



TITLE: Restraint and Seclusion for Violent or Self-Destructive Behavior

EFFECTIVE DATE: June 2020

OWNER OF THIS POLICY: Chief Nursing Officer

SCOPE: This policy applies to Workforce Members at all departments of Baptist Hospital, Gulf Breeze Hospital, and Jay Hospital.

STATEMENT OF PURPOSE: To ensure Restraints are used appropriately and safely with respect for patients' rights.

DEFINITIONS:

Episode: A single continuous use of the same type of Restraint and/or Seclusion

Face to Face Evaluation: An assessment of the patient within 1 hour after the initiation of Restraint or Seclusion for violent or self-destructive behavior.

Least Restrictive Interventions: Include, but are not limited to, diversional activities, increased supervision, visitation with a family member, comfort measures, etc.

Medication Restraint: A drug used as a restriction to manage the patient's behavior and is not a Standard Treatment or Dosage for the condition of the patient. Appropriate or therapeutic doses of medications that enable the patient to more effectively or appropriately function in the world around them are not considered a Medication Restraint.

Physical Hold: A specific type of restraint where the patient is held in a manner that restricts the patient's movement against his or her will. A physical hold is time limited to 15 minutes. Physically holding a patient during forced psychotropic medication administration is considered a restraint. A 1 hour Face to Face Evaluation is required with an order for a Physical Hold.

Restraint: 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 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 purposes 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). A Restraint **excludes** the use of handcuffs or other restrictive devices applied by law enforcement officials who are not employed by or contracted by the hospital when the use of such devices is for custody, detention, and public safety reasons, and is not involved in the provision of care. NOTE: A LINET Bed with both upper and mid side rails up (4 side rails) is not considered a restraint.

Prolonged Restraint or Seclusion: Violent or Self-Destructive: Restraint or Seclusion \geq 12 consecutive hours.

Provider a licensed physician, physician assistant (PA) or advanced practice registered nurse (APRN) who has appropriate privileges or scope of employment to order Restraints and Seclusion.

Restraint Oversight Committee: Committee whose purpose is to assist Workforce Members with adhering to policies and procedures related to Restraint and Seclusion.

Seclusion: Involuntary confinement of a patient alone or in a room or area from which the patient is physically prevented from leaving. A situation where a patient is restricted to a room or area alone and Workforce Members are physically intervening to prevent the patient from leaving the room or area is also considered Seclusion. Seclusion may only be used for the management of Violent or Self-Destructive behaviors that jeopardize the immediate physical safety of the patient, a Workforce Member, or others.

Standard Treatment/Dosage of a drug or medication: The medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications it is manufactured and labeled to address, including listed dosage parameters. The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization. The use of medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation and on the physician's or other Provider's knowledge of that patient's expected and actual response to the medication. There is an expectation that the medication enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of the medication.

Violent or Self-Destructive Behavior ("Violent Behavior") Restraint: Used to manage behavior that jeopardizes the immediate safety of the patient, Workforce Member or others.

Workforce Members: Full, part time, or prn employees, credentialed and employed physicians, volunteers, and students of BHC and/or its affiliates, and any employees or personnel of independent contractors of BHC and/or its affiliates working under the direct supervision of a BHC leader.

POLICY:

1. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from Restraint or Seclusion, of any form, that is not medically necessary or that is imposed as a means of coercion, discipline, convenience, or retaliation. The use of Restraints or Seclusion will only be used to ensure the immediate physical safety of the patient, a Workforce Member, or others. Restraints or Seclusion must never create a barrier to the provision of safe and appropriate care, treatments, and other interventions.
2. Restraints may only be used when less restrictive interventions have been determined to be ineffective and the patient assessment meets criteria for use. Restraint or Seclusion must be discontinued at the earliest possible time.

PROCEDURE

1. A Provider order for Restraint or Seclusion shall be obtained prior to the application of Restraints. In emergency situations, when the need for intervention may occur quickly, a trained RN may initiate the application of the Restraint or Seclusion.
 - a. The order for Restraint or Seclusion must be obtained either during the emergency application of the Restraint or Seclusion or immediately (within a few minutes) after application.
 - b. The ordering Physician must authenticate the Restraint or Seclusion order within 24 hours. If the ordering provider is not the patient's attending physician, the attending physician must be consulted to be informed that the patient required Restraints or Seclusion. The order for Restraint or Seclusion must include:
 - The reason (medical necessity; rationale for the use)
 - The type of Restraint or Seclusion
 - The extremity or body part to be restrained
 - The duration (timeframe) for the intervention

2. The use of PRN or standing orders is prohibited for any form of Restraint or Seclusion except as follows:
 - a. Geri chair. If a patient requires the use of a Geri chair with the tray locked in place in order for the patient to safely be out of bed, a standing or PRN order is permitted.
 - b. Raised side rails. If a patient's status requires that all bedrails be raised (Restraint) while the patient is in bed, a standing or PRN order is permitted.
 - c. Repetitive self-mutilating behavior. If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyham Syndrome, and the patient engages in repetitive self-mutilating behavior, a standing order or PRN order for Restraint to be applied in accordance with specific parameters established in the treatment plan is permitted.

