HOLY CROSS HEALTH
A Member of Trinity Health

# Patient Care: Restraints, Seclusion, and Physical Hold

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| **Owner/Dept: Elaine Medley, Senior Director Acute Care/ Critical Care/ Patient Care Services (HCH)** | **Date approved: 12/02/2025** |
| **Approved by: Medical Executive Committee (HCGH) - Approver Group, Medical Executive Committee (HCH) - Approver Group, Kimberly Elliott (Chief Nurse Officer), Maggie Perih (RHM Chief Nursing Officer)** | **Next Review Date:** 12**/02/2028** |
| **Affected Departments: All Clinical Staff (HCGH), All Clinical Staff (HCH), All Medical & Dental Staff (HCH), All Medical Staff (HCGH), Behavioral Health (HCH), Behavioral Health Services (HCGH), Emergency Center (HCH)** | |

**DO NOT MANUALLY ENTER ANY DATA ABOVE THIS LINE**

**Purpose**

To outline the Holy Cross Health policy and patient care management for using restraints, seclusion, and physical holds.

**Scope**

All Colleagues
All Medical and Dental Staff

**Policy overview**

Patients have the right to be free from restraints and/or seclusion of any form that are not clinically justified or are used as a means of coercion, discipline, convenience, or retaliation. The goal of this policy is to minimize the use of restraints/seclusion, protect patient's rights, dignity and well-being, and prevent injury to patients, staff and others. This includes consideration of any pre-existing medical condition, any cognitive or physical disabilities, or history of abuse that might make the patient more vulnerable to risk during restraint/seclusion. Restraint, seclusion and physical holds are discontinued as soon as possible.

Restraint, seclusion, and physical hold are only implemented:

- In clinically justifiable situations, such as when less restrictive measures have failed
- Based on individual assessment
- In the least restrictive manner possible
- According to safe and appropriate restraining techniques

**Non-Violent/Non Self-Destructive** standards are implemented for medical or surgical purposes and apply when the primary reason for use directly supports medical healing and to:

- allow medical treatments to continue without interruption
- provide safety when the patient is unable to follow directions

**Violent/Self-Destructive** standards are implemented to protect the individual against injury to self or others resulting from an emotional or behavioral disorder, and apply to any patient regardless of the setting who presents with extreme agitation and/or dangerous behavior. Such patients cannot be reasoned with, persuaded, contained, delayed or denied. In these instances, control must be established by staff in order to prevent serious injury to patient or others. Although law enforcement officers may be called upon for assistance, hospital staff must implement restraints without delay. Patient seclusion is used *when the patient demonstrates behavior that creates an imminent risk of a patient physically harming themselves or others, including staff. Nonphysical interventions are the first choice as an intervention, unless safety demands an immediate physical response*. Patient rights, dignity, and safety are considered when seclusion becomes necessary. Seclusion for behavior management is an emergency use of seclusion to restrict patient movement in response to aggressive, destructive, violent or suicidal behaviors that place the patient or others in imminent danger.

***Note***: *Holy Cross Health uses seclusion as indicated in the emergency center, behavioral health unit and in limited situations in the in-patient setting.*

**Definitions**

| Term | Definitions |
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| Physical 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 |
| Chemical restraint | A drug or medication used as a restriction to manage the patient's violent or self-destructive behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition |
| Seclusion | The involuntary confinement of a patient alone in a room or an area from which they are physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior. |
| Seclusion Room | A room or area which a patient cannot exit without staff approval or assistance. |
| Physical Hold | A brief physical restraint which restricts the patient's voluntary movement. The patient is unable to easily "escape" from the hold. The patient is held against their will for purposes of medicating, escorting, or to prevent injury to self or others. This requires an LIP order and a face-to-face assessment. |
| Violent or self-destructive | Behavior that becomes aggressive, presenting an immediate, |

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| behavior | serious danger to the patient's safety or that of others, such as kicking, flailing, punching. |
| Licensed Independent Practitioner (LIP) | Any practitioner permitted by State law and hospital policy to order restraints for patients independently, within the scope of the individual's license and consistent with the individually granted clinical privileges. For the purpose of this policy, the LIP may be an advanced practice nurse/physician assistant or physician (M.D. or D.O. -Doctor of Osteopathy.). The Centers for Medicare and Medical Services (CMS) regulations would necessitate the individual be able to perform both the physiological and psychological components of the 1-hour face-to-face evaluation (CMS Final Rule, 2008). |
| Treating Physician | The LIP who has overall responsibility and authority for the management and care of the patient and is aware of and involved in decisions on treatment and intervention. A hospitalist or intensivist is considered a treating physician. (Note: Holy Cross Health does not use the term "attending" physician, however the definition of treating is intended to connote equivalency. |

**Policy exceptions**

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 permit the patient to participate in activities without the risk of physical harm.

