midland memorial hospital

Title:	Restraint or Seclusion & Associated Death Reporting Guidelines				
Version:	8	**Approved:**	Robert Dent (COO/CNO Senior Vice President), Russell Meyers (President /Chief Exec Officer)	**Date:**	01/28/2017

Purpose:
To define the Midland Memorial Hospital (hereinafter referred to as the 'hospital') policy regarding the restraint and/or seclusion of a patient. Further, to describe the procedure for reporting and documenting any restraint associated death or patient death within 24 hours of restraint use.

Policy:
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, that is not medically necessary, or that is imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, staff members, or others or to support medical healing. Restraints or seclusion be discontinued at the earliest possible time.

The organization will work to actively decrease the use of restraint or seclusion. When restraint or seclusion is necessary, such activity will be undertaken in a manner that protects the patient's health and safety and preserves his or her dignity, rights, and well-being. The use of restraint/seclusion is a last resort, after alternative interventions have been determined to be ineffective to protect the patient or others from harm.

Definitions:

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; or 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.

A restraint does not include devices, such as orthopedic 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.

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 only be used for the management of violent or self – destructive behavior of patients when there is an immediate danger of harm to the patient, a staff member, or others. (Example: a patient with an involuntary hold for psychological evaluation who is not allowed to leave his/her room.)

"**Reasonably Assumed" - "**In this contest includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compressions, restriction of breathing or asphyxiation." – CRF 42, Part 482, HHS (2006)

*****Seclusion is used mostly in the Emergency Department Areas.*****

Exclusions:

The following are, by definition, not considered restraint or seclusion and are specifically excluded from this policy:

- A voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such support.
- Standard practices that include limitation of mobility or temporary immobilization during medical, dental, diagnostic procedures, or surgical positioning and related post-procedure care processes when such practice is considered an inherent part of the procedure.
- Recovery from anesthesia that occurs when the patient is in the intensive care unit or recovery room is considered part of the surgical procedure; therefore, medically necessary restraint use in this setting would not need to meet the requirements of this standard. However, if the intervention is maintained when the patient is transferred to another unit, or recovers from the effects of the anesthesia (whichever occurs first), a restraint order would be necessary and the requirements of the standard(s) must be followed.
- Helmets.
- Comforting of children or adolescents.
- Placing patients in a voluntary time out in an unlocked room in which the patient is not prevented from leaving.
- The use of handcuffs or other restrictive devices applied by law enforcement officials, not employed or contracted by the hospital, when the use is for custody, detention and public safety reasons and not involved in the provision of health care.
- The use of side rails to assist a patient with safety, unless the use is such that the side rails prevent patient mobility (e.g. all four side rails up).
- Medication (including PRN) used as a standard part of a patient's treatment plan provided the following criteria met:
  - 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 the medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician/LIP's knowledge of that patient's expected and actual response to the medication.

Criteria for Use of Restraint or Seclusion

- The use of restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, staff or others or to support medical healing.

- Must be discontinued at the earliest possible time.
- The use of restraint or seclusion is based on the assessed needs of the patient. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member or others from harm. Less restrictive interventions may include, but are not necessarily limited to:
  - Re-orientation,
  - De-escalation,
  - Limit setting,
  - Increased observation and monitoring,
  - Use of a sitter,
  - Change in the patient's physical environment,
  - Review and modification of medication regimens.
- Written modification to the patient's plan of care
- Restraint and seclusion may not be used simultaneously, unless the patient is continually monitored, face-to-face, by an assigned, trained staff member; or continually (without interruption) monitored by trained staff using both audio and visual equipment in close proximity to the patient.

Reporting of Deaths of Patients in Restraint or Seclusion

The organization will report deaths associated with the use of seclusion or restraint to the Center for Medicare Services (CMS). Reporting may also occur to other external agencies as required by state law and/or organization policy. Each death referenced below will be reported by the Manager of Clinical Operations or designee and documented in the electronic medical record. Release of Body Clinical Operations Internal Restraint Death Log

The CMS regional office must be informed by telephone**,** facsimile or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death of each reportable death. The CMS regional office will determine if an investigation is warranted.

