Mary Lanning
HEALTHCARE

RESTRAINT OR SECLUSION FOR PATIENTS WITH NON-VIOLENT / NON-SELF-DESTRUCTIVE & VIOLENT / SELF-DESTRUCTIVE

Policy: ADM234.00, **v.27** **Effective: 06/10/2025**
Category: Joint Commission **Origination Date:** 03/01/2002

I. PURPOSE:

We are committed to the belief that all patients have the right to be free from restraints of any form that are not medically necessary. Restraints and seclusion are never to be used as a means of coercion, discipline, convenience, or retaliation by staff. As such, restraints and seclusion will only be used when non-physical interventions have failed; when there is an imminent risk of a patient physically harming themselves or others, including staff; or are medically necessary. When a patient is in restraints or seclusion, all available measures will be used to ensure that they are discontinued as soon as possible. Staff is educated on the dangers of restraints and seclusion, emphasizing how restraints and seclusion are perceived by an individual with psychosocial issues, with the goal of preserving the patient's safety and dignity, and while reducing the need for the use of restraint and seclusion.

II. POLICY:

A. **Intent of restraints**:

1. The use of restraints/seclusion is limited to emergencies in which there is an imminent risk of a patient physically harming themselves or staff, and when nonphysical intervention has not been effective. This includes restraint use in medical-surgical patients at risk for harming themselves by prematurely discontinuing tubes, lines, drains, etc. required to treat their medical/surgical conditions.
2. To protect the individual or others from immediate physical injury when less restrictive methods fail to ensure safety.
3. To promote patient safety and to prevent individual injury associated with premature discontinuation of tubes, lines, drains, etc.
4. All attempts will be made to prevent/reduce restraints/seclusion usage.
5. Restraints will be discontinued at the earliest possible time.
6. Restraints are not used for staff convenience or punishment.

III. DEFINITIONS:

A. Physical Restraint:

1. Any manual method physical or mechanical device material or equipment that immobilizes or reduces the ability of a patient to move his or her body, arms, legs or head freely. Physically holding a patient for forced medications is a physical restraint. Incidents that are not physical restraints include:
    a) Physically holding 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 risk of physical harm.

b) An IV board unless it is tied down or attached to the bed.

c) Holding a child for an injection to protect them from injury.

d) Protective helmets

e) If a patient can remove the device it is not a restraint.

f) Orthopedically prescribed devices

g) Surgical dressing or bandages

B. Chemical Restraints:

1. 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 standard treatment or dosage for the patient's condition.

   a) A medication - not prescribed to treat the patient's medical condition.

   b) That is administered with the primary intent of medically restraining a patient who presents a likelihood of serious physical injury to themselves or others.

   c) As an example, a chemical restraint could reduce a patient's alertness, cause a patient to fall asleep, or otherwise render them unable to function normally.

C. Seclusion:

1. Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate safety of the patient, staff member or others.

D. Law Enforcement Restraint Devices/Forensic Restraints:

1. The use of handcuffs or other restrictive devices applied by law enforcement officials who are not employed by or contracted by the hospital is for the custody, detention and public safety reasons and is not involved in the provision of health care. The law enforcement officers who maintain custody and direct supervision of their prisoner (hospital patient) are responsible for the use, application and monitoring of these restrictive devices in accordance with Federal and State law. Therefore, the use of restrictive devices applied by and monitored by law enforcement officers who are not employed or contracted by the hospital and who maintain custody and direct supervision of their prisoner are not governed by restraint and seclusion standards.