Restraint standards do not apply when:

1. Handcuffs or other restrictive devices are applied by law enforcement officials for security purposes.
2. Using holding for comfort or comforting of children during procedures.
3. Soft restraints applied to maintain the safety of the patient who is recovering from anesthesia.
4. Four or full side rails are used to protect the patient from falling out of bed or stretcher.
   a. Procedural sedation (including preoperative and postoperative)
   b. Whenever the bed is in high position
   c. Seizure precautions or other involuntary movements
   d. Stretcher or other narrow table
   e. Any semi-comatose or comatose patient
   f. When using for patient transport
   g. When the patient needs assistance in turning and for leverage
   h. On a certain type of therapeutic beds
   i. For pediatric patients:
      - Full use of side rails at night and whenever patient condition warrants.
      - With use of a crib for infants 6 months and older, the canopy must be down and secured.
      - Infants up to 15 pounds may be placed in a pediatric bassinet.

***Note***: Use of all 4-side rails or 2 full side rails may be considered a restraint if the intent of the side rails is to restrict someone's freedom of movement. For example: If the intent is to prevent the patient from getting out of bed rather than simply falling out of bed, and the patient cannot lower the side rails, the use of side rails would constitute restraint.

**Restraint devices used at Holy Cross Health**

Restraint equipment used at Holy Cross Health includes:

- Roll belts or Wrap Around (non self-release)
- Geri-chair (non self-release)
- Hand mitts

- Four/full side rails (see exceptions)
- Soft limb holders** (***)
- Hard limb holders**

**Four-point restraints are considered a Category I restraint as it limits the patient's mobility to the extent that the patient would not be able to independently reposition him or herself or would otherwise be rendered helpless in an emergency. (*COMAR 10.21.12.02*)

A specific device used to restrain a patient does not in itself determine whether it is a restraint. It is the device's intended use, its involuntary application, and the identified patient need that determine whether a device is used as a restraint. Because it is the intended use of a device that determines whether or not it is a restraint, some devices can be considered a restraint in one situation and not considered a restraint in other situations.

**Restraint procedure**

Hospital and medical staff will follow the steps outlined in either:
Table 1. Care of the patient requiring **non-violent, non self-destructive** restraint OR
Table 2. Care of the patient requiring **violent/self-destructive** restraint

