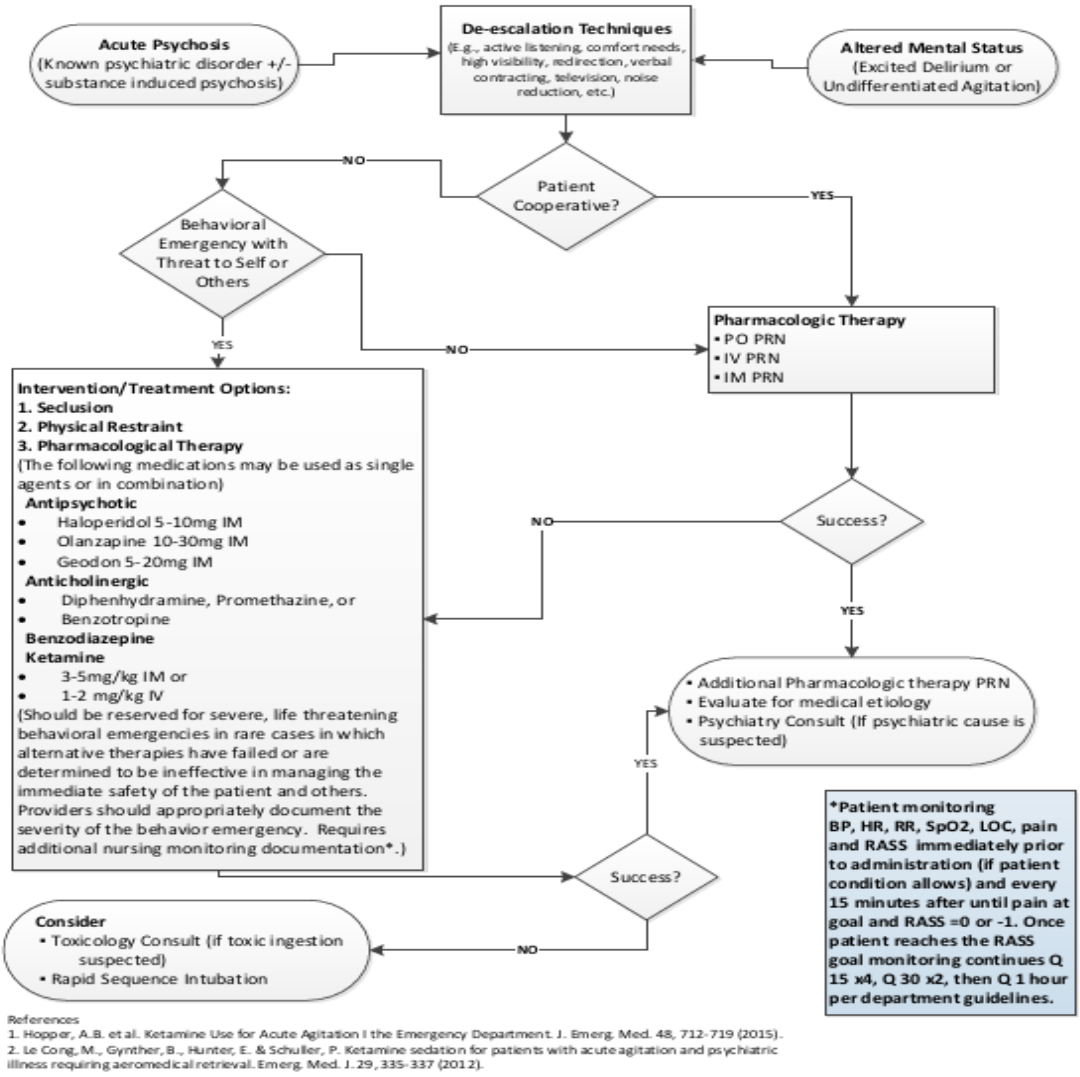
> *Example of a Chemical Restraint Scenario: A hospitalized patient is administered Thorazine hourly if blood pressure and arousal state reach a certain elevated level. Thorazine was administered PRN to maintain a lowered blood pressure and keep the patient asleep. This is not standard treatment for the patient's condition.*

iv. ***Physical restraint***: Any manual method, physical or mechanical device, material or equipment attached or adjacent to the patient's body that reduces the ability of a patient to move his or her arms, legs, body or head freely and that he/ she cannot easily remove. Types of physical restraints include:

a. Soft extremity holder
b. Body holder (strap or vest)
c. Restraints suitable for violent/self-destructive such as leather wrist and ankle restraints
d. Devices that serve multiple purposes, such as a geri chair, when they have the effect of restricting a patient's movement and cannot be easily removed by the patient
e. Enclosure beds, including cribs, with a restrictive netting over the top
f. Hand mitts are considered a restraint if one of the following conditions are met:
    i. The mitts are applied so tightly that the patient's hand or fingers are immobilized (hand movement at wrist joint is prevented and/or fingers will not "wiggle").
    ii. When the mitts are so bulky that the patient's ability to use their hands is significantly reduced so that normal function is prevented (Example: patient is unable to use hands to push his/her body up in the bed or cannot push call light).
    iii. When the mitts are pinned, or otherwise attached to bedding, using a wrist restraint in addition to the mitts.
g. Physical/Therapeutic Hold: a manual method to restrict patient movement.
    i. A grasp on a patient that the patient cannot easily escape from, in order to escort the patient to another location
    ii. Physically holding a patient for forced medications

B. ***Emergency Behavioral Health Medication Administration:*** A situation in which, in the opinion of the physician, it is immediately necessary to administer medication to ameliorate the signs and symptoms of a patient's mental illness and to prevent:
1. imminent probable death or substantial bodily harm to the patient because the patient:
    a) is threatening or attempting to commit suicide or serious bodily harm; or
    b) is behaving in a manner that indicates that the patient is unable to satisfy the patient's need for nourishment, essential medical care, or self-protection; or
    c) imminent physical or emotional harm to others because of threats, attempts, or other acts the patient makes or commits.
2. **The ordering of Emergency Behavioral Medications on a PRN basis is prohibited** and will need to be reordered by the physician prior to each administration.
3. Refer to CHRISTUS SETHS Policy entitled "Guidelines for the Management of Aggressive and Combative Patients" for additional information.

Algorithm for the Treatment of Aggressive/Combative Patients



References
1. Hopper, A.B. et al. Ketamine Use for Acute Agitation I the Emergency Department. J. Emerg. Med. 48, 712-719 (2015).
2. le Cong, M., Gynther, B., Hunter, E. & Schuller, P. Ketamine sedation for patients with acute agitation and psychiatric illness requiring aeromedical retrieval. Emerg. Med. J. 29, 335-337 (2012).

C. ***Psychotropic medication***: A medication prescribed for the treatment of symptoms of psychosis or other severe mental or emotional disorders and that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state when treating the symptoms of mental illness. "Psychotropic medication" includes the following categories when used as described in the context above:

1. antipsychotics or neuroleptics;
2. antidepressants;
3. agents for control of mania or depression;
4. antianxiety agents
5. sedatives, hypnotics, or other sleep-promoting drugs; and
6. psychomotor stimulants.

D. ***Non-restraints***: 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, 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) [42CFR 482.13(e)(1)(i)C]. The following are NOT considered restraints and do not require an order:

1. Handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety, which are not involved in the provision of patient care.
2. Voluntary adaptive/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 a mechanical support. These include, but are not limited to, positioning wedges, bivalves, casts, splints, lapboards, head support systems, lateral/axillary straps, and/or ankle straps as part of a prescribed seating system.
3. Positioning or securing devices (methods that involve physically holding the patient) to maintain the position, limit mobility, or temporarily immobilize during medical, dental, diagnostic or surgical procedures. These include, but are not limited to, IV arm boards, abdominal binders, swaddling devices, surgical positioning, radiotherapy procedures, and protection of surgical and treatment sites in children.
4. Surgical dressings or bandages.
5. Protective helmets.
6. Prescribed orthopedic devices.
7. Age or developmentally appropriate protective safety interventions (such as stroller and swing safety belts, raised crib rails and crib covers) that a safety conscious, child care provider outside the hospital would utilize to protect an infant, toddler, or preschool-aged child.
8. Any device that a patient can easily remove is not considered a restraint. "Easily removed" indicates that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff considering the patient's condition and ability to accomplish the objective, e.g. side rails which can be put down by the patient, not climbed over; buckles, ties, and knots which can be intentionally unbuckled by the patient.
9. Restriction of the patient to an unlocked room or area in a situation that is not involuntary.
10. Bed side rails, which are used to facilitate patient mobility or to provide patient safety (such as keeping the patient from falling out of bed) which is ascertained through each individual patient assessment. It is considered standard of practice to raise the side rails when the patient is on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of bed. The risk of side rail use is weighed against the risk presented by the patient's behavior as ascertained through individual assessment.