IV. RESPONSIBILITIES:

Nursing Staff and Practitioners

V. PROCEDURE:

A. ASSESSMENT FOR RESTRAINTS/SECLUSION

1. Non-Violent / Non-Self-Destructive

a) Non-Violent/Non Self Destructive restraints are used to keep patients safe, preventing them from interfering with medical intervention. Examples include soft wrist restraints, net beds, mitts and geri chairs.

b) Prior to the initiation of restraints, all patients will be assessed and less restrictive measures to modify behavior will be attempted. These may include:

- Companionship and supervision
- Collaboration with the provider
- Discontinuance of tubes as soon as medically possible
- Modification of the environment
- Psychosocial intervention
- Offering fluids and assistance with elimination every 2 hours while awake.
- Diversionary and/or physical activity
- Playing soft music
- Increasing staff/patient interactions
- Bed/chair alarms
- Exploration of possible causes of restlessness, agitation, or noise, such as pain, infection, electrolyte imbalance, aphasia, psychiatric disorders, etc.
- Functioning hearing aids and clean glasses are assured
- Increasing physical activity if restless (as patient is able)
- Consideration of PT/OT evaluation for alternative measures
- Consideration of psychiatric screening/consult, as appropriate
- Passive range of motion
- Utilization of PRN Medications

c) When attempts at less restrictive measures fail, and soft restraints are applied, patients will be monitored and reassessed every 2 hours by trained staff that are able to demonstrate competencies in performance in assessments in the use of restraints. The trained staff includes RNs, LPNs and C.N.A.s. These assessments will be documented every 2 hours or more frequently if condition warrants. Assessments shall include:

- Signs of injury associated with restraint
- Nutrition and hydration
- Circulation and range of motion in the extremities
- Vital signs approximately every 4 hours or more frequently if patient condition warrants
- Hygiene and elimination

- Physical and psychological status and comfort
- Readiness for discontinuation of restraint

d) If Non-violent/non self-destructive (soft cuffs) are utilized for a violent and/or self-destructive patient all rationale for initiation, monitoring and documentation for a violent and self-destructive patient needs to be completed.

2. Violent / Self-Destructive

Violent restraints/Self Destructive restraints are used to control a patient who is otherwise going to hurt themselves or others. This is not a medical intervention like a non-violent restraint, examples:

- 4 point (wrists and ankle**) /** physical
- Chemical
- Seclusion
- Physical Hold

b) Patients will be assessed upon admission and behavior issues will be addressed within the plan of care. This information will be passed on with each shift report and the plan of care will be updated/revised as indicated by patient behavior. Interventions for managing verbal and physical aggression may include:

- Techniques that help the patient control their behavior.
- Pre-existing medical conditions, physical disabilities/limitations that potentially place the patient at a greater risk, if restraints/seclusion are used.
- Any history of sexual or physical abuse that places the patient at greater psychological risk, if restraints/seclusion are used.
- Input from patient and family to identify, and include in the plan of care, techniques used in the past to help patient maintain behavior control.
- Education to patient and family regarding reason/rationale for restraint/seclusion use.

c) Prior to the initiation of restraints, all patients will be assessed and less restrictive measures to modify behavior will be attempted. Restraint alternatives that could be used before placing a patient into restraints/ seclusion include, but are not limited to, the following:

- Companionship and supervision
- Collaboration with the physician
- Modification of the environment
- Psychosocial intervention
- Diversionary and/or physical activity
- Playing soft music
- Increasing staff/patient interactions

- Increasing physical activity if restless (as patient is able)
- Utilization of PRN Medications

d) Assessment of the individual shall be made upon initiation of restraints or seclusion by trained staff that is able to demonstrate competencies in performance in assessments in the use of restraints. The trained staff includes RNs, LPNs and C.N.A.s. Assessments shall include:

- Signs of injury associated with restraint or seclusion
- Circulation and range of motion in the extremities
- Physical and psychological status and comfort
- Readiness for discontinuation of restraint or seclusion
- Nutrition and hydration
- Vital signs (respirations must be noted)
- Hygiene and elimination

B. ORDERS FOR RESTRAINTS/SECLUSION

1. Non-Violent / Non-Self-Destructive

a) Patients requiring restraints for physical safety to maintain the presence of tubes, lines, drains, etc. required for medical-surgical therapy.