EXCEPTION: The use of handcuffs or other restrictive devices applied by law enforcement officials who are not employed by or contracted by the hospital when the use of such devices is for custody, detention, and public safety reasons, and is not involved in the provision of care is not considered a form of Restraint. The application, monitoring, and removal of forensic devices are the responsibility of the law enforcement officers. The hospital and its Workforce Members are responsible for providing safe and appropriate care to the patient.

3. Face to Face Evaluation:
 - a. Within 1 hour of initiation of Restraint or Seclusion for violent or self-destructive behavior an assessment of the patient will be completed to include:
 - i. evaluating the patient's immediate situation,
 - ii. the patient's reaction to the intervention,
 - iii. the patient's medical and behavioral condition, and
 - iv. the need to continue or terminate the Restraint or Seclusion.
 - d. The Face to Face evaluation is completed by a physician or other qualified licensed provider, or Registered Nurse who has been appropriately trained.

- e. If the one hour face-to-face evaluation is not completed by a Provider, the Provider responsible for the care of the patient shall be consulted as soon as possible after completion of the evaluation.
- f. Face to Face evaluation is required with the initial order as well as with each order renewal.

4. The following order intervals apply:

Patient Population	Order Interval
Adults (18+)	Every 4 hours
Adolescents (9-17)	Every 2 hours
Children (8 or less)	Every hour
Physical Hold (for all ages)	15 minutes

- a. Restraint or Seclusion order renewal for Violent or Self-Destructive Behavior may only be continued for up to 24-hours after which time the patient must be reassessed by a Provider before a new order may be issued.
- b. If Restraint or Seclusion ceases prior to the expiration of the initial order, a new order is required before Restraint or Seclusion can be re-initiated.

5. Assessment and Documentation

- a. Initial Assessment – A comprehensive assessment should be performed and documented with the use of Restraint and Seclusion. The assessment should include a physical assessment to identify medical problems that may be causing behavior changes in the patient, environmental factors, treatment plan and that the least restrictive measures have been determined ineffective to protect the patient or others from harm.
- b. Vital signs are obtained after Restraints are applied, as ordered and PRN.
- c. With Restraints or Seclusion, the patient is assessed and documented on every 15 minutes. The assessment and documentation are based on the patient's individual needs and clinical condition taking into consideration the following:
 - Repositioning
 - Range of motion exercises
 - Medical issues that may be contributing to behaviors
 - Respiratory Status
 - Circulatory Status
 - Hydration and nutritional needs
 - Hygiene and elimination needs
 - Signs of Injury
 - Signs of distress
 - Mental status
 - Cognitive function

- Skin integrity (color, warmth, movement of restrained body parts)
 - Type of Restraint, proper placement and security of Restraints
 - Alternatives to Restraint
 - Readiness for release of Restraint or Seclusion
- d. Staff response to signs of distress may include repositioning the patient, discontinuing the Restraint, or summoning medical attention as necessary.
 - e. Plan of Care -- The use of Restraint or Seclusion must be documented in the plan of care based on assessment and evaluation of the patient.
 - f. The plan of care should be reviewed and updated daily and as needed based on the patient's reassessment and reevaluation status.

6. Simultaneous Use of Restraint and Seclusion:

- a. For any patient population, if Restraint and Seclusion are used simultaneously, the patient must be continually monitored face-to-face, by an assigned, trained Workforce Member; or continually monitored by a trained Workforce Member using both video and audio equipment. Such monitoring shall be in close proximity to the patient and ongoing, without interruption.
- b. Simultaneous use of Restraint and Seclusion cannot be used for children less than 18 years of age.

7. Discontinuation of Restraint or Seclusion:

- a. The provider and/or RN must assess and monitor a patient's condition on an ongoing basis to ensure that the patient is released from Restraint or Seclusion at the earliest possible time. Once the Restraint or Seclusion is no longer needed, the Restraint must be removed. The decision to discontinue the intervention should be based on the determination that the need for Restraint is no longer present or that the patient's needs can be addressed using less restrictive methods. The decision to discontinue Restraint is made by the RN or Provider
- b. If Restraint or Seclusion is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating the use of Restraint or Seclusion. Note: Discontinuing a Restraint or Seclusion order and then subsequently restarting the same order would constitute a PRN order and is not permissible.
- c. A temporary release that occurs for the purpose of caring for a patient's needs such as toileting, feeding, and range of motion, is not considered a discontinuation of the Restraint or Seclusion and should be documented as released and reapplied.
- d. Emergency medical or environmental situations may necessitate immediate removal of Restraints or Seclusion. For Forensic patients, work with law enforcement to immediately remove handcuffs or other restrictive devices should an emergency condition occur.

