Violent Restraint and Seclusion

Learning & Development

For those that will apply restraints

Purpose for Training

Samaritan Health Services (SHS) has created the following training to meet the didactic requirement for education related to Centers for Medicare & Medicaid Services (CMS) regulation 482.13(f)

Assignment of this training has been approved by SHS VP's of Patient Care Services.

Objectives

- Distinguish patient rights and safety related to restraint use
- Recognize the importance of exhausting alternative methods prior to restraint application
- Identify appropriate indications for violent restraint use
- Review essential elements of SHS Violent Restraints procedure, including age specific differences
- Review violent restraint documentation and monitoring requirements
- Outline seclusion requirements as related to the seclusion policy

Why Do We Apply Violent Restraints?

To control violent or self-destructive behavior that jeopardizes the immediate safety of patients, visitors, and staff members.

Violent Restraints are **not** applied by staff for:

- Convenience
- Coercion
- Discipline
- Retaliation

Patient's Perspectives of Restraints

What does it feel like to be restrained?

This can vary:

- Patient's might feel lonely or isolated
- They might feel like they are being punished
- Others feel angry, fearful, or humiliated
- Some may become anxious or suffer from an exacerbation of Post-Traumatic Stress Disorder (PTSD)

Risks Related to Restraint Use

- Loss of therapeutic relationship or trust with caregivers
- Traumatization or re-traumatization
- Physical injury
- Death

Definitions

Violent/Self Destructive Restraint:

- Violent or self-destructive behavior is that which jeopardizes the immediate physical safety of the patient, a staff member, or others; a restraint that fully immobilizes that patient is considered for violent use

Physical Hold:

- Physically holding a patient during a forced administration of a psychotropic medication is considered restraint. Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, hands, fingers, or head freely.
- Requires an order.

Continuous Observation:

- Uninterrupted, on-going, in-person/face-to-face observation of the patient

Policy Implementation

- RN performs an individual assessment that includes patient's behavior, physical status, and environment to identify the possible cause of the patient's combativeness or other harmful behavior.
- Utilize and document alternatives to restraints.
- If alternatives fail, obtain Licensed Individual Practitioner (LIP) order unless emergent.
- If emergent, then order must be obtained after initiation based on patient condition.

Restraints may be applied **only** by staff trained in the use of violent or self-destructive restraints

Alternatives to Restraints

Restraints may be initiated only when clinically justified and when alternatives to restraints have been exhausted

Possible alternatives include:

- Reorient/reassure patient
- Re-evaluate/disguise equipment
- Medication given
- Alarm
- Family/friends at bedside
- Staff member in attendance
- Limit setting
- Discussing stressors
- Redirect/distract patient
- Pharmacy consult requested
- Decrease stimuli
- Offer comfort measures
- Identify alternative coping
- Identify precursors to episode

Document all alternatives attempted as required by Center for Medicare and Medicaid Services(CMS)

Exceptions

A physical restraint does not include devices such as:

- Orthopedically prescribed devices
- Handcuffs or other restrictive deices applied by law enforcement officials.
- Padded side rails when put up for seizure precautions.
- If a patient can lower side rails when they want to this is not a restraint and should be documented in the patient's record.

Violent Restraint Orders

The use of restraint must be in accordance with the order of the LIP who is responsible for the care of the patient.

- If restraint is ordered by another provider, the LIP responsible for the patient must be notified as soon as possible.

Order must be obtained prior to the application of restraints, except in emergency situations.

- In emergency situations, an order must be obtained during the application of the restraint, or immediately after the restraint has been applied.

Violent Restraint Orders (cont.)

The order must include:

- Clinical justification for the application of a restraint(s).
- Type of restraint(s) applied.

Leg restraints shall never be applied without arm restraints.

- If patient is in non-violent restraints and all extremities are immobilized, then that is considered a violent restraint.

Violent Restraint Orders (cont.)

- Restraints must be discontinued at the earliest possible time, regardless of the time identified on the order.
- An order for restrain use is never to be written as a standing or PRN order.
- The standards do not apply to restraints during surgical procedures and the related post anesthesia care, soft restraints are to be used.

Face To Face Assessment

A physician, LIP, or specially trained RN or PA must see the patient face-to-face within 1 hour after the initiation of restraints regardless if the restraints are discontinued prior to that time to evaluate and document:

- Patient's immediate situation
- Patient's reaction to the intervention
- Patient's medical and behavioral condition
- The need to continue or terminate the restraint , and
- Evaluation of history, drugs/medications, and recent labs

Restraint Orders: Age-Specific Guidelines

New orders must be obtained every:

- 4 hours for adults 18 years and older
- 2 hours for children and adolescents 9-17 years of age
- 1 hour for children under 9 years of age

When original order is about to expire, the patient must b e reassessed by the RN or PA who will then contact the LIP to obtain direction as to whether to renew the order or other treatment options.

- The restraint order may be renewed in accordance with these limits for up to a total of 24 hours.