b) All acute medical-surgical restraints will be applied and continued pursuant to an order by the physician or other authorized licensed practitioner primarily responsible for the patient's ongoing care, treatment, and services.

c) If a provider is not available to issue a restraint order, a registered nurse initiates restraints based upon an appropriate assessment of the patient. The physician or other authorized licensed practitioner who is primarily responsible for the patient's ongoing care or their designee must be notified as soon as possible, preferably within one hour after the application of restraints, to obtain a telephone order.

d) All orders for acute medical-surgical restraints will be time-limited, not to exceed 1 day, and will not be written as a standing order or for an as-needed (PRN) basis.

e) A new acute medical-surgical restraint order must be obtained from the primary care practitioner when:

- The patient requires the continued use of restraints longer than 1 day.
- Restraints have been discontinued and the patient's behavior requires the restraints to be reapplied.

f) Patients can be released from Non-violent restraints temporarily for cares.

g) An in person assessment of the patient by their physician or other authorized licensed practitioner, in collaboration with the nursing staff, is required daily to adequately assess the need for continued and/or re-initiation of the restraint order.

2. Violent /Self-Destructive / Chemical Restraint

a) All restraints and seclusions are applied and continued pursuant to an order by the provider primarily responsible for the patient's ongoing care, treatment, and services.

b) If a patient is in a physical hold if available ancillary staff may be assigned to observe the patient for signs of distress.

3. If a provider is not available to issue a restraint order, a registered nurse initiates restraints or seclusion based upon an appropriate assessment of the patient. The RN will immediately notify and obtain an order from the physician or other authorized licensed practitioner.

   a) Trained Behavioral Services Unit registered nurse or physician or other authorized licensed practitioner will complete a face-to-face assessment of the patient within one hour of application of restraint, placement in seclusion or physical hold. (Face to face portion of the violent restraint flow sheet).

   b) The BSU RN will review, as soon as possible, with the licensed practitioner the results of the one hour face-to-face assessment. A Face to Face may be completed by a provider. These elements are required:

      - Review with the physician or other authorized licensed practitioner:
      - The patient’s medical and behavioral condition.
      - The evaluation of the patient’s immediate situation.
      - The patient’s reaction to the intervention.
      - The need to continue or terminate the restraint or seclusion.

   c) The provider ordering the restraint is considered the attending. Notification of the attending provider occurs when the order is obtained.

   d) Time-limited renewal orders for use of behavioral restraints shall be:

      - Ages 18 years and older, 4 hours
      - Ages 9-17, 2 hours
      - Children under 9, 1 hour
      - Orders for restraint or seclusion shall not be written as a standing order or on an as needed (PRN) basis.

   e) If restraints/seclusion continues beyond the 1, 2, or 4 hour(s) per age category, a renewal order may be obtained by a telephone order from the provider, up to 24 hours. A new order for chemical restraint is based on a new episode. If a chemical restraint is ordered and the dose is not effective (behavior has not changed) then the subsequent dose would not be considered a "new" restraint requiring a new order. However, if another chemical restraint is required after time has passed and the initial dose was effective that is a new restraint episode and requires a new order, face to face and further requirements.

   f) If the patient remains in restraints for 24 hours after the original order, the physician or other authorized licensed practitioner must perform a face-to-face assessment of the patient before a new order can be obtained.

g) While a patient is in physical restraints or seclusion, continuous one-on-one staff observation will be completed. Assessment of the individual shall be conducted upon initiation of restrains or seclusion and documented every 15 minutes until discontinued.

h) Patients who are chemically restrained will have vital signs every 15 minutes for 2 hours and every 1 hour for 2 additional hours. Documentation includes psychological status, current behavior and vital signs. Vital signs are inclusive of heart rate, respiration, blood pressure and oxygen level. If unable to obtain a full set of vitals due to agitation and/or threats to the safety of staff or patients, minimum monitoring should include respiratory rate. Patients on a continuous drip chemical restraint will have documentation of psychological status, current behavior and vital signs every 1 hour and for 2 hours after discontinuation of the medication.