Note: The elevation of all four side rails is considered a restraint.

11. Mitts that are not pinned down or attached to bedding.

12. A brief physical hold is not considered a restraint for patients in a psychiatric emergency provided that:

i. the individual currently exhibits behavior that meets the definition of psychiatric emergency as defined in this subchapter, or the individual is currently under a court order allowing the facility to administer medication without consent of the individual, the individual is refusing medication, and the medication ordered is permitted by the court order;

ii. the purpose of administering medication is active treatment to reduce symptoms of a diagnosed mental illness;

iii. using medication to reduce specified symptoms of a diagnosed mental illness is standard clinical practice;

iv. the specific medication and dosage ordered can be clinically justified as in keeping with standard clinical practice and are appropriate for reduction of specified target symptoms; and

v. the physical hold is terminated as soon as the medication is administered.

E. ***Seclusion***: The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving via a locked door or physical interventions. Seclusion is used only for the management of violent or self-destructive behavior [42 CFR 482.13(e)(1)(ii)]. Seclusion does not include the following:

1. ***A patient physically restrained alone in an unlocked room***
2. ***Confinement in a locked unit***
3. ***Timeout for which the patient consented to and is not physically prevented from leaving***

F. ***Licensed Independent Practitioner (LIP)***: A Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, and other individuals credentialed by the hospital as LIPs who are responsible for the care of the patient.

G. ***Authorized Registered Nurse***: A Registered Nurse who has completed training and demonstrated competency with the components required to be able to restrain and/or seclude a patient who may initiate restraints and/or seclusion according to the guidelines established.

V. PROCEDURE:

A. Patient Assessment (Medical/Surgical healing support and behavioral reasons):
When considering restraint use, pertinent data from the patient admission assessment and treatment plan will be evaluated. This data should include: the patient's behavior and the interventions used, alternatives to restraint and other patient safety issues, physical status and reason for admission, fall risk, nutritional status, physical strength and mobility, toileting needs, medications, behavioral and cognitive status, and pain management needs. If data analysis indicates patient may be at risk for restraint usage, this should be reflected in the patient's individualized care plan. Alternatives to restraint and other patient safety issues are integrated into the patient care planning process. Restraint usage or seclusion is not based on patient restraint history or solely on a history of dangerous behavior.

B. A Registered Nurse with current demonstrated competency may initiate restraint use *in an emergency*, based on an appropriate assessment of the patient.
C. Restraint and/or seclusion are used only when less restrictive, alternative interventions are ineffective. See list of alternatives below:

Alternatives to Restraint: Nonviolent or Non self-destructive	**Alternatives to Restraint/Seclusion: Violent or Self-Destructive behavior**
Prior to the initiation of restraints, alternatives to restraint should be attempted* and documented. Based on the nurse's assessment of the patient, these alternatives may include, but are not limited to, the following: 1. Increased observation 2. Contracting with patient 3. Reality orientation 4. Diversional activities 5. Reduction of stimuli 6. Offering liquid, food, or toileting as appropriate 7. Verbal de-escalation 8. Family/significant other/sitter at bedside 9. Medication review 10. Ambulation and/or repositioning **Less restrictive interventions do not always need to be tried, but less restrictive interventions must be determined by LIP or competent RN to be ineffective to protect the patient or others from harm prior to the induction of more restrictive measures.*	Nonphysical techniques are the preferred intervention in the management of behavior. These interventions may include, but are not limited to: 1. Redirecting the patient's focus 2. Employing verbal de-escalation 3. Other pertinent techniques

D. Selecting the Type of Restraint and Patient Safety Implications for Non-Violent/Non Self-Destructive or Violent/Self-Destructive reasons: In selecting the type of physical intervention, the Registered Nurse will consider information learned from the patient's initial assessment. (Applies to both Non-Violent/Non Self-Destructive and Violent/Self Destructive reasons)
   1. The following types of restraints are approved for use:
      a) Soft extremity holder
      b) Body holder (strap or vest)
      c) Mittens (secured)
      d) Various restraints utilized for violent/self-destructive reasons such as leather wrist and ankle restraints
   2. When choosing the type of restraint, certain patient safety issues must be considered. Special care will be utilized when selecting types of restraints for vulnerable populations identified at higher risk for adverse effects. These may include:
      a) Cognitively impaired patients with mental status changes
      b)

c) Physically, developmentally, or emotionally impaired patients that may include the frail, the elderly, and patients with a history of sexual or physical abuse
d) Pediatric patients