Provider information:

a. Hospital name, address, and NPI provider number

Patient information:

a. Patient name, date of birth
b. Admitting diagnosis
c. Date of admission
d. Date and time of death
e. Cause of death
f. Circumstances surrounding the death

Associated restraint reporting criteria:

a. Death occurred while the patient was in restraint or in seclusion

b. Death occurred within 24 hours after restraint or seclusion was removed
c. Death occurred within one (1) week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. ``Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.
d. When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:
    i. Any death that occurs while a patient is in such restraints.
    ii. Any death that occurs within 24 hours after a patient has been removed from such restraints.
e. The staff must document in the patient's medical record the date and time the death was:
    i. Reported to CMS for deaths or
    ii. Recorded in the internal log or other system for deaths described above in paragraph (d).
    ***Documentation of death in the internal log must be dated within 7 days of the date of death. Clinical Operations Internal Restraint Death Log.

Process: The Nurse Manager of Clinical Operations, or designee, will report to the regional CMS office by telephone, fax or email, any restraint-associated or seclusion-associated death "no later than the close of business the next business day following knowledge of the patient's death.", Clinical Operations Internal Restraint Death Log Release of Body .

RESTRAINTS USED TO MANAGE NON-VIOLENT/NON-SELF DESTRUCTIVE BEHAVIOR

Restraint use associated with non-violent or non-self-destructive behavior may be indicated, but only when it directly supports medical healing.

Ordering Restraints Used to Manage Non-Violent/Non-Self Destructive Behavior

The use of restraint must be in accordance with the order of a physician or designee who is responsible for the care of the patient. This includes the authority of a physician to delegate this task to a mid-level provider, to the extent recognized under State law or regulatory mechanism. At a minimum, physicians/LIP authorized to order restraints must have a working knowledge of hospital policy regarding the use of restraint. At the time of initial appointment and at reappointment, each physician's/LP's credentialing file will have a signed acknowledgement stating that they have received and read the Restraint or Seclusion policy and that they understand their obligations to patients as stated in the policy. The attending physician must be consulted as soon as possible[1] if the attending physician did not order the restraint.

Orders for the use of restraint must never be written as a standing order or on an as needed basis (PRN).

[1] As soon as possible is defined as within a 24 hour period following the issuance of the restraint or seclusion order.

Special note: Orders written in association with a transfer in level/location of care {e.i. emergency department (ED) to critical care unit (CCU)} are valid when the restraint use is current (restraints are on the patient). If the restraints are removed prior to arrival to the new location, the "delayed ongoing order" is no longer valid. A new order for restraints must be obtain from the new provider prior to application.

Each order for restraint must contain at least the following information:

- The name of the patient being restrained,
- The date and time of the order,
- The name of the physician/LIP ordering the restraint,
- The type of restraint to be applied,
- The time limit (duration) of the restraint.

If there is to be any variation from this policy for monitoring of the patient and/or release from restraint before the order expires, then the rationale for such variation must be contained in the order. Orders are required each calendar day.

In an emergency situation, a registered nurse can initiate the least restrictive, yet effective restraint without a prior order by a physician or designee, based on an appropriate assessment of the patient. In this case, a physician or designee must be contacted either during or immediately[2] after the application of the restraint for an order.

The initial order for restraint must be time limited and shall not exceed 24 hours. Based on individual patient needs, renewal orders for restraints used to manage non-violent/non-self-destructive behaviors shall be obtained each calendar day. Renewal orders shall be based on an examination of the patient by a physician or designee.