**Table 1. Care of the patient requiring *non-violent, non-self-destructive restraint***

| Key Steps | Non-violent, non-destructive behavior |
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| **Determine the need for restraint, and risk/benefit** | The RN or LIP will:<br>• Attempt alternatives and document the patient's response if restraint is needed<br>• Assess the behavioral need for restraint (clinical justification), such as:<br>o Attempting interruption of medical treatments or equipment, such as pulling tubes or drains<br>o Attempting activity that poses a safety risk and unable to follow direction<br>• Assess for current physical and psychological risk factors as well as special needs:<br>o Medical conditions, drugs, medications<br>o Environmental factors that might have precipitated the episode<br>o History of sexual or physical abuse<br>• Choose the least restrictive device |
| **Obtain an order for the device to be applied**<br><br>**(if 4-point restraints are used, you must follow Table 2c. Violent)** | 1. Obtain the order prior to initiation (exception: emergency application)<br>• Emergency application: RN may initiate if he/she assesses need for immediate intervention to prevent the patient from harming self or others.<br>• In emergency application situations, the LIP must be notified and the order obtained either during the emergency application or immediately (within a few minutes) after the restraint has been applied.<br>• Orders are time limited, specific to type and location of the restraint, dated, and signed.<br>2. Restraint orders are **not** written as a standing or PRN order.<br>3. If the treating LIP did not initiate the original order he/she must be notified. |
| **Initiation of restraint** | Only an RN or LIP may direct initiation. |
| **Apply the restraint and document initiation** | 1. The RN, or designated staff trained in the application of restraint, will apply the restraint in accordance with established procedure.<br>a. Security personnel may be requested to assist the team in application. The RN caring for the patient is responsible for the correct, safe application of restraints and safety devices, no matter who applies them.<br>2. The RN provides an explanation to the patient, and significant other when appropriate, as to the reason for restraint and the behavior criteria for discontinuation.<br>• The RN must document the following:<br>a. Events leading up to the need for intervention<br>b. The use of alternative measures and patient response<br>c. The time restraint was initiated<br>d. Clinical justification for restraint (behavior-specific)<br>e. Type of restraint(s) utilized (***must match order***)<br>4. Initiate the restraint plan of care |
| | The LIP must conduct an in-person evaluation within 24 hours of initiation of restraint – even if the intervention was discontinued prior to the evaluation |
| **Provide monitoring and interventions to maintain safety, dignity and rights** | 1. Keep door open unless staff in room providing care.<br>2. Monitoring is accomplished by observation, interaction with the patient, or related direct examination of the patient by qualified staff.<br>a. The RN may delegate components of monitoring and provision of general care needs to other trained staff members within the scope of their practice or licensure, but the RN is responsible for supervising all delegated components.<br>3. Reassessment and monitoring consists of the following criteria:<br>a. A description of the patient's behavior and intervention used<br>b. Alternatives or less restrictive interventions attempted (as applicable)<br>c. Patient's condition or symptoms that warrant use of restraint<br>d. Patient's response to the intervention used, including the need for continued use of the intervention<br>e. Appropriate application, device, and site<br>f. Physical and emotional well-being, signs of injury from restraint<br>g. Patient rights, dignity and safety are maintained<br>4. Minimum observation, intervention, & documentation is every two hours*:<br>a. Observe type of restraint, circulation check of extremity restrained, proper body |

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| | alignment, and skin intact at restraint site.<br>b. Provide the following interventions while the patient is awake unless contraindicated by circumstances: offer of food/fluid, range of motion or massage, toileting or hygiene, any special needs.<br>*Frequency of assessment and monitoring takes into consideration variables such as patient condition, cognitive status, and risks associated with the use of the chosen intervention, and other relevant factors. Visual checks are acceptable if the patient is asleep or too agitated to be approached.<br>5. A patient requiring transport while in restraint must have trained staff accompany the patient. |
| **Document every two hours** | 1. RN to use the EMR or appropriate documentation to the type of restraint and document every two hours:<br>• Restraint type/site<br>• Skin/circulation<br>• Nutrition/hydration<br>• Hygiene/elimination<br>• Cognitive/emotional response<br>• ROM/positioning<br>• Behavior observed<br>• Evaluation for continued use and least restrictive measure<br>2. RN to review the restraint plan of care every shift and revise as needed |
| **Continuation of restraint** | • Obtain an order each calendar day the patient is in restraint based on LIP examination. It is Holy Cross Health's policy that renewal is based upon the calendar day.<br>• Obtain an order with each new episode. |
| **Discontinuation** | 1. The RN by discontinue restraints as soon as the reason for implementation is resolved and this discontinues the restraint order.<br>• Upon discontinuation the nurse must complete the documentation using the EMR or paper form.<br>• Discontinue the order to prevent documentation tasks continuing to fire.<br>2. Once restraint is discontinued, further use constitutes a new episode of restraint requiring a new order.<br>Exception: A restraint is not considered discontinued in the following situations:<br>• A temporary, directly supervised release that occurs for the purpose of caring for a patient's needs (e.g. ADLs, toileting, medical treatment)<br>• As long as the patient remains under direct staff supervision in the patient's room |

