TuftsMedicine
Lowell General Hospital

Hospital Policy and Procedure Manual, Vol. 1, Provision of Care, Treatment and Services

Title: *Restraints and/or Seclusion*
Author/Reviewer: *Clinical Operations Director*
IMPORTANT NOTICE: The official version of this policy is contained in Ellucid and may have been revised since the document was printed.

I. PURPOSE:

This policy establishes guidelines to protect the rights and safety of our patients, staff and other included individuals by promoting safe and appropriate usage and monitoring of restraints. This policy includes when a restraint is required, nursing will document communication with the patient and the family in regards to the reason for restraint or seclusion and the behavioral expectations for release and discontinuing restraint or seclusion occurs timely with restraint initiation.

II. SCOPE:

Physician**,** Licensed Independent Practitioner **(**LIP)**,** Registered Nurse (RN), Security, and appropriately licensed staff/professionals involved in the ordering, application, monitoring, and assessment of restraints of the:

- Violent/Self-Destructive Patient
- Non-Violent/Non-Self-Destructive Patient

Note: This policy does not apply to 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.

III. PHILOSOPHY:

The American Medical Association (AMA) recognizes that individuals have a fundamental right to be free from unreasonable bodily restraint. At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient and others from harm.

Restraints and/or seclusion are only to be used when clinically necessary to improve the patient's well-being when all other available, less restrictive measures have been found to be ineffective to protect the patient, staff, or other individuals. Restraints shall not be used as a means of coercion, discipline, convenience or retaliation by staff. For incapacitated patients, their designated surrogate healthcare decisionmaker must be promptly contacted and informed of the need for restraint and/or seclusion. The ultimate goal is a restraint free environment.

This policy is applicable to all hospital patients of all ages, including inpatients and outpatients, in situations where the use of restraint or seclusion becomes necessary, regardless of patient location or treatment setting.

IV. DEFINITIONS:

1) **Non-violent behavior:** Behavioral changes primarily related to a patient's medical and/or surgical condition and the behavior results in interference with necessary treatment. This includes behavior that may be classified as irrational or uncooperative. Examples include, but are not limited to, pulling at lines, tubes, or dressings, dementia, delirium, and behaviors such as agitation, restlessness, confusion, disorientation, and unaware of physical limitations.
2) **Violent/self-destructive behavior:** Behaviors consistent with an emotional or behavioral disorder and/or the patient is at risk for injury to self or others. Examples include, but are not limited to, attempted suicide, physical assault, or violent behavior.
3) **Restraint:** A restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.
    a. **Physical Restraint:** Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he/she cannot easily remove that directly restricts freedom of movement or normal access to one's body. Holding a patient in a manner that restricts his/her movement (this would include therapeutic holds) constitutes restraint for that patient.
    b. **Medication Restraint:** 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
4) **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.**
5) **Episode:** A single or continuous time period during which a patient is restrained according to this policy. This includes the time from the initiation of restraint until termination of the order. Temporary release/removal of physical restraints that occurs when caring for a patient's needs (e.g. feeding, bathing, range of motion) is **not** considered termination of the episode.
6) **Constant Observation:** An increased level of observation where continuous monitoring techniques including, but not limited to, video monitoring or direct visualization of the patient are used to assure the safety and well-being of the patient and others within the patient care environment.

V. EXCEPTIONS TO THE DEFINITION OF RESTRAINT:

1) A voluntary mechanical support or medically necessary device used to achieve proper body positions, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is **not** considered a restraint (leg, neck, back or head brace.)
2) Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers) that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool aged child would **not** be considered restraint for the purposes of this policy.
3) 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).

VI. POLICY

It is recognized that in order to protect patient and staff safety, that the application of restraints may be required to ensure the immediate physical safety of the patient, staff members, or other individuals. The decision to use a restraint or seclusion is **not** driven by diagnosis, but by individualized patient assessment. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, staff, of others individuals from harm. Restraints are discontinued at the earliest possible time, regardless of the scheduled expiration of the order. The use of restraint and seclusion should be in accordance with a modification to the patient's plan of care.

VII. PHYSICAL RESTRAINT TYPES:

- Mitts
    - Considered a restraint, if the mitts restrict the movement of fingers and/or are tied and restricts movement of the arms.

- Lap/Waist Belt
- Chair with affixed Table
- Full Siderails
- Soft restraint (soft extremity cuffs)
- Mechanical Restraint (Velcro extremity cuffs)
    - Only to be used by Security to restrain patients who are violent/self-destructive.
- Physical hold for forced psychotropic medication
- Oral spit hoods
- Enclosed Bed
- Tucking or tying bed sheets to restrict movement
- Any equipment which restricts the environment, physical activity, and/or normal access of a patient

A side rail is <u>NOT</u> a restraint when used:

- On a bed or stretcher to transport patients from one point to another.
- As an assistive device for increasing the competent patient's mobility.
- After the administration of pre/post medications.
- At the request of the alert and oriented patient who is able to follow directions and use the call light.
- The intent of the side rail is to prevent the patient from inadvertently falling out of bed.