Application of Restraints

Restraint shall be applied/removed in accordance with the following:

- The type of restraint used shall be consistent with the type of restraint ordered (Electronic orders are placed just prior to application).
- Restraints will be applied with safe and appropriate techniques[3], evaluated frequently for continuation and ended at the earliest possible time.
- Restraint devices are to be applied/removed in accordance with manufacturer's instructions and used in a manner consistent with their intended purpose.
- Restraint devices are to be applied/removed in a manner that preserves the dignity, comfort, and well-being of the patient.
- Restraints will be secured to the bed frame if being used while the patient is in bed. Restraints should never be tied to the mattress or side rails.

[2] The word "immediately: is defined as being without any time delay.

[3]An assessment should be conducted following the application of a physical restraint to assure that devices have been properly applied and that the patient did not sustain an injury or other untoward event in the process. Any significant findings should be documented in the patient's medical record along with actions subsequently taken.

- Restraints will be secured to the patient and bed frame using the quick release snap buckle.
- Restraint devices are to be applied/removed only by staff authorized, trained, and with the demonstrated competency to do so.

Monitoring of the Patient in Restraints Used to Manage Non-Violent/Non-Self Destructive Behavior

Patients in restraint will be evaluated/monitored at least every two (2) hours or more frequently if necessary based on individual patient needs.

Appropriately qualified staff will monitor/evaluate the patient on the following:

- The physical and emotional well-being of the patient,
- Vital signs,
- Circulation,
- Any hydration, hygiene, elimination, range of motion, or comfort needs the patient may have,
- Skin integrity.

Termination of Restraint

Restraint will be terminated at the earliest possible time regardless of the time length of the order. If restraint is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating the use of restraint. Documentation of removal time will be included in nursing documentation.

If a patient is released from restraint and later exhibits behavior that can only be handled through the use of restraint, a new order is required. Trial release is not permitted. However, a temporary release that occurs for the purpose of caring for a patient's needs, for example, toileting, feeding, and range of motion, is not considered a trial release or termination of restraint.

Documentation

Each episode of restraint should contain at least the following documentation in the patient's medical record:

- The complete order for restraint,
- Alternatives or other less restrictive interventions attempted or considered (as applicable),
- The patient's condition or symptom(s) that warranted the use of the restraint,
- The patient's response to the intervention(s) used, including the rationale for continued use of the intervention,
- Evidence that the plan of care reflected the use of restraint.

Training and Competency of Staff

Staff[4] involved with the application of a restraint, providing care for a patient in restraint, or assessing and monitoring the condition of the patient must be trained and competent. Staff must be trained and able to demonstrate competency in the application of restraints, monitoring, assessment, and providing care for a patient in restraint prior to doing so. Training of staff will occur upon hire (during the first 30 days of

[4] In the context of this policy, the word "staff" means an employee or contract worker. Volunteers are not permitted to provide any care, treatment or service to patients in restraint or seclusion. Students must be under the direct supervision of staff when engaging in any aspect of this policy.

employment) and at least on an annual basis thereafter. (*No staff should apply restraints without appropriate competencies and training)*

Staff is required to have education, training, and demonstrated knowledge based on the specific needs of the patient population served in at least the following:

- Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint,
- The use of nonphysical intervention skills,
- Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition,
- The safe application and use of all types of restraint used, 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 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, and vital signs,
- The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors. The organization will document in the staff personnel records that the training and demonstration of competency were successfully completed.

RESTRAINTS USED TO MANAGE VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR

Ordering of Restraints Used to Manage Violent or Self- Destructive Behavior (*Seclusion*)

The use of restraint must be in accordance with the order of a physician or designee who is responsible for the care of the patient. This includes the authority of a physician to delegate this task to a mid-level provider, to the extent recognized under State law or regulatory mechanism. At a minimum, physicians/LIPs authorized to order restraint or seclusion must have a working knowledge of hospital policy regarding the use of restraint. At the time of initial appointment and at reappointment, each physician's/LP's credentialing file will have a signed acknowledgement stating that they have received and read the Restraint or Seclusion policy and that they understand their obligations to patients as stated in the policy. The attending physician must be consulted as soon as possible[5] if the attending physician did not order the restraint.

Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

Special note: Orders written in association with a transfer in level/location of care {e.i. emergency department (ED) to critical care unit (CCU)} are valid when the restraint use is current (restraints are on the patient). If the

[5] As soon as possible is defined as within a 24 hour period following the issuance of the restraint or seclusion order.

restraints are removed prior to arrival to the new location, the "delayed ongoing order" is no longer valid. A new order for restraints must be obtain from the new provider prior to application.

Each order for restraint must contain at least the following information:
- The name of the patient being restrained
- The date and time of the order
- The name of the physician ordering the restraint
- The type of restraint to be applied
- The time limit (duration) of the restraint

In an emergency situation, the least restrictive, yet effective restraint may be initiated by authorized and qualified Registered Nurses, without a prior order by a physician or designee, based on an appropriate assessment of the patient. In this case, a physician or designee must be contacted immediately[6] thereafter for an order.

Each order for restraint or seclusion used to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff or others must be ordered/renewed in accordance with the following limits for each calendar day:
- Up to four (4) hours for adults age 18 and older,
- Up to two (2) hours for children and adolescents ages 9 to 17,
- Up to one (1) hour for patients under age 9.

Each calendar day, before writing a new order a physician or designee who is responsible for the care of the patient must see and assess the patient.

Application of Restraints

Restraint shall be applied/removed in accordance with the following:
- The type of restraint used shall be consistent with the type of restraint ordered,
- Restraints will be applied with safe and appropriate techniques[7], evaluated frequently for continuation and ended at the earliest possible time,
- Restraint devices are to be applied/removed in accordance with manufacturer's instructions and used in a manner consistent with their intended purpose,
- Restraint devices are to be applied/removed in a manner that preserves the dignity, comfort, and well-being of the patient,
- Restraints will be secured to the bed frame if being used while the patient is in bed. Restraints should never be tied to the mattress or side rails. Knots shall be tied so that they may be released quickly in the event of an emergency,

[6] The word "immediately: is defined as being without any time delay.

[7] An assessment should be conducted following the application of a physical restraint to assure that devices have been properly applied and that the patient did not sustain an injury or other untoward event in the process. Any significant findings should be documented in the patient's medical record along with actions subsequently taken.

- Restraint devices are to be applied/removed only by staff authorized, trained, and with the demonstrated competency to do so.

Assessment & Evaluation Requirements Restraints or Seclusion to Manage Violent or Self-Destructive Behavior

The patient must be seen face-to-face within one (1) hour after the initiation of the intervention by a physician or designee; or RN who has been trained in accordance with the requirements of this policy.
The one-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient. Therefore, the practitioner who conducts this evaluation must be able to complete both a physical and behavioral assessment of the patient in accordance with state law, his or her scope of practice, and organization policy.

The purpose of the face-to-face evaluation is to assess:

- The patient's immediate situation,
- The patient's reaction to the intervention,
- The patient's medical and behavioral condition and
- The need to continue or terminate the restraint or seclusion.

If the face-to-face evaluation is conducted by an RN, the RN must consult the attending physician or designee who is responsible for the care of the patient as soon as possible after the completing the evaluation. Such consultation should occur before the end of the RN's shift. The face-to-face assessment must be documented in the patient's medical record.

Monitoring/Evaluation of a Patient in Restraints to Manage Violent or Self-Destructive Behavior

Appropriately qualified staff will monitor/evaluate the patient on the following:

- Patient behavior
- Circulation,
- Vital signs,
- Any hydration, hygiene, elimination, range of motion, or comfort needs the patient may have
- Rationale to continue the restraint or seclusion

Patients placed in restraints to manage violent or self-destructive behavior will be evaluated/monitored at least every 30 minutes or more frequently based on individual patient needs.

Notification of Clinical Leadership for Extended/Multiple Episodes of Restraints to Manage Violent or Self-Destructive Behavior

The Clinical Manager/Director will be immediately notified of any instance in which a patient remains in restraint or seclusion for more than 12 hours, or experiences two or more separate episodes of restraint or seclusion of any duration within 12 hours. Thereafter, the Clinical Managers are notified every 24 hours if either of these conditions continues.