E. The use of restraints and/or seclusion necessitates a written modification of the patient's plan of care.

Restraint Orders: Non-violent or Non self-destructive	**Restraint/Seclusion Orders: Violent or Self-Destructive behavior**
1. LIP issues the order for use of restraints. 2. In response to an unanticipated change in patient condition that is considered an emergency, restraints may be initiated by a Registered Nurse. 3. The nurse immediately (within a few minutes) notifies a licensed independent practitioner (LIP) and requests a verbal or written order. If restraints are initiated based on a significant change in patient condition, the LIP is notified immediately. 4. A written order based on an examination by the LIP is entered into the record within 24 hours. The order must be time-limited to the next calendar day and include clinical justification, date, time, and type of restraint. Standing orders/protocols or PRN (as needed) orders for restraint are prohibited. 5. Continued use of restraint beyond 24 hours is based on patient examination by the LIP. Renewal orders are issued no less than once each calendar day. Orders must contain clear clinical justification and type of restraint. Orders must contain clear clinical rationale, type of restraint, behaviors to monitor for, and potential early release of restraints.	1. Restraints/Seclusion for behavioral reasons may be initiated by an RN in an emergency. The licensed independent practitioner (LIP) must be immediately notified (within one hour) to obtain an order for the restraint/seclusion. If a consulting LIP and/or designee give order for restraint/seclusion, the attending LIP will be notified. 2. Telephone or written orders are **time-limited:** a. 4 hours: patient 18 years and older b. 2 hours: patients 9-17 years c. 1 hour: children under age 9 years 3. A physician/other LIP, registered nurse, other than the nurse who initiated the use of restraint or seclusion, who is trained to assess, medical and psychiatric stability and has demonstrated and documented competence or a LIP may conduct the face-to-face evaluation no later than one hour after the time the restraint or seclusion was initiated. The evaluation and subsequent documentation shall address: a. the patient's immediate situation b. the patient's reaction to the intervention c. the patient's medical and behavioral condition d. the patient's need to continue or terminate the restraints or seclusion e. supply staff with guidance in identifying ways to help patient regain control f. revise the patient's plan of care, treatment and service as needed g. write the order * Refer to state standards and regulations regarding who is a recognized LIP and who may conduct face-to-face evaluations. 4. Time limited orders do not mean that restraint/seclusion must be applied for the entire length of time for which the order is written. Restraint/seclusion should be discontinued as soon as the patient meets the behavior criteria for restraint/seclusion discontinuation. Standing or PRN (as needed) orders for restraint/seclusion are prohibited. 5. If restraint/seclusion episode needs to continue beyond expiration of the time-limited order, a new order is obtained from the LIP. Orders must contain clear clinical rationale for restraint/seclusion, type of restraint/ seclusion, behaviors to monitor for, and potential early release of restraint/seclusion.

F. Notification of Attending Physician:
The attending physician responsible of the management and care of the patient shall be notified about the use of restraint as soon as possible if he/she is not the ordering physician.

G. If the face-to-face evaluation of a violent/psychiatric restrained or secluded patient is completed by a trained registered nurse or physician assistant, he/she must consult the attending physician or other licensed practitioner who is responsible for the care of the patient as soon as possible after the completion of the 1-hour face-to-face examination.

H. Notification of Family:
Every effort will be made to promptly notify the patient's family concerning the need for, and application of, restraint if information to the family is not contraindicated.

I. Patient/Family Education:
The physician or licensed nurse will educate the patient and family regarding restraints if information to the family is not contraindicated. This education will include alternatives attempted, need for restraint, criteria for removal of restraint, and patient safety issues. The family will be assured that the patient's safety, physical and emotional needs, dignity and privacy will be respected at all times.