**Table 2a. Care of the patient with *violent, self-destructive behavior – Physical Hold***

| Key Steps | Physical Hold Key Points |
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| **Determine the immediate need, risk, and benefit** | • Physical hold (manual restraint) is only to be used on an emergency basis when a person's behavior poses an imminent risk of physical harm to self or others and less restrictive strategies have not achieved safety.<br>• Emergency use must meet the following conditions:<br>o Immediate intervention must be needed to protect the person or others from imminent risk of physical harm;<br>o The type of hold must be the least restrictive necessary to eliminate the immediate risk of harm and effectively achieve safety;<br>o Must end as soon as possible. |
| **Order, face-to-face evaluation** | • The ordering and face-to-face evaluation must occur as stated in Table 2c.<br>• If the patient is released before the LIP arrives to perform the assessment, the LIP **must** still see the patient to perform the assessment within 1 hour. |
| **Initiation & application** | • Only an RN or LIP may direct initiation.<br>o If the patient is released before the LIP arrives to perform the assessment, the LIP **must** still see the patient to perform the assessment within 1 hour.<br>• Only trained staff may apply a physical hold. Security personnel may be requested to assist the team in application, but the RN is responsible for the correct and safe application.<br>• The physical hold **must not**:<br>o Maintain the patient in the prone (face down) position. As quickly as possible the patient must be restored to a standing, sitting, side lying, or supine position.<br>o Include back or chest pressure when in supine, side-lying, or prone position. |
| **Monitoring, documentation, discontinuation** | • An RN, who is not implementing the hold, is responsible for continuous assessment for the duration of the hold.<br>• If patient exhibits any type of physical distress (e.g., states cannot breathe), the RN monitoring the situation will reassess if the hold is being applied correctly and safely and changes to the hold must be made accordingly. Documentation in the patient progress record must include:<br>o Explicit description of the behavior requiring a physical hold.<br>o Patient position during the hold.<br>o Duration of hold.<br><br>No matter how brief the physical hold, all documentation must still be documented in the patient's medical record as soon as possible. At the latest, it will be documented by the end of the staff member's shift. This includes any orders, face-to-face assessment, and all other assessments. |
| **Proceed to Table 2c.** | **The key points above are in addition to those on Table 2c.** |

**Table 2b. Care of the patient with *violent, self-destructive behavior – Chemical Restraint***

| Key Steps | Chemical Restraint Key Points |
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| **Differentiate between situations in which the use of a drug/medication is chemical restraint or not.** | A drug or medication, given by the parenteral route (IM or IV), that is not being used as a standard treatment for the patient's medical or psychiatric condition, and that results in restricting the patient's freedom of movement is a chemical restraint. **Avoid using terms that are symptoms (e.g. agitation)**, use terms that describe the dangerous behavior you are using medication to control (e.g. kicking). For example:<br>• Haldol for kicking (punching, pinching, biting, throwing objects)<br>• Lorazepam for punching<br>• Thorazine for dangerous destruction of property<br><br>Chemical restraints should NOT be ordered as a 'prn' medication unless they are ordered prn x 1 (times once) if patient is punching, biting, throwing objects (describe violent activity)' and is only good for 24 hours.<br><br>Chemical restraints DO NOT include medications used as part of a patient's standard medical or psychiatric treatment, and are administered within the standard dosage for the patient's condition; appropriate doses of sleeping medication prescribed for patients with insomnia, anti-anxiety medication prescribed to calm a patient who is anxious. For example:<br>• A patient on an alcohol withdrawal protocol may periodically need PRN medication to maintain prevent escalation to aggressive or violent behaviors. Staff administers a PRN medication to prevent these outbursts. The use of the medication enables the patient to better interact with others or function more effectively. The availability of a PRN medication to prevent behavioral escalation is standard for this patient's medical condition.<br>• Similarly, patient assessed and undergoing treatment for delirium.<br><br>All patients, including those admitted for an emergency mental health evaluation, have the right to refuse assessment and treatment (including medication). Only if the physician determines that the patient is about to harm himself or others may it be ordered to give the IM or IV medication by holding down the patient. The physician MUST document the specific behaviors that led to this decision and order both a physical hold (Table 2a) and the medication. This will also require a face-to-face by the physician as well as all the other required documentation for violent restraints.<br><br>**See Pharmacy policy 'PRN Medications' for more information on chemical restraints. |
| **Initiation & Orderable** | Chemical restraints may only be administered after an LIP has conducted a face-to-face assessment of the patient. The order must state:<br>• Reason for the medication<br>• Never expressed as a standing PRN order – a new order is required for each dose. May be ordered PRN x 1 for a specific behavior and only good for 24 hours. |
| **Assessment** | The RN must include appropriate monitoring to the medication used. E.g. airway |
| **Proceed to Table 2c.** | **The key points above are in addition to those on Table 2c.** |

