General Information

Policy Name:	Restraints: Medical/Surgical or Behavioral Health Restraints and/or Seclusion
Category:	Med/Surg
Applies To:	Behavioral Health Services, Cardiac Services, Dialysis, ED, ICU, Med/Surg, Medical Imaging, Medical Staff, Neuro ICU, OB, QI, Risk Management, Security, Transport
Key Words:	Restraint, Secluded, Behavioral, Device, Protection, Death
Associated Forms & Policies:	Behavioral Health Restraint Order Form (Doc #3019) CMS Electronic Restraint Death Reporting Link CMS Restraint Death Worksheet (Doc #CMS-10455) Daily 1:1 Behavioral Form (Doc #8053) Report of Death in Restraint to CMS (Doc #7424) Restraint Documentation Record (Doc #5307) Restraint Order Form Med Surgical (Doc #3019A) Safety Watch, Security Watch (P0696) Security Patient Watch Handoff Communication Tool (Doc #5350)
Original Effective Date:	06/01/06
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This Version's Effective Date:	08/04/23

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Policy

Crouse Hospital's leadership, nursing and medical staffs are committed to continually improving our practices to protect and respect patient's rights and dignity. Crouse Hospital is striving to foster a physical, social and cultural environment that limits the use of restraints to only justified and clinically appropriate situations, and elimination of restraints whenever possible. Each patient has the right to be free from restraint or seclusion imposed as a means of coercion, discipline or convenience. Crouse Hospital is ultimately committed to using the least amount of restraint for the least amount of time. It is the responsibility of both providers and staff to know and understand the content of this policy.

The goal for management of the patient is to protect health and safety, and to preserve dignity, rights, and well-being by educating the patient, family and staff in prevention strategies, innovative alternatives and process improvement. Restraint or seclusion can be used when it is necessary to ensure the immediate physical safety of the patient, staff or others.

This policy applies to all Crouse Hospital patients regardless of patient location or status.

Exceptions:

The decision to use a restraint is driven by an individual patient assessment not by diagnosis. Therefore, these standards do not apply to the following situations:

a) **Medical immobilization:** Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic or surgical procedures and related post procedural care processes. This includes the protection of surgical and treatment sites in pediatric patients.

b) **Adaptive support/protective devices:** Mechanisms used with the intent to permit a patient to achieve maximum bodily function. These devices would include:

- orthopedic appliances
- braces
- wheelchairs
- table-tops or full side-rails that assist a patient to self-reposition.

c) **Forensic devices:** Handcuffs and/or shackles applied and monitored by law enforcement officials.

d) **Holding a child:** For the purpose of this policy, a staff member picking up, redirecting or holding an infant, preschool age child or toddler to comfort the patient is not considered a restraint.

Clinical Justification Criteria:

The decision to restrain or not to restrain is made through a comprehensive individual assessment of the patient and is not driven by a diagnosis. The comprehensive individualized patient assessment should include a physical assessment to identify medical problems that may be causing behavior changes in the patient (i.e. temperature elevations, hypoxia, hypoglycemia, drug interactions or drug effects.)

- Physiological: Assess for underlying pathology (infection, fecal impaction), comfort, pain relief, hunger, thirst, warmth, regular toileting, bedside commode/urinal, a change in treatment or removal of tubes/lines. Correct visual and/or hearing impairments and review medications. Maintain or improve function with exercise, OT/PT/Speech Therapy.
- Psychological: Gentle re-orientation, companionship, family intervention, therapeutic touch, active listening, reassurance, verbal de-escalation, security object (something to hold), validation of needs, reminiscence.
- Social: The use of diversional activity/therapeutic activity such as music, simple tasks, and picture books
- Environment: Place the patient in a high observation area, assess for ligature risk, access to call bell or bed/chair alarms, assess for appropriate seating, safe bed exit, decrease stimulation, night lighting (or increased lighting), and environmental temperature. Assess environment for unattended items, sharp objects, furniture that can be easily thrown, the patient's own items, etc.

When assessing and care planning for that patient, the healthcare team should consider whether the patient has a recent history of falling or a medical condition or symptom that indicates a need for a proactive intervention. The rationale for restraining a patient because he/she "might" fall is inadequate for using restraint.

Staff must assess and monitor a patient's condition on an ongoing basis to ensure that the patient is safe and his/her needs are met and is released from restraint or seclusion at the earliest possible time.