Patient Monitoring and Documentation: Nonviolent or non-self-destructive behavior	**Patient Monitoring and Documentation: Violent or self-destructive behavior**
1. The patient's individual assessed needs are used to guide the frequency, nature, and extent of patient monitoring. 2. The patient will be monitored in person by trained and competent staff as needed and minimally every two hours by an RN/LVN for the following: a. Change in condition impacting need for restraint b. Skin and circulation c. Respiratory status d. Review of vital signs e. Capillary refill distal to restraint f. Fluid/food as appropriate g. Elimination and toileting h. Position change and release of restraint i. Readiness for discontinuation of restraints. 3. The above assessments and reassessments will be recorded on the appropriate forms or electronic documentation record and will be included in the patient's medical record. By assessing and documenting the six items above, the RN will ensure the patient's safety, as well as preservation of personal rights and dignity.	1. The patient restrained/secluded for behavioral reason is assessed at the initiation of the restraint/seclusion event and **every 15 minutes** thereafter. 2. Patients are monitored through continuous, in-person observation by an assigned trained and competent staff member. 3. If the patient is in a physical hold, a second staff member is assigned to observe the patient. 4. The patient is assessed every 15 minutes, as appropriate to his/her condition and needs, for the following components [(*) items require documentation within the medical record every 15 minutes]: a. Signs of injury associated with the application of restraint/skin integrity* b. Circulation/pulse (cardiac status) and range of motion in the extremities* c. Respiratory status* d. Nutrition/hydration e. Hygiene and elimination f. Physical and psychological status and comfort g. Readiness for discontinuation of restraint h. Expected behavior for restraint removal 5. Staff will provide assistance to patient in meeting behavior criteria for the discontinuation of restraint/seclusion. 6. Staff will document the time that restraint/seclusion was terminated based on expected behavior criteria. 7. The above assessment/reassessments will be recorded appropriately, and the indications for restraint/seclusion and strategies to remove them will become part of the patient's plan of care.

Patient Reevaluation: Non Violent or non-self-destructive behavior	**Patient Reevaluation: Violent or self-destructive behavior**
1. Daily documented reevaluation by the LIP for continued use of restraints is required. 2. Every 24 hours, a Registered Nurse will assess the patient for continued use of restraint, *and discontinue whenever possible, after RN assessment*.	1. Before an order for application of restraint/seclusion expires, the qualified RN reevaluates the patient's behavior for the need for continued restraint/seclusion and obtains an order from the LIP when assessment indicates the need for continued restraint/seclusion. 2. Reevaluation will occur: a. Every 4 hours for adults 18 years and older b. Every 2 hours for children & youth 9-17 years c. Every hour for children under the age of 9 years 3. Following the initial application of restraint/seclusion, the LIP conducts an in-person assessment at least: a. Every 8 hours for patients 18 years and older b. Every 4 hours for patients 17 years and younger 4. LIP will re-evaluate the efficacy of the patient's treatment plan and work with the patient to identify ways to help regain control. 5. A qualified RN will immediately notify the shift supervisor of any instance in which a patient remains in restraint/seclusion for more than 12 hours or experiences 2 or more separate episodes of restraint/seclusion of any duration within 12 hours. Thereafter, the shift supervisor is notified every 24 hours if either of the above conditions continues.

J. Reporting to CMS:
   1. Deaths of individuals in restraints other than 2-point soft-wrist types and all seclusion deaths must be reported to CMS.
   2. The hospital shall maintain a log (or other system) of all restraint deaths. Deaths that occur when in soft, 2-point wrist restraints do not need to be reported to CMS for dates

3. following May 16, 2012. The log (or other system) must be made available to CMS upon request.
4. Any reportable death must be reported to CMS, by telephone, facsimile or by electronic means, no later than the close of the next business day following knowledge of the patient's death.

Performance Improvement: Non Violent or non-self-destructive behavior	**Performance Improvement: Violent or self-destructive behavior**
In order to reduce risk and promote patient safety, aggregate data is measured and analyzed for high-risk processes related to restraints. Measurement and analysis may be performed on the following indicators, as appropriate: 1. Appropriate restraint order by LIP for restraint: time-limited, clinical justification, type of restraint, date/time, and LIP signature 2. Renewal orders issued every calendar day with required components and exam by LIP 3. Documented use of alternatives to restraint 4. Required documentation of patient monitoring at least every two hours. 5. Total numbers of episodes of restraint by unit and shift	In order to reduce risk and promote patient safety, the records of patients restrained/secluded for behavioral reasons are reviewed and data is measured and analyzed for high-risk processes related to restraints/seclusion. Measurement and analysis may be performed on the following indicators: 1. The shift during which the episode occurs 2. The setting/unit/location where the episode occurs 3. The staff who initiated restraint or seclusion 4. The length of each episode 5. The date and time each episode is initiated 6. The day of the week each episode is initiated 7. The type of restraint used 8. Any injuries sustained by the patient or staff 9. Identification of the patient 10. The patient's age, gender issues 11. The use of psychoactive medications as an alternative to restraint or seclusion or to enable their discontinuation 12. Documented evidence of imminent harm to self (patient) or to others 13. Evidence of face-to-face assessment by LIP within one hour of restraint/seclusion application 14. Restraint/seclusion order is time-limited, based on patient age 15. Evidence of continuous 1:1 patient monitoring by qualified staff 16. Required documentation of patient monitoring every 15 minutes by qualified staff 17. Appropriate reevaluation by LIP 18. Behavior criteria established for restraint/seclusion removal 19. Documentation of expected behavior achieved 20. Documentation of time restraints/seclusion terminated At a minimum, psychotropic medication utilization in each service setting must be reviewed and evaluated at least semiannually and strategies for improvement identified using accepted guidelines. Required areas of review include: 1. appropriateness of prescribing (including choice of medication, dose, and route); 2. documentation; 3. polypharmacy; 4. emergency use of psychoactive medication; 5. PRN use; 6. medication errors; 7. adverse drug reactions; and 8. frequency of medication monitoring. 9. Medication utilization will be reviewed by the medical staff and necessary strategies for improvement approved by the medical staff for implementation.