**Table 2c. Care of the patient with *violent, self-destructive behavior***

| Key Steps | Violent, self-destructive behavior |
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| **Determine the need for restraint, and risk/benefit** | The RN or LIP will:<br>• Attempt alternatives and document the patient's response if restraint is needed<br>  o Make a reasonable effort to verbally persuade the patient to cooperate<br>• Assess the behavioral need for restraint (clinical justification), such as:<br>  o Behavior that poses an imminent danger to the physical safety of the patient, staff or others such as kicking, punching, flailing<br>  o Rapidly decompensating behavior requiring a physical hold to administer medications, deliver care, or escort<br>• Assess for current physical and psychological risk factors as well as special needs:<br>  o Medical conditions, drugs, medications<br>  o Environmental factors that might have precipitated the episode<br>  o History of sexual or physical abuse<br>• Choose the least restrictive device<br>  o If the patient is spitting and staff are concerned about exposure to saliva, staff will don personal protective equipment (PPE) to protect themselves.<br>  ▪ If there is a risk of immediate harm to the staff or patient, and staff has not been able to don the PPE, the patient can have a surgical mask applied temporarily for the few minutes it takes to don the PPE. The mask will then be removed. During this time, the patient is monitored by the nurse. The nurse is responsible for monitoring the patient's safety including respiratory status. |
| **Obtain an order for the device to be applied or physical hold** | 1. Obtain the order prior to initiation (exception: emergency application)<br>• Emergency application: RN may initiate if he/she assesses need for immediate intervention to prevent the patient from harming self or others.<br>  o The LIP must be notified and the order obtained either during the emergency application or immediately (within a few minutes) thereafter.<br>2. Orders are time limited, specific to type and location of the restraint, dated, and signed.<br>• No standing or PRN orders.<br>• The order may <u>not</u> exceed:<br>  o 4 hours for adults ages 18 or older,<br>  o 2 hours for children ages 9-17,<br>  o 1 hour for children under 9.<br>3. If the treating LIP did not initiate the original order he/she must be notified. |
| **Initiation of restraint** | Only an RN or LIP may direct initiation. |
| **Apply the restraint and document initiation** | 1. The RN, or designated staff trained in the application of restraint, will apply the restraint in accordance with established procedure.<br>• Security personnel may be requested to assist the team in application. The RN is responsible for the correct, safe application of restraints and safety devices, no matter who applies them.<br>• If patient exhibits any type of physical distress (e.g., states cannot breathe), the RN who is monitoring the situation will reassess if restraints are being applied correctly and safely and changes to the hold must be made accordingly.<br>• The RN provides an explanation to the patient, and significant other when appropriate, as to the reason for restraint and the behavior criteria for discontinuation.<br>2. The RN must document:<br>a. Events leading up to the need for intervention<br>b. The use of alternative measures and patient response<br>c. The time restraint was initiated<br>d. Clinical justification for restraint (behavior-specific)<br>e. Type of restraint(s) utilized (***must match order***)<br>3. Modify the patient's plan of care |
| **4-point restraints** | Patients in **Category I restraint** require the RN to make and document personal contact |