It is important to understand that the standards for both Medical-Surgical and Behavioral Health specifically state that it is not an acceptable reason to restrain a patient for the convenience of the staff or to serve as a substitute for adequate staffing to monitor patient.

Transporting Patient Off Unit:

An RN must make an individual assessment of the patient's behavior (i.e. exhibits short term memory impairment and ability to follow commands) and the patient's care needs with regard to his/her safety and preservation of dignity prior to transport off the unit.

Whenever possible and feasible (based on the medical need) a portable/alternative procedure will be used. If there is no alternative option acceptable to the ordering Licensed Provider (LP) and/or Radiologist, the patient will be provided with appropriate intervention and supervision.

Education of LPs:

Upon initial appointment LPs are required to read the policy entitled, "Restraints: Medical/Surgical or Behavioral Health Restraints and/or Seclusion".

Procedure

Restraints For Medical/Surgical (Device Protection):

Orders to Initiate Restraints:

- Must be made by an LP prior to implementation except in emergent situations.
- A Registered Nurse may determine that the need to restrain the patient is clinically justified if the LP is not immediately available. An LP order must be obtained either during the emergency application of the restraint or seclusion, or immediately (within a few minutes) after the restraint or seclusion has been applied. The reason for use of restraint must be documented within the Medical Record.
- An in-person evaluation and assessment by an LP must be completed within 1 hour of the application of emergency restraints.

- Upon initiation of any restraint the registered nurse must notify the attending/covering attending physician/designee as soon as possible
- Each new restraint order is time-limited up to a maximum of 1 calendar day and cannot be written as PRN.
- The order is always written on a Restraint Order Form Med Surgical (Doc #3019A)
- The restraint may be removed before the indicated maximum length of time if the patient meets the criteria for discontinuation. Once the restraint is removed, **a new order** must be obtained for **each new restraint episode.**

Assessment/Monitoring by Staff:

- The assessment includes (appropriate to the type of restraint):
  - The least restrictive interventions are used
  - Correct application
  - Signs of any injury associated with the application of the restraint.
  - Nutrition/hydration needs are met.
  - Circulation and range of motion in the extremities.
  - Vital signs including respiration as indicated.
  - Hygiene and elimination.
  - Physical and psychological status and comfort.
  - Readiness for discontinuation of restraint.
- Monitoring is accomplished by observation, interaction with the patient and/or direct exam of the patient by qualified staff. Monitoring determines:
  - The physical and emotional well-being of the patient.
  - The patient's right, dignity and safety are maintained.
  - If less restrictive methods or removal is possible.
  - Changes in the patient's behavior or clinical condition are or have occurred.
  - Bedrail gaps are protected.
  - Need for emergency care.
- Assessment/monitoring is documented on the Restraint Documentation Record (Doc #5307).
- Patients are assessed and monitored every 2 hours or more frequently according to the patient's need. Frequency of monitoring (beyond every 2 hours) is made on an individual basis and includes a rationale that reflects consideration of the individual's medical needs and healthcare status.
- When an LP is called and they do not respond to the request to complete an initial evaluation within 1 hour of the placement of restraints, the Registered Nurse will complete an occurrence report.

Family Notification:

- Families will be included in discussion of restraint issues when practical.

Order Renewal:

- Renewal of a restraint order is issued once each calendar day and is based on the LP’s in-person evaluation.

Discontinuation:

- An LP or RN may discontinue a restraint based on the assessment of patient's condition.
- The restraint may be removed before the indicated maximum length of time if the patient meets criteria for discontinuation.

  Note: This is considered termination of the order and reapplication will require a new order.
- Discontinuation of the restraint must be documented on the Restraint Documentation Record.

Restraints for Behavioral Health in Any Setting:

Orders:

- The decision to implement restraints or seclusion is based on:
  - Comprehensive assessment of the patient.
  - Reason for restraint.
  - The patient's current behaviors.
  - Potential harm to self or others.
  - Ineffective outcomes from least restrictive interventions.
- The decision to implement a restraint or seclusion must be made by the LP who is primarily responsible for the patient's ongoing care.
- If the LP is not immediately available, a Registered Professional Nurse may initiate the restraint or seclusion if criteria for restraints are met as listed above. In these emergency application situations, the order must be obtained either during the emergency application of the restraint or seclusion, or immediately (within a few minutes) after the restraint or seclusion has been applied.
- The LP must complete an initial evaluation of the patient's physical and behavioral status within one hour after the initiation of restraints or seclusion. The evaluation includes determining the need for continuing restraints or seclusion and identifying strategies for discontinuation. "An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, medications, most recent lab results, etc. The purpose of the 1-hour face-to-face evaluation is to complete a comprehensive review of the patient's condition and determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior." (DNV NIAHO) The assessment is to occur after the initiation of restraint and can also serve as an order for renewal.
- Each written order is time-limited:
  - 4 hours for 18 years or older
  - 2 hours for children and adolescents aged 9-17
  - 1 hour for patients under 9.
- The order cannot be written as PRN.
- Time limited orders do not imply that restraints must remain on for the entire timed period. If the patient achieves criteria for discontinuation the restraint should be terminated at the earliest possible release. If the restraint is discontinued documentation of the behavior/circumstances must be made in the medical record.
- When restraint or seclusion is terminated before the time-limited order expires, a new order must be obtained to reapply the restraints or seclusion. The order is written on the Behavioral Health Restraint Order Form (Doc #3019).
- Upon initiation of any restraint the registered nurse must notify the attending/covering/designee

physician as soon as possible.

Notification:

- If the patient has consented to have family kept informed regarding his/her care, staff attempts to contact the family promptly to inform them of the restraint episode. This is documented on the Restraint Documentation Record (Doc #5307).
- As early as possible after initiation of restraint or seclusion for behavioral health purposes the patient is informed of the reason why restraint or seclusion was initiated and what criteria there is for their discontinuation.

Notification of Clinical Leadership:

- On all prolonged restraints (restraints on for longer than 5 days) the medical team will review and evaluate alternatives and/or interventions

RN Assessment/Monitoring:

- Observation and documentation is performed every 15 minutes or sooner according to the patient's needs. Frequency of assessment is made on an individual basis which includes a rationale that reflects consideration of the individual's medical needs and healthcare status.
- All patients for the safety of themselves and monitors will be placed in a gown upon initiation of restraints if not already done so.
- The RN assessment includes as appropriate to the type of restraint or seclusion, the following:
    - Correct application of restraint.
    - Signs of any injury associated with the application of the restraint.
    - Nutrition/hydration needs are met.
    - Circulation and range of motion in the extremities.
    - Vital signs including respirations.
    - Hygiene and elimination.
    - Physical and psychological status and comfort.
    - Readiness for discontinuation of restraint.
- Monitoring is accomplished by observation, interaction with the patient or direct exam of the patient by qualified staff. The monitoring determines:
    - The physical and emotional well-being of the patient.
    - That the patient's rights, dignity and safety are maintained.
    - If less restrictive methods or removal is possible.
    - Changes in the patient's behavior or clinical condition.
    - Criteria for discontinuation.
    - If the unsafe situation continues to exist.
- The assessment is completed and documented on the Restraint Documentation Record (Doc #5307).

Re-evaluation:

- Re-evaluation includes an assessment to determine the degree to which the restraint or seclusion has accomplished the desired outcome.
- The re-assessment is performed by the LP as follows:
    - Within 1 hour after initiation, which can also serve as an order and

- With each time-limited order.

- The re-evaluation is documented on the Behavioral Health Restraint Order Form (Doc #3019). If the LP who gives the order for continuation of restraint or seclusion is not the Attending, the Attending is notified of the patient's status.

Termination of Restraints:

- As early as feasible and appropriate in the restraint or seclusion process the patient is informed of the reasons for the interventions and behaviors the patient must exhibit to have restraints removed or to be released from seclusion. The patient's plan of care includes strategies to achieve desired behavior. Restraints are removed as soon as possible when the patient demonstrates desired behaviors. Termination of restraints is done after assessment by an RN or LP.

Debriefing:

- After behavioral restraint or seclusion has been discontinued the LP or RN debriefs the patient. This session includes a discussion with the patient on:
  - Why restraint took place.
  - Did the staff's actions allow the patient to gain control?
  - Was the patient given a chance to gain control?
  - Was the patient offered choices before staff intervened?
  - Did the staff consider your choices before they intervened?
  - Did the patient feel safe during restraint?
  - Does the patient have suggestions to avoid restraint in the future?

Reporting of Death Following Restraint or Seclusion

Upon gaining knowledge of a patient dying following restraint or seclusion, the Department of Quality Improvement MUST be immediately notified so as to inform CMS. Please complete CMS Restraint Death Worksheet (Doc #CMS-10455) located on Hospital Documents and send to Quality Improvement.