If the patient does not have the physical capacity to get out of bed regardless if the side rails are raised or not, for example, a paraplegic patient.

VIII. <u>LESS RESTRICTIVE INTERVENTIONS:</u>

Staff will utilize and document appropriate alternatives prior to resorting to restraints. Alternatives may include, but are not limited to, as appropriate for the patient's needs: (Appendix A)

1) 1:1 patient care
2) Repositioning
3) Re-evaluate equipment
4) Disguise equipment
5) Pain management
6) Alarm
7) Non-secured mitt
8) Reorientation to surroundings
9) Diversionary activities
10) Increased frequency of nursing rounds
11) Verbal redirection
12) Decrease stimulation
13) Family/friends to remain with patient, if possible

IX. <u>ASSESSMENT:</u>

1) An initial comprehensive individual patient assessment of the patient should include a review of the patient's clinical status to determine whether a change in the patient's condition may be contributing to the patient's symptoms. The review must also determine whether the risks associated with the use of the restraint or seclusion are outweighed by the risk of not using restraints and whether a less restrictive device/intervention could offer the same benefit with less risk.
2) A physician, LIP or RN must be involved in an initial assessment of the patient to determine the need for a restraint. Special consideration of needs and risks will be given to vulnerable populations who are cognitively or physically challenged, pediatric or require emergency care.
3) In addition to the assessments required under this section, patients who are in restraints are to be monitored and re-assessed on a periodic basis, as described below.

X. <u>PROCEDURE:</u>

1) Following patient assessment and determination that a restraint or seclusion is appropriate and necessary, and less restrictive methods have been ineffective.

Physician/LIP
Complete restraint order, including start time of restraint, restraint type, restraint reason and duration of restraint.
A physician or other authorized licensed practitioner is responsible for the patient's care orders for the use of restraint or seclusion.
The attending physician is consulted as soon as possible, if they did not order the restraint or seclusion.
Orders must never be written as a standing or as needed (prn) order.

RN
Obtain an order for restraint or seclusion, if clinically indicated.
In an emergency, based upon an RN's assessment, a restraint or seclusion may be initiated. The Physician/LIP must be notified and an order obtained, as soon as possible and as outlined in the table below.
Communication with the patient and the family in regards to the reason for restraint or seclusion and the behavioral expectations for release and discontinuing restraint or seclusion.
Ensure restraint devices are applied by staff who have completed required training.

2) Ensure any patient that is restrained for **violent or self-destructive behaviors** is under **constant observation.**
3) Request support from Security when applying or releasing restraints used for a violent/self-destructive patient.
4) **Assessment and Documentation:** (outlined in corresponding tables)
    a. Violent/Self Destructive Restraints
    b. Non-violent Restraints

Violent/Self-Destructive Restraints	
Initial Order	Order prior to application or, in an emergency, as soon as possible
Initial Documentation	Documentation in the patient's medical record should indicate a clear progression of how less restrictive interventions or techniques were attempted prior to the introduction of more restrictive measures. This should include: • The patient's behavior, *alternatives*, and intervention used • The rationale for the use of the restraint • The patient's response to the use of the restraint indicating affect and behavior • The reason for continuation of the restraint • Any variation from the hospital's policy and procedure for monitoring a patient in restraint. • Family Notification
Order Timeframe	• 4 hours for adults • 2 hours for patients 9-17 • 1 hour for children under the age of 9
Face-to-Face Assessment (Physician/LIP)	Required within **1 hour** after initiation of the restraint/seclusion to evaluate: • Immediate situation • Reaction to the intervention • Medical and behavioral condition • Need to continue or terminate the restraint or seclusion
Order Renewal	• Every 4 hours for adults • Every 2 hours for patients age 9-17 • Every 1 hour for children under the age of 9
Physician/LIP Reassessment	• Every 24 hours • Evaluates the patient before writing a new order for restraint or seclusion • Reassess the Plan of Care (POC) and document in the patient's medical record • Consider a psychiatric evaluation
Nursing Observation, Reassessment	• Every 15 minutes, minimum • Document patient reassessments including the following: **Justification:** • Clinical Justification **Education** • Discontinuation Criteria • Criteria Explained • Patient Response **Restraint Monitoring Assessment** • Psychological status • Physical Comfort • Circulation • Continuous Observation • Physical Comfort • Range of Motion • Fluids • Food/Meal • Hygiene/Elimination **Restraint Type:** • Type of location of the restraint
Discontinuation	• When behavior resolves, RN may discontinue • Document date/time of discontinuation • Security should be called to remove restraints on violent/self-destructive patients