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| | with the patient every hour for the purpose of: (COMAR 10.21.12.08)<br>• Determining if the patient has any special needs which might need attention;<br>• Checking the circulation of the extremities restrained;<br>• Adjusting the restraint;<br>• Realigning the body and/or massaging the extremities restrained.<br>• Head of bed elevated 45 degrees |
| **Conduct a Face-to-Face Evaluation** | A face-to-face assessment by an LIP must occur within **one hour** of the initial restraint application to evaluate the:<br>• Patient's immediate situation<br>• Patient's reaction to the intervention<br>• Patient's medical and behavioral condition<br>• Need to continue or terminate the restraint<br>If the patient is released from restraints before the LIP arrives to perform the assessment, the LIP **must** still see the patient to perform the assessment within 1 hour. |
| **Provide monitoring and interventions to maintain safety, dignity and rights** | 1. Keep door open unless staff in room providing care.<br>2. Monitoring is accomplished by observation, interaction with the patient, or related direct examination of the patient by qualified staff.<br>a. The RN may delegate components of monitoring and provision of general care needs to other trained staff members within the scope of their practice or licensure, but the RN is responsible for supervising all delegated components.<br>3. Reassessment and monitoring consists of the following criteria:<br>a. A description of the patient's behavior and intervention used<br>b. Alternatives or less restrictive interventions attempted (as applicable)<br>c. Patient's condition or symptoms that warrant use of restraint<br>d. Patient's response to the intervention used, including the need for continued use of the intervention<br>e. Appropriate application, device, and site<br>f. Physical and emotional well-being, signs of injury from restraint<br>g. Patient rights, dignity and safety are maintained<br>4. Frequency of observation and intervention:<br>• Observation and monitoring frequency: continuous<br>• Every 15 minutes, purposefully observe the patient's behavior<br>• A minimum of every two hours:<br>o Observe type of restraint, circulation check of extremity restrained, proper body alignment, and skin intact at restraint site.<br>o Provide the following interventions while the patient is awake unless contraindicated by circumstances: offer of food/fluid, range of motion or massage, toileting or hygiene, any special needs.<br>• Frequency of assessment and monitoring takes into consideration variables such as patient condition, cognitive status, and risks associated with the use of the chosen intervention, and other relevant factors. Visual checks are acceptable if the patient is asleep or too agitated to be approached.<br>5. A patient requiring transport while in restraint must be accompanied by trained staff. |
| **Document on the violent restraint form every 15 minutes, every hour, every two hours, & review/update plan of care every shift** | 1. Every 15 minutes, document the behavior observed.<br>2. RN to document every hour personal contact with the patient for the purpose of:<br>• Determining any special needs<br>• Checking circulation of restrained extremities<br>• Adjusting the restraint if needed<br>• Realigning the body or massaging the restrained extremities<br>3. RN to document the following every two hours:<br>• Restraint type/site<br>• Skin/circulation<br>• Nutrition/hydration<br>• Hygiene/elimination<br>• Cognitive/emotional response |

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| | • ROM/positioning<br>• Behavior observed<br>• Evaluation for continued use and least restrictive measure<br>4. Safety attendants document observation components noted every 15 minutes as directed by RN.<br>5. RN to review the restraint plan of care every shift and revise as needed |
| **Continuation of restraint** | 1. Face-to-face evaluation of continued need for restraint every 24 hours after the original order by the LIP, with documentation of findings supporting the continued use of restraint.<br>2. Orders may be renewed according to the above time limits for a maximum of 24 consecutive hours. |
| **Discontinuation** | 1. The RN will discontinue restraints as soon as the reason for implementation is resolved and this discontinues the restraint order.<br>• Upon discontinuation the nurse must complete the documentation using the EMR or paper form.<br>• Discontinue the order to prevent documentation tasks continuing to fire.<br>2. Once restraint is discontinued, further use constitutes a new episode of restraint requiring a new order.<br>Exception: A restraint is not considered discontinued in the following situations:<br>• A temporary, directly supervised release that occurs for the purpose of caring for a patient's needs (e.g. ADLs, toileting, medical treatment)<br>• As long as the patient remains under direct staff supervision in the patient's room (the staff member present serves the same purpose as the restraint). |