K. Associate Education:
1. All associates who render direct patient care will demonstrate restraint/seclusion competency in their setting (behavioral and/or non-behavioral) upon initial hiring, before participating in the use of restraint and/or seclusion, and annually thereafter. The demonstrated competency includes all required elements for restraints utilized to support medical/surgical healing and restraint/seclusion used for behavioral reasons, as appropriate. Based on the population served, staff education, training, and demonstrated knowledge focus on the following:
   a) Recognition of when to contact emergency medical assistance to evaluate and/or treat the patient's physical status
   b) Recognition of signs of incorrectly applied restraints
   c) Taking vital signs and interpreting their relevance to the patient's physical safety
   d) Recognition of the patient's nutritional and hydration needs
   e) Checking the patient's circulation and range of motion in his or her extremities
   f) Addressing the patient's hygiene and elimination
   g) Addressing the patient's physical and psychological status and comfort
   h) Recognition of age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a patient reacts to physical contact
   i) The use of criteria for discontinuing restraint or seclusion for behavioral health purposes
   j) Helping the patient meet criteria for discontinuing restraint or seclusion
   k) Recognition of the patient's readiness for discontinuing restraint or seclusion
   l) Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion
   m) Use of nonphysical intervention skills
   n) Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition
   o) Safe application and use of all types of restraint/seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
   p) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
   q) Monitoring the physical and psychological well-being of the patient who is restrained/secluded including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion
   r) Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification
2. Individuals providing staff training must be qualified as evidenced by education, training and experience in techniques used to address patient behaviors.
3. Training shall be documented in personnel or staff development records.

VI. STAKEHOLDERS:

A. Leadership is:
   1. Committed to the goal of a restraint-free environment and will ensure accountability for compliance with restraint policy.
   2. Responsible for assuring that LIPs or staff who are competent to initiate emergency medical care and cardiopulmonary resuscitation for patients who are restrained or secluded for behavioral health purposes are available at all times.

B. Registered nurses are committed to exploring any and all other options prior to initiating restraints or seclusion, discontinuing the restraints/seclusion as soon as possible, and complying with all other aspects of the policy, including, but not limited to, proper care planning and documentation, assuring the needs of the patient are met, and requesting LIP/trained nurse evaluation of the patient within an hour of application.

C. LIP is committed to evaluating the patient and seeking root causes for clinical indication of restraints/seclusion to correct the underlying issue/change in patient condition. Each practitioner will have a working knowledge of the hospital policy regarding the use of restraint and seclusion. LIP will adhere to the hospital's policies, laws, and regulations when ordering the use of restraints and/or seclusion.

VII. REFERENCES/REGULATIONS/REQUIREMENTS:

The Joint Commission/Centers for Medicare and Medicaid Services. TJC Accreditation Program: Hospital; Chapter: Provision of Care, Treatment, and Services. © 2009 The Joint Commission; 14-27

Centers for Medicare and Medicaid Services. Medicare and Medicaid Programs; Hospital Conditions of Participation: Patient Rights. Federal Register, (42 CFR Part 482), Vol 77, No. 95. May 16, 2012.

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US Government Printing Office, Electronic Code of Federal Regulations. §482.13 Patient Rights 2(e). Retrieved from: http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=123b0a1af9468b64d6c0b49285ace955&rgn=div8&view=text&node=42:5.0.1.1.1.2.4.3&idno=42

APPROVAL:

Executive Leadership	Signature: _____
Quality	Signature: _____
Emergency Medicine	Signature: _____
Nursing	Signature: _____
VPMA	Signature: _____