Non-Violent Restraints	
Initial Order	Order prior to application or, in an emergency, as soon as possible
Initial Documentation	Documentation in the patient's medical record should indicate a clear progression of how less restrictive interventions or techniques were attempted prior to the introduction of more restrictive measures. This should include: • The patient's behavior, *alternatives*, and intervention used • The rationale for the use of the restraint • The patient's response to the use of the restraint indicating affect and behavior • The reason for continuation of the restraint • Any variation from the hospital's policy and procedure for monitoring a patient in restraint. • Family Notification
Order Timeframe	Per Episode
Face-to-Face Assessment (Physician/LIP)	Required <u>within 24 hours</u>
Order Renewal	<u>Per Episode</u>
Physician/LIP Reassessment	Each calendar day reassess the Plan of Care (POC) and document in the patient's medical record
Nursing Observation, Reassessment	Every 2 hours, minimum Document patient reassessments including the following: **Assessment:** • Patient Behavior, level of agitation • Clinical Justification • Less Restrictive Alternative **Restraint Monitoring Assessment** • Restraint Skin Assessment • Restraint ROM • Restraint Nutrition/Hydration Status • Restraint Hygiene/Elimination Status • Restraint discontinue Readiness attempts. **Education** • Discontinuation Criteria • Criteria Explained • Patient's Response **Restraint Type:** • Type of location of the restraint
Required Nursing Documentation each shift (every 8 hours)	• Vital signs, as indicated • Signs of injury associated with the application of restraint
Discontinuation	• When behavior resolves, RN may discontinue • Document date/time of discontinuation and discontinue restraint order

XI. <u>TERMINATION OF RESTRAINT:</u>

1) Utilize least restrictive device based on ongoing assessment.
2) Discontinue the restraint as soon as a Physician, LIP, or RN reassessment indicates it is appropriate.
3) Criteria for discontinuation includes: assessment by licensed staff reveals that the patient no longer displays behavior that puts self or others at risk for injury.

4) If a patient requires 24 hours of continuous violent restraints or seclusion the RN will review with members of the interdisciplinary care team the POC to consider the patient's situation and appropriate alternatives to violent restraints or seclusion.
5) For all restraints: The POC will be revised by a member of the interdisciplinary care team to achieve patient outcomes.

XII. ONGOING EDUCATION AND TRAINING:

Physicians and other authorized licensed independent practitioners will be provided with the policy and procedure upon receipt of initial privileges. Changes to the policy will be shared with the medical staff, as necessary. Physicians and other licensed practitioners authorized to order restraint or seclusion have a working knowledge of the hospital policy regarding the use of restraint and seclusion.

Ongoing restraint and seclusion education and training must be provided both as part of the initial orientation of all new and contract staff and as a part of ongoing in-service training for all staff that have direct patient care responsibilities. Training will occur upon orientation to any unit that is using restraints for the violent/self-destructive patient.

LGH will maintain a documented educational, instructional training program for the use of restraint techniques, seclusion, alternatives methods for handling behavior, symptoms, including the appropriate application, monitoring, assessment and removal.

XIII. REFERENCE(S):

1) Centers for Medicare and Medicaid. February 21, 2020. CMS Conditions of Participation for Hospitals, 42 C.F.R. § 482.13, Survey Manual, Appendix A.
2) Massachusetts General Laws, Patient Rights, 111 M.G.L. 70E.
3) Massachusetts Department of Public Health, Licensure of Hospitals, 105 CMR 130.
4) The Joint Commission E-edition (2022). Chapter: Provision of Care, Treatment and Services. PC.03.05.01 – PC.03.05.19.
5) American Medical Association, Medical Ethics Opinion. Accessed February 23, 2022.

XIV. ATTACHMENTS:

A. Alternatives to Restraint
B. Questions & Answers About Restraint Use

XV. ASSOCIATED ELECTRONIC DOCUMENTS:

Sentinel Events and Serious Reportable Events Policy

XVI. POLICY TRACKING RECORD

Formerly Named:

Restraint and Seclusion for Violent/Self-Destructive Management (In-Patient BHS Excluded)
Restraints for Acute Medical and Surgical Care (renamed 7/2013)
Restraint or Seclusion of the Violent/Self-Destructive Patient & Restraint for Non-Violent/Non-Self-Destructive Patient

Reviewed/Revised: 10/97; 11/00; 1/02; 10/03; 8/04; 7/06; 1/07; 7/09; 10/12; 3/13; 1/18, 4/21; 2/22; 3/23

XVII. ENDORSEMENT:

Director of Emergency Department Services, Quality Improvement Specialist, Policy Review Committee, Nurse Practice Council, VP PCS CNE

Attachment A

ALTERNATIVES TO RESTRAINT USE

The nurse will try appropriate/applicable alternatives before instituting restraints.