**Table 2d. Care of the patient in *Seclusion***

| Key Steps | Violent, self-destructive behavior and use of Seclusion |
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| **Determine the need for seclusion, and risk/benefit** | The RN or LIP will:<br>• Attempt alternatives and document the patient's response if seclusion is needed<br>  o Make a reasonable effort to verbally persuade the patient to cooperate<br>• Assess the behavioral need for seclusion (clinical justification), such as:<br>  o Behaviors posing imminent danger to the physical safety of the patient, staff or others such as kicking, punching, flailing<br>  o Rapidly decompensating behavior requiring a physical hold to administer medications, deliver care, or escort<br>• Assess for current physical and psychological risk factors as well as special needs:<br>  o Medical conditions, drugs, medications<br>  o Environmental factors that might have precipitated the episode<br>  o History of sexual or physical abuse |
| **Obtain an order for the device to be applied or physical hold** | 1. Obtain the order prior to initiation (exception: emergency situation)<br>• Emergency situation: RN may initiate if he/she assesses need for immediate intervention to prevent the patient from harming self or others.<br>  o The LIP must be notified and the order obtained either during the emergency situation or immediately (within a few minutes) thereafter.<br>2. Orders are time limited, specific to type and of the restraint, dated, and signed.<br>• No standing or PRN orders.<br>• The order may <u>not</u> exceed:<br>  o 4 hours for adults ages 18 or older,<br>  o 2 hours for children ages 9-17,<br>  o 1 hour for children under 9.<br>3. If the treating LIP did not initiate the original order he/she must be notified. |
| **Initiation of seclusion** | Only an RN or LIP may direct initiation. |
| **Beginning seclusion and document initiation** | 1. The RN, or designated staff trained in seclusion will place the patient in seclusion in accordance with established procedure.<br>• Security personnel may be requested to assist the team. The RN is responsible for correct, safe initiation of seclusion no matter who assists them in the intervention.<br>• If patient exhibits any type of physical distress (e.g., states cannot breathe), the RN who is monitoring the situation will reassess if restraints are being applied correctly and safely and changes to the hold must be made accordingly.<br>• The RN provides an explanation to the patient, and significant other when appropriate, as to the reason for restraint and the behavior criteria for discontinuation.<br>3. The RN must document:<br>a. Events leading up to the need for intervention<br>b. The use of alternative measures and patient response<br>c. The time restraint was initiated<br>d. Clinical justification for restraint (behavior-specific)<br>e. Type of restraint(s) utilized (***must match order***)<br>3. Modify the patient's plan of care |
| **Conduct a Face-to-Face Evaluation** | A <u>face-to-face assessment</u> by an LIP must occur within **one hour** of the initial restraint application to evaluate the:<br>• Patient's immediate situation<br>• Patient's reaction to the intervention<br>• Patient's medical and behavioral condition<br>• Need to continue or terminate the restraint<br>If the patient is released from restraints before the LIP arrives to perform the assessment, the LIP **must** still see the patient to perform the assessment within 1 hour. |
| **Provide monitoring and interventions to maintain safety, dignity and rights** | 1. Keep door open unless staff in room providing care.<br>2. Monitoring is accomplished by observation, interaction with the patient, or related direct examination of the patient by qualified staff. |

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| | a. The RN may delegate components of monitoring and provision of general care needs to other trained staff members within the scope of their practice or licensure, but the RN is responsible for supervising all delegated components.<br>3. Reassessment and monitoring consists of the following criteria:<br>h. A description of the patient's behavior and intervention used<br>i. Alternatives or less restrictive interventions attempted (as applicable)<br>j. Patient's condition or symptoms that warrant use of restraint<br>k. Patient's response to the intervention used, including the need for continued use of the intervention<br>l. Appropriate application, device, and site<br>m. Physical and emotional well-being, signs of injury from restraint<br>n. Patient rights, dignity and safety are maintained<br>4. Frequency of observation and intervention:<br>• Observation and monitoring frequency: continuous<br>• Every 15 minutes, purposefully observe the patient's behavior<br>• A minimum of every two hours:<br>o Observe type of restraint, circulation check of extremity restrained, proper body alignment, and skin intact at restraint site.<br>o Provide the following interventions while the patient is awake unless contraindicated by circumstances: offer of food/fluid, range of motion or massage, toileting or hygiene, any special needs.<br>• Frequency of assessment and monitoring takes into consideration variables such as patient condition, cognitive status, and risks associated with the use of the chosen and other relevant factors. Visual checks are acceptable if the patient is asleep or too agitated to be approached.<br>5. A patient requiring transport while in seclusion must be accompanied by trained staff. |
| **Document on the violent restraint form every 15 minutes, every hour, every two hours, & review/update plan of care every shift** | 1. Every 15 minutes, document the behavior observed.<br>2. RN to document every hour <u>personal contact</u> with the patient for the purpose of:<br>• Determining any special needs<br>• Checking circulation of restrained extremities<br>• Adjusting the restraint if needed<br>• Realigning the body or massaging the restrained extremities<br>3. RN to document the following every two hours:<br>• Restraint type/site (seclusion)<br>• Skin/circulation<br>• Nutrition/hydration<br>• Hygiene/elimination<br>• Cognitive/emotional response<br>• ROM/positioning<br>• Behavior observed<br>• Evaluation for continued use and least restrictive measure<br>4. Safety attendants document observation components noted every 15 minutes as directed by RN.<br>5. RN to review the restraint/seclusion plan of care every shift and revise as needed |
| **Continuation of restraint** | 1. Face-to-face evaluation of continued need for restraint every 24 hours after the original order by the LIP, with documentation of findings supporting the continued use of restraint/seclusion.<br>2. Orders may be renewed according to the above time limits for a maximum of 24 consecutive hours. |
| **Discontinuation** | 1. The RN will discontinue seclusion as soon as the reason for implementation is resolved and this discontinues the restraint/seclusion order.<br>• Upon discontinuation the nurse must complete the documentation using the EMR or paper form.<br>• Discontinue the order to prevent documentation tasks continuing to fire.<br>2. Once restraint/seclusion is discontinued, further use constitutes a new episode of restraint/seclusion requiring a new order. |