For Quality Improvement Department:

- 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. The Quality Improvement Department will 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 within 24 hours of their death; and
  - Each death known to the hospital that occurs within one week after restraint or seclusion was discontinued 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
  - Those deaths in restraint that are excluded above must be maintained in log in the Quality Improvement Department and must be readily available to CMS at their request. Entries in the log must be made within 7 calendar days following the patient death.
  - The following must also be documented in the patient's medical record for any patient whose death is associated with the use of restraint or seclusion:
    - The date and time the death was reported to CMS for deaths required to be directly

reported; or

- The date and time the death was recorded in the hospital's/CAH's internal log or other system

- The Department of Quality Improvement will complete the Report of Death in Restraint to CMS (Doc #7424) and place in the patient record and report the death to CMS through the CMS Electronic Restraint Death Reporting Link.

Documentation for Medical/Surgical/Behavioral Restraint/Seclusion:

- Orders for restraints are documented on the Behavioral Health Restraint Order Form (Doc #3019) or Restraint Order Form Med Surgical (Doc #3019A).
- Monitoring of the patient in restraints is documented on Restraint Documentation Record (Doc #5307)).
- Care Team discussions regarding plan of care and any subsequent changes are documented in the progress notes.
- Care plan relating to restraints started when restraints are initiated and resolved on discontinuation in the EMR. (Inpatient Only)

Patient/Family Education:

- To facilitate patient/family participation, discuss the following:
  - The organization's philosophy for the use of restraints.
  - The reasons for use of restraints.
  - The alternatives considered and attempted.
  - The consequences of using alternatives and/or restraints.
  - Patient and family insight related to the prevention of self-harm and potential alternatives.
  - Incorporation of patient/family preferences whenever possible.
  - Participation which could reduce the need for restraints.

Competency & Training Requirements:

- Direct caregivers will demonstrate competency related to the proper and safe use of restraint and seclusion during initial orientation and new initiatives. Direct caregivers in the Emergency Department, the ICU and the Restraint Champions will also receive return demonstration training on an annual basis.
- Training shall minimally include: The proper and safe use of seclusion and restraint application and techniques and alternative methods for handling behaviors, symptoms and situations that traditionally have been treated through the use of restraint or seclusion.
- Review of Policy and Procedure specific to patient and staff safety and restraint and seclusion.
- Means of access to staff qualified to assess and provide restraint and seclusion.
- Proper documentation of restraint and seclusion to support implementation, assessment, monitoring and evaluation for a patient in restraint or seclusion.
- Awareness among staff about how the use of restraint or seclusion may be experienced by the individual, especially from the patient's perspective.
- Steps to help preserve the individual's safety and dignity when restraint or seclusion is used.

Performance Improvement & Quality Measurements:

- Continuous data collection on restraint and seclusion usage supports identification of opportunities for

improvement. Restraint and seclusion data is reviewed and reported to the appropriate Performance Improvement Council.

- A master log of all episodes of restraint is maintained to assist with the analysis.
- Data is collected for each episode of restraint or seclusion for behavioral health purposes and includes:
    - Unit
    - Shift
    - Staff who initiated
    - Length of episode
    - Type of restraint
    - Patient identifier
    - Patient age and gender
    - Any injuries sustained by staff or patient

References

CMS Conditions of Participation, Section 482.13 (e), (f), (g). NIAHO Accreditation Requirements Revision 23-0 (May 9th 2023)

Definitions

PRN:

As needed

Restraint:

Any method (physical, chemical or seclusion) which is intended to restrict a person's access to his/or her body, restricts his or her freedom of movement or is not a usual and customary part of a medical diagnostic or treatment procedure to which the patient or his /her legal representative has consented to.

Physical Restraint:

Any 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.

Physical Hold:

Holding a patient in a manner that restricts the patient’s movement against the patient’s will. Physically holding a patient to administer a psychotropic medication is considered a restraint.

Devices Which Serve Multiple Purposes:

Side-rails, when they have the effect of restraining a patient's movement and cannot be easily removed by the patient, constitute a restraint (i.e. all side rails up.)

Chemical Restraints (i.e. drugs used as restraint):

- A medication used to restrict a person's freedom of movement or to manage or control aggressive behavior in an emergent situation that is not a part of standard treatment for the patient's medical or psychiatric condition.
- Medications that are part of the patient's regular medical regimen (including PRN medications) are not considered drug restraints, even if the purpose is to control ongoing behavior:
    - Therapeutic doses of psychotropic medication for patients