Restraint Orders: Age-Specific Guidelines

- After each 24 hours of continuous restraint, and prior to further extension of the restraint, an examination and second opinion must occur by a second LIP.

- If a patient needs to remain in restraint beyond 24 hours after the original order, a face-to-face assessment by a LIP must occur before a new order for the continued use is written.

If the restraint is discontinued prior to the expiration of the order, a new order must be obtained prior to re-initiation.

- The new order requires another 1-hour face-to-face evaluation.

Posey® Neoprene Locking Restraints

Blue = wrist

Red = ankle

SHS utilizes Posey® neoprene locking restraint for violent restraint in the hospital setting

Posey® Neoprene Locking Restraints

- The neoprene cuff is placed on the patient's bare skin and secured with the short tail and locking buckle.
- Once secured to the patient, Posey® restraints are then secured to the bed frame with the long tail and locking buckle
- Posey restraints are released using the Posey® universal key on the buckle locks

Restraint Procedure

Initiate the following precautions when applying restraints:

- Maintain respect for patient rights and dignity and provide for privacy
- Utilize sufficient number of trained personnel to apply violent, self-destructive restraints
- Apply restraints securely, attaching to the bed frame, not the rails
  - See Lippincott policy “Limb Restraint Application.”

Violent Restraint Considerations

- Never utilize two point, or “soft” restraints on an individual in assaultive crisis
- Only restrain and release as a team, 5-10 people
- Maintain compassionate care for patient
- Restraint placement must be verified by an RN before staff remove any physical hold of the patient
- Minimize traumatization, do not remove clothing unnecessarily, do not spread legs

Documentation-RN

Initial documentation after restraint application:

- Physician notification of restraint application
- Individual assessment
- Alternatives attempted and failed
- Vital signs per patient condition
- Initiate violent restraint care plan
- Time and type of restraints applied
- Patient’s response to restraints
- Family notification regarding the use of restraints as appropriate
- Patient response to education

Prolonged Use

Violent restraints in use more than 24 hours is considered “prolonged use”

If there is prolonged use of violent restraints and their continued use is required, the plan of care will be reviewed by the treatment team which includes the LIP, PA, management, and care staff to identify possible actions to reduce or eliminate the use of restraints

The care plan review and its outcome is documented in the patient’s medical record

Reporting Restraint Associated Deaths

- Hospitals must report the following deaths associated with restraint and seclusion directly to their CMS Regional Office no later than the close of business on the next business day following knowledge of the patient’s death.

Hospitals must report:

- Each death that occurs while a patient is in restraint or seclusion, excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion at the time of death
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion, excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion at the time of death
- Each death known to the hospital that occurs within one 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 types(s) of restraint used on the patient during this time.

Violent Restraint Standards of Care

Time Frame	Discipline	Intervention
Continuous Observation	RN/CNA	• Performed continuous in person observation by an assigned staff member • RN ONLY - Readiness to remove restraints
Every 15 minutes	RN/CNA	• Safety and comfort check.
One hour face-to-face Evaluation (within 1 hour of initiation)	LIP or Special trained RN/PA only	• Evaluation of Patient's Immediate a) Medical Condition b) Behavioral Condition c) Condition review include history d) Patient Reaction to Intervention e) Need to continue
Every 2 Hours	RN/CNA	• Physical comfort • Fluids/Food • Elimination
Every 4 Hours	RN	• Range of motion • Circulation/Skin integrity • Mental status • Patient reaction to intervention
Daily Care	RN/CNA	• VS to meet patient care needs and comply with plan of care • Hygiene
Every 24 Hours	Treatment Team	• Review Plan of Care
24 hour Face-to-Face evaluation	Physician or LIP	• Must repeat the 1 hour face-to-face evaluation for prolonged use prior to 24 hours • Prior to further extension of the violent restraint, an examination and second opinion must occur by a second physician

Table is located in the "Use of Violent Restaints Policy"

Patient Safety Monitoring

Complications related to violent restraint use can include but are not limited to:

- skin breakdown
- impaired circulation
- incontinence
- psychological distress
- strangulation

Patients in violent restraints must be monitored continuously and all suspected complications must be reported **immediately**

Consider Restraint Removal When…

- Patient's behavior has de-escalated to the point that they are no longer an imminent danger to self or others
- Satisfactory alternative arrangements have been made to supervise the patient or other alternatives to restraints are now effective, e.g., sitter or companion
- Patient exhibits an appropriate cognitive and/or behavioral condition which allows participation in his/her plan of care

Once the assessment is complete, and the restraints have been removed, any subsequent escalating behaviors/actions warranting restraint use will require a new restraint order

Restraint Removal

Based on reassessment and observed behaviors, nursing staff may release restraints before the order time limit is reached

Release of Restraints

- The team (5 or more people) will slowly remove the restraints and remain at the bedside under constant observation to ensure the situation stays safe
- Remove the restraints from the patient before removing them from the bed frame
- If the behavior /actions begin again, re-apply restraints and obtain a new order

Restraint Care

- Clean or dispose of restraints after each use. Neoprene restraints are cleaned by staff using approved cleaner. If visibly soiled send to laundry or contact EVS for cleaning.