Termination of Restraint or Seclusion

Restraint or seclusion will be terminated at the earliest possible time regardless of the time length of the order. 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.

If a patient is released from restraint or seclusion and later exhibits behavior that can only be handled through the use of restraint or seclusion, a new order is required. Trial release is not permitted. However, a temporary release that occurs for the purpose of caring for a patient's needs, for example, toileting, feeding, and range of motion, is not considered a trial release or termination of restraint or seclusion.

Documentation

For each episode of restraint or seclusion used to manage violent or self-destructive behavior, the following will be documented in the medical record:

- Orders for the use of restraint and/or seclusion,
- The description of the patient's behavior,
- Alternative/less restrictive interventions attempted, as applicable
- Patient's response to interventions used, including rationale for continued use,
- The one hour face-to-face medical and behavioral evaluation
- Monitoring and assessment activities,
- Continuous monitoring of the patient in seclusion,
- Any injuries the patient sustained and the treatment for these injuries.

Staff Training and Competency

In addition to the training and competency requirements for restraints or seclusion used to manage non-violent or non-self-destructive behavior, staff involved in restraint or seclusion used to manage violent or self-destructive behavior will receive education, training and demonstrated knowledge as follows:

- Techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances requiring the use of restraint or seclusion,
- The use of non-physical intervention skills, including de-escalation and dealing with aggressive behavior,
- Choosing the lease restrictive method based on individual patient assessed needs,
- Safe application and use of all types of restraint or seclusion,
- How to recognize physical and psychological distress (e.g. positional asphyxia),
- Behavioral changes indicating restraint or seclusion is no longer necessary,
- The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including recertification requirements.

Quality Monitoring

The organization will monitor and evaluate the use of restraint and seclusion on a continual basis as a part of the Quality Management System. This information is reported to the Performance Improvement Committee quarterly. The aggregate data regarding the use of restraint and seclusion will be analyzed for the identification of patterns and trends.

Monitoring will occur with a monthly log addressing the elements below:

Specific Data to be Collected for Restraint & Seclusion Use

For each episode of restraint or seclusion, the hospital collects the following data:

- The shift during which the episode occurs,
- Date of the order
- The staff who initiated restraint or seclusion,
- The length of each episode,
- The day of the week each episode is initiated,
- The type of restraint used, (including physical restraint and/or (chemical)drugs used as a restraint),
- Any injuries sustained by the patient or staff,
- The patient's age,
- The patient's gender,
- Compliance with requirements defined in the standard as well as ongoing evaluation of prolonged use of restraints on patients. (Prolonged use for non-violent non-self-destructive restraints is more than 8 consecutive days on any one patient as decided by the Chief Nursing Officer, CNO)

For Violent and Self-Destructive Behavior, the log will maintain restraint use in hours per patient. For Non-violent and Non-Self-Destructive Behavior, the log will maintain restraint use in days per patient.

References

CMS - *§482.13* Condition of Participation: Patient's Rights – Rev. 5.16.12.

DNV Healthcare Inc. Patient Rights (PR). In *NIAHO Accreditation Requirements Interpretive Guidelines and Surveyor Guidance* Det Norske Veritas Healthcare, Inc. PR.6

42 CFR, Part 482, HHS (2006) http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10455.pdf

Revision number	Date	Description of Document or Document Change
8	01/28/2017	New Version: We combined the Restraint and Seclusion Policy and Associated Death Reporting policy to read as one policy. We added and removed hyperlinks to logs and other documents within PolicyTech. We renamed procedure of reporting to process for reporting. When this guideline is approved we will archive Restraint & Seclusion and Restraint-Seclusion Associated Death Reporting policies. The new name of this policy is: Restraint & Seclusion & Associated Death Reporting Guidelines. Brandi McDonald made one adjustment on page 4 language no content changes just combined two. B. Evans 2nd complete review stopped after Robyn Kedzie approved combined group.