8. Mandatory Reporting: For Baptist Hospital only, patients who have been diagnosed or are being treated for a possible diagnosis of mental illness, each Restraint or

Seclusion Episode must be reported in BHC electronic incident reporting system for subsequent mandatory reporting to Department of Children and Families.

9. Quality Monitoring:

- a. The use of Restraint and Seclusion will be monitored and evaluated on a continual basis as part of the quality management system.
- b. Aggregate data regarding the use of Restraint or Seclusion will be routinely collected and analyzed by the Restraint Oversight Committee to identify trends, deficiencies and educational opportunities
- c. Prolonged Restraint or Seclusion and any use of Medication Restraint will be reviewed by the provider and RN and reported to the Restraint Oversight Committee for analysis.
- d. The Restraint Oversight Committee will conduct intensive analysis any time a patient is injured through the use of Restraint or Seclusion or a Workforce Member is injured through application of a Restraint or Seclusion.

10. Reporting of Deaths:

- a. Any deaths meeting the criteria set forth in sections i-iii below shall be immediately entered into BHC electronic incident reporting system. The Risk Management department will report such deaths to the CMS Regional Office no later than the close of business on the next business day following the day of the patient's death, and will report to the Department of Children and Families as required. The House Supervisor will document in the patient's medical record the date and time that the relevant agencies were notified.
 - i. Any death while the patient was in Restraints or Seclusion at the time of death (excluding patients who were only in two point soft wrist Restraints and who were not in Seclusion at the time of death);
 - ii. Any death within 24 hours of the patient being in Restraints or Seclusion (excluding patients who were only in two point soft wrist Restraints and who were not in Seclusion within 24 hours of their death);
 - iii. Any death that occurs within one week of the patient being in Restraints or Seclusion where it is reasonable to assume the Restraint or Seclusion contributed directly or indirectly to the patient's death (regardless of the type of Restraint)
- b. Any death meeting the criteria set forth in section i-ii below shall be recorded in the Hospital's death log and reported in BHC electronic incident reporting system. The log entry must be made no later than seven days after the date of the patient's death.
 - i. Any death while a patient was in Restraints but not Seclusion and the only Restraint used on the patient were applied exclusively to the patient's wrists and were composed solely of soft, non-rigid, cloth-like materials.
 - ii. Any death that occurs within 24 hours after the patient has been removed from Restraint when no Seclusion has been used and the only Restraints used on the patient were applied exclusively to the patient's wrists and were composed solely of soft, non-rigid, cloth like materials.

11. Immediate access to the patient by the patient's representative should be permitted even if the patient is in Restraint or seclusion, unless such access would be detrimental to the patient, in accordance with FL. Stat.394.459.
12. Appropriate Workforce Members will receive Restraint or Seclusion education and training based on role and level of direct patient-care. Training will occur as part of orientation, prior to performing any Restraint or Seclusion related activities, and annually. Appropriate Workforce Members will demonstrate competency in the application of Restraints or Seclusion, monitoring, assessment, and providing care for a patient in Restraints or Seclusion prior to performing any Restraint or Seclusion related activities, and annually.
 - a. The hospital requires appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:
 - Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require Restraint or seclusion;
 - The use of non-physical intervention skills, including de-escalation and dealing with aggressive behavior;
 - Choosing the least restrictive intervention based on an individualized assessment of the patients' medical or behavioral status or condition;
 - The safe application and use of all types of Restraints or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);
 - Clinical identification of specific behavioral changes that indicate that Restraint or seclusion is no longer necessary;
 - Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1- hour face-to-face evaluation; and;
 - The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including recertification requirements.

Elsevier provides guidelines only and is not meant to establish the standard of care in each case. Actual treatment may differ based on clinical judgment and circumstances.

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REFERENCES:

CMS Conditions of Participation and Interpretive Guidelines: 482.13(e) Standard: Restraint or Seclusion, Interpretive Guidelines 482.13(e) through (g), Effective/Implementation dates: 08-30-13.

NIAHO Accreditation Requirements, Interpretive Guidelines and Surveyor Guidance-Revision 18-2

CMS 42 CFR Section 482.13(g) Death Reporting Requirements
CMS "Report of a Hospital Death Associated with Restraint or Seclusion"
<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html> search
for Form CMS-10455
State of Florida, Department of Children & Families: Baker Act Handbook and User
Reference Guide 2014, Appendix I-8
Fla. Stat. 394.459.

RESCISSION:

Restraints for Violent or Self Destructive Behavior, issued 12/19, is hereby rescinded.