Use of Seclusion

Seclusion is the involuntary confinement of a patient alone in a designated room or area from which the patient is physically prevented from leaving and may only be used for the management of violent or self-destructive behavior

To guide appropriate and safe use of seclusion it must:

- Be only for the management of violent or self-destructive behavior
- Protect the health and safety of the patient and others in the immediate area
- Preserve the patients rights, dignity, and well being
- Be based on the patients assessed needs and after alternatives to seclusion use have failed

Seclusion Orders

- The use of seclusion must be in accordance with an order from a physician or other LIP responsible for the patient.
- An order for seclusion must be obtained prior to the intervention of seclusion, except in emergency situations.
- In emergency situations, an order must be obtained immediately after implementation.
- Standing or PRN seclusion order is prohibited.
- Must include the clinical justification for seclusions.
- The attending physician or physician responsible for care and management of the patient must be notified at the earliest possible time if seclusion is ordered by another LIP.

Seclusion Orders: Age-Specific Guidelines

New orders must be obtained every:

- 4 hours for adults 18 years and older
- 2 hours for children and adolescents 9-17 years of age
- 1 hour for children under 9 years of age

When original order is about to expire, the patient must b e reassessed by the RN or PA who will then contact the LIP to obtain direction as to whether to renew the order or other treatment options.

- After each 24 hours of continuous seclusion, and prior to further extension of the seclusion, an examination and second opinion must occur by a second physician and face-to-face assessment by a LIP must occur.

Seclusion Procedure

Prior to utilizing seclusion...

- An RN must perform an individual assessment that includes the patient's behavior, physical status, and environment to identify the possible cause of the patient's combativeness, or other harmful behavior
- Utilize alternatives to seclusion as appropriate – companionship of family, friends or environmental adjustments
- If these alternatives fail, then initiate the least restrictive method of restraint

Seclusion Procedure (Cont.)

While implementing seclusion the following precautions must be initiated:

- Maintain respect for the patients rights and dignity while maintaining privacy
- Utilization enough trained personnel for implementing seclusion
- Ensure the room is safely cleared and door locked

Initiate 1:1 patient observation with direct observation or camera for video and audio monitoring

Seclusion Documentation

The initial documentation of seclusion will include:

- Individual assessment-if an assessment parameter cannot be met due to the patient's condition, document behaviors requiring seclusion
- Alternatives attempted and failed
- Vital signs per patient condition
- Initiate seclusion care plan
- Time seclusion initiated
- Patient's response to education of discontinuation criteria
- Family notification as appropriate
- Physician notification

Seclusion Event Standards of Care

Evaluation/Intervention/Documentation Evaluation results for the patient during the designed time frames are to be considered to meet patient care needs and comply with the plan of care. Documentation of the evaluation and intervention is completed after each time frame.		
Time Frame	**Discipline**	**Intervention**
Continuous Observation	RN/CNA	• Continuous in person observation by an assigned staff member • RN ONLY – Readiness to remove from seclusion
Every 15 minutes	RN/CNA	Safety and comfort check
One-hour face to face evaluation (within 1 hour or initiation)	LIP or Special trained RN/PA only	Evaluation of Patient's Immediate • Medical Condition • Behavioral Condition • Condition review include history • Patient Reaction to Intervention • Need to continue
Every 2 hours	RN/CNA	• Physical comfort • Fluids / Food • Elimination
Every 4 hours	RN	• Range of motion • Circulation/Skin integrity • Mental status • Patient reaction to intervention
Daily Care	RN/CNA	• VS to meet patient care needs and comply with plan of care • Hygiene
Every 24 hours	Treatment Team	• Review Plan of Care
24-hour face to face evaluation	Physician or LIP	• Must repeat the 1-hour face to face evaluation for prolonged use prior to 24 hours • Prior to further extension of restraint/seclusion, an examination and second opinion must occur by a second physician

Table found in "Use of Seclusion Policy"

Release From Seclusion

Consider removal from seclusion when:

- The patient's behavior has de-escalated to the point that the patient is no longer an imminent danger to self or others
- Satisfactory alternative arrangements have been made to supervise the patient or other alternatives are now effective, e.g., sitter or companion
- Patient exhibits an appropriate cognitive and/or behavioral condition which allows them to participate in the plan of care

Release From Seclusion (Cont.)

- Based on reassessment and observed behaviors, nursing staff may release the patient from seclusion before the time limit is reached
- Assess the patient's behavior during this period when seclusion is discontinued
- Once the reassessment is complete and the patient released from seclusion, any subsequent escalated behaviors/actions warranting seclusion use will require a new order from the LIP

In Summary...

The use of restraints and seclusion should never be taken lightly

Always utilize alternatives prior to restraining

It is an issue of patient rights and dignity

If you have questions, consult nursing leadership or refer to SHS policy

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