i) When appropriate, and as directed by the patient, the patient's family can be notified of the need for the use of restraint and seclusion.

j) If the patient has a guardian, the staff may notify the patient's guardian of the need for the use of restraint or seclusion, and will involve them in the plan regarding efforts to reduce the need for further restraint or seclusion use.

k) Patients CANNOT be released from violent/physical restraints on a trial basis.

l) Patients CAN be released from violent/physical restraints temporarily for cares.

m) Patients CANNOT be released limb by limb when discontinuing violent/physical restraints

n) Physicians or other licensed practitioners have the authority for discontinuation of restraints. The following is the behavior criteria for discontinuation of restraints and includes but is not limited to:

- Cessation of aggressive behavior
- Cessation of self-harm behavior

o) Both patient and staff may participate in debriefing about the restraint or seclusion episode to assist in reducing the recurrent use of restraint and seclusion no longer than 24 hours after the episode. This includes: (Form NSG-901)

- What led to the incident and what could have been handled differently
- An evaluation of the patient's physical well-being, and right to privacy

C. DOCUMENTATION

1. **Non-Violent Restraint Flow sheet**

a) Complete Restraints-non-violent order

b) Behaviors exhibited by patient that necessitated restraint intervention

c) Date and time patient was placed into restraints.

d) Types of less restrictive measures tried and patient response to measures.

e) Type of restraint utilized, and extremities restrained.

f) Complete Restraint/Seclusion Log-(BSU only)

g) Complete Restraint/Seclusion Checklist. Provide to Nursing Manager-(BSU only)

h) Patient behavior after removal from restraints.

i) An Occurrence Report will be completed if patient is injured.

j) Modification made to Care Plan.

2. **Violent Restraint Flow sheet**

a) Behaviors exhibited by patient that necessitated intervention, including that patient was informed of reason for application of restraints, and why the behavior needs to change to be released from restraint.

b) Types of less restrictive measures tried and patient response to measures.

c) Obtain Restraint Violent order.

d) Continuous monitoring of the patient and assessment documented every 15 minutes. Restraint On-going Evaluation and Vital Signs portion of Violent Restraint Flow sheet.

e) Complete Restraint/Seclusion Checklist. Give to Nursing Manager. (Form NSG-902) This document is not included in the patient's chart-(BSU only)

f) Patient behavior after removal from restraints. Restraint discontinuation portion of Violent Restraint Flow sheet.

g) Modification made to care plan.

h) Restraint debriefing, may be completed and is located under Restraint Debriefing Violent Restraint Flow sheet, to be completed within 24 hours of removal from restraints.

i) Guardian/POA may be notified within 24 hours by nursing and document under Restraint Discontinuation of the Violent Restraint Flow sheet.

j) Complete Restraint/Seclusion Log-(BSU only)

k) Occurrence Report-(BSU only)

D. STAFF EDUCATION

1. As part of orientation all nurses undergo training and demonstrate competency. Annual competency will occur as part of Nonviolent Crisis intervention training for Behavioral Services, Emergency Department Staff, ICU, Security, and House Supervisors. All nurses will complete restraint education through Care Learning on an annual basis. Individuals providing the staff training must be qualified as evidenced by education, training, and experience in techniques used to address the patients' behaviors. This education includes the following:

a) Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition.

b) Strategies to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of restraint or seclusion.

c) Use of non-physical intervention skills.

d) How to recognize signs of physical or psychological distress in patients who are being held, restrained, or secluded.

e) Direct-care staff members also receive ongoing training in and demonstrate competence in the safe use of restraint, including physical holding techniques, take-down procedures, and the application and removal of mechanical restraints.

f) Staff members who are authorized to initiate restraints/seclusion and/or perform evaluations/reevaluations of patients in restraints/seclusion must also be competent and trained to assess the readiness for restraint discontinuation. Staff will also be educated on when and how to establish a new restraint order when restraints must continue and/or how to obtain a new order if patient requires the re-application of restraints.

~~g)~~ Staff monitoring a patient in restraints will be competent in first aid techniques and certified in the use of cardiopulmonary resuscitation, including periodic recertification.

h) Utilizing behavior criteria for discontinuing restraint or seclusion and how to help patients in meeting these criteria.

i) BSU RN Education for face-to-face assessment.

- RNs will only complete the Face to Face Assessment when they have completed the initial training. The training will include:
- Monitoring the physical and psychological well-being of the patient.
- Respiratory and circulatory status
- Skin integrity
- Vital signs
- The initial education will be instructed by a professional with the following credentials: CNS, CNL, APRN or MD.
- On a yearly basis there will be renewal training for RN's completing the Face to Face Assessment

E. PHYSICIANS & LICENSED PRACTITIONERS EDUCATION

1. The physician or other authorized provider will be educated routinely regarding the Restraint & Seclusion policy. The physician or other authorized licensed practitioner will review the policy when credentialed and every 2 years when re-credentialed.

F. Quality Monitoring

1. All restraint episodes will be reviewed for patient safety, quality and compliance.

G. DEATH OF A PATIENT

1. <u>Violent / Self-Destructive</u>

a) The hospital is required to report the following information to the Centers for Medicare & Medicaid Services (CMS) regarding deaths related to restraints (this

requirement does not apply to deaths related to the use of soft wrist restraints).

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

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

d) Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death.

e) The deaths addressed in PC.03.05.19. EP 1 are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, facsimile or electronically, no later than the close of the next business day following knowledge of patient's death.

2. Non-Violent / Non-Self-Destructive

a) Nursing units need to notify the House Supervisor of all deaths in the hospital in order to potentially complete the required log of a patient who has died within 24 hours of being placed in a non-behavioral restraint.

b) The House Supervisor is required to complete Patient Death Log, when no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material. The House Supervisor will do the following:

- Records in a log or other system, any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient.
- Records in a log or other system, any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient.
- Documents in the patient record the date and time that the death was recorded in the log or other system.
- Records in a log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es).
- Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request.

VI. REFERENCES

A. The Joint Commission. (2025). 2025 Comprehensive Accreditation Manual for Hospitals. Oak Brook, IL: Joint Commission Resources.

B. Centers for Medicaid and Medicare Services. (2016). State Operations Manual, Rev. 89. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

VII. COLLABORATED WITH:

N/A

VIII. DISTRIBUTION:

A. Hospital Wide Nursing Staff

B. Medical Staff

C. Administration

IX. RESCISSIONS

A. Origination Date: 03/2002

B. Reviews/Revisions: 03/05, 03/06, 7/2013 06/2008, 10/2008, 04/2010, 07/2011, 02/2014, 02/2014, 5/2014, 7/2014; 9/2016; 2/2017, 05/2017, 11/2018, 11/2019, 03/2021, 07/2021, 7/25/2023, 06/2025

1. 02/2017 no change to policy, removed double wording
2. 05/2017 Title name changed. Previously Restraint / Seclusion; changed Procedure headings to reflect new wordage; updated references.
3. 11/2019 - Minor wordage changes to Violent/Self-Destructive and Violent Restraint Flow Sheet points.
4. 9/30/2020 Added the wording "tele-health medicine does not fulfill this requirement" to the policy.
5. 01/04/2021 deleted sending copies to QI and Unit Director.
6. 09/01/2022 revised vs25.
7. 07/25/2023 Revised vs 26 added if using soft cuff to document rationale.

X. REVIEW AND REISSUE DATE:

A. Two (2) years from effective date

B. Next 06/2027

XI. FOLLOW-UP RESPONSIBILITY:

A. Director of Behavioral Services

B. Director of Patient Safety/Risk

XII. ATTACHMENTS:

A. NSG-900 Restraint Seclusion Log

B. NSG-901 Restraint Critique

C. NSG-902 Behavioral Restraint Checklist