# Addendum A: Safety and quality

**Patient Safety**

The charge nurse is responsible for knowing the restraint status of patients in their department. In addition, each hospital has a "Restraints" folder that contains a list of patients in restraint in their department. In the event of fire/disaster, the staff member monitoring observation and physiological needs of the patient is responsible for removing the restraints and moving the patient to a safe location if indicated.

In the case of injury to a patient while in restraints the nurse must contact Patient Safety either through a phone call or by filling out a report in VOICE. The nurse must also notify the physician and unit manager.

When restraining children under the age of 12, staff may not use four-point restraints (all four limbs simultaneously) or apply force to long bone joints.

**Performance Improvement**

Holy Cross Health takes actions to comply with regulatory requirements through its performance improvement activities (PI). Restraint data is collected and aggregated monthly, analyzed and reported to the Quality Improvement Council quarterly.

**Reportable conditions**

**Restraint-Related Deaths (excluding soft 2-point wrist restraints)**

The hospital is required to report to the Centers for Medicare and Medicaid Services (CMS) no later than the close of business the next business day following the patient's death, with documentation of date/time of notification in the medical record, when:

- Death occurs while a patient is in restraint physical hold
- Death occurs within 24 hours after the patient has been removed from restraint or physical hold,
- Death occurs within one week after restraint or physical hold and it is reasonable to assume that use of restraint contributed directly or indirectly to a patient's death.

**Soft 2-Point Wrist Restraints-Related Deaths**

The hospital is required to maintain a log that captures the following elements required by CMS:

- Patient's name, date of birth,
- Date of death;
- Name of attending physician or other licensed independent practitioner who is responsible for the care of the patient;
- Medical record number; and
- The primary diagnosis (es).

This log will be maintained by the Accreditation/Regulatory Coordinator and **must** be made available to CMS immediately upon request.

***Note*:** Deaths that meet the requirements for inclusion on the internal log must be recorded on that log within seven (7) days of a patient's death.

***Note*: For All Restraint-Related Deaths**: When a patient meets the mandatory reporting criteria, staff is responsible for completing relevant sections of the Patient Expiration Report, completing a Hospital Safety Report, and notifying his/her manager. In addition, it is imperative that the Initiation and Discontinuation documentation is completed in the patient's medical record. The hospital is required to report the total length of time (hours) the patient was in restraints.

## Addendum B: Training and Education

**Staff Education, Training, & Competency**

All staff participating in restraint episodes will receive training in one or more of the following as part of orientation and on a periodic basis thereafter in accordance with their position, job duties, and responsibilities: hospital policy, strategies to identify triggering circumstances, alternatives and less restrictive interventions, proper application and use, assessment/reassessment, patient monitoring and care needs, observation, protection of patient's dignity, rights, and well-being, and recognition of signs of physical and psychological distress and appropriate response (e.g. cardiopulmonary resuscitation). These include:

| | | |
|---|---|---|
| Nursing assistants/techs | Orientation/ annually | Application, observation, signs of distress and response, monitoring and care needs |
| Patient safety attendant | Orientation/ annually | Application, observation, signs of distress and response, monitoring and care needs |
| RNs/LPNs | Orientation/ annually | Application, observation, signs of distress and response, alternatives and less restrictive interventions |
| Security, Code Green responders | Orientation/ annually | Application, signs of distress and response |
| Patient Safety Associate | Orientation/ Annually | Monitoring, observation, signs of distress and response |

Staff involved in incidental removal and reapplication of restraint will receive training in safe application. These staff include staff who are considered part of the response team for Code Green.

Selected staff receives training in the use of nonphysical intervention (e.g. security). Additional educational activities will be planned based on changes in policy and quality improvement data.

*Medical staff*: All Medical staff members/LIPs are responsible for having a working knowledge of the Holy Cross Health restraint policy.

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**Related policies**

- Security: Code Green - Aggressive Behavior Incidents, Response Team for

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