A. **Providing companionship and supervision.**
   1. Ask family, friends, or volunteers to stay with the patient.
   2. More frequent rounding on high risk patients.

B. **Adapt Treatment Plan**
   1. Initiate oral (as opposed to IV or NG) feedings.
   2. Remove catheters and drains as soon as possible.
   3. Initiate regular toileting schedule.
   4. Do not leave patient alone while toileting.

C. **Modifying the environment**
   1. Increase or decrease the amount of light in the room, depending on glare and the patient's preference or needs.
   2. Position the bedside commode so that the patient can use it easily.
   3. Arrange for patient to be near the nurse's station, unless the stimulation triggers agitation or worsens confusion.
   4. Implement use of low-level bed, so the patient can move about freely in bed without falling.
   5. Leave the bed rails down if the patient tends to climb over them, or use half rails to prevent rolling out of bed.
   6. Reduce environment noise.
   7. Keep the call button accessible.
   8. Use special furniture accordingly (a lower bed, a reclining chair).
   9. Personal safety alarm use

D. **Reality orientation and psychosocial interventions**
   1. Involve the patient in conversation.
   2. Explain procedures to reduce fear and convey a sense of calm.
   3. Provide reality links when appropriate (TV, radio, calendar, clock).
   4. Use relaxation techniques (therapeutic touch, massage, warm baths).
   5. Use active listening to elicit the patient's feelings.
   6. Provide consistent care routine.
   7. Offer choices when able.

E. **Offering diversionary and physical activities**
   1. Use TV, radio, or music for diversion (depending on the patient's cognitive capacity and individual preferences).
   2. Provide exercise and ambulation whenever possible.
   3. Initiate training in activities of daily living.
   4. Use physical and occupational therapists to help the patient increase his strength and endurance and feel a sense of accomplishment.

F. **Designing creative alternatives**
   1. Use music chosen specifically for the patient to reduce agitation or to provide diversion.
   2. Use a pressure-sensitive bed or chair pads with alarms for alerting staff to an unsteady patient standing without help.
   3. Develop toileting routines to facilitate elimination and reduce falls related to elimination.
   4. Consult with other disciplines about appropriate interventions.

Attachment B

Lowell General Hospital

Questions and Answers about Restraint Use

What is a restraint?

- A restraint is any method that limits a person's movement or access to his/her body.

Why are restraints ever used?

- First, you should know that Lowell General Hospital is committed to providing a restraint free environment whenever possible. Restraints are used as a last resort to protect a patient or others from injury and to support effective care. The nursing staff can explain to you exactly why restraints are being used in the case of your loved one and outline the risks and benefits in your loved one's case.

Can something be done instead of restraints?

- Prior to ever using restraint on a patient, the nursing staff will consider other options. Other options may be: providing companionship or supervision, changing or eliminating bothersome treatments, assisting the patient to a new position, making sure the patient is free of pain, use of special furniture, offering other activities such as TV, radio or sitting in a chair.

How long will the restraint stay on?

- The nursing staff will discontinue the use of restraint completely as soon as the patient's condition allows. While restraints are in use, the nursing staff monitors the patient very closely, offering frequent opportunities for toileting, hydration, nutrition and exercise. Every couple of hours the nursing staff will release the restraint, check the patient's skin under a restraint and provide an opportunity for the patient to move around.

We don't want our loved one restrained, what can we do?

- You can assist the nursing staff in our goal of keeping all of our patients out of restraints. Talk to the nurse caring for your loved one and find out why the restraints are being used and what you can do to help. Sometimes, if a family is willing to sit with a patient and watch their activities, restraints can be avoided. It is always helpful when families reassure and reorient confused patients.

Is the doctor aware that the patient is restrained?

- Yes, the doctor is always notified if restraint is used.

We still don't agree that our loved one should be restrained, is there anyone else we can talk to?

- Absolutely, we want your concerns to be heard and your questions answered to your satisfaction. Our nurses are committed to including you in planning the care for your loved one; however, we realize that sometimes the circumstances surrounding restraint use are very difficult. We encourage families who have continues concerns after speaking to the nurse to speak to the Nurse Manager of the unit or to speak to a representative from our Patient Relations department. The Patient Relations Specialist can be reached by calling 978-937-6458. During evenings, nights and weekends, there is an Administrative Supervisor who is available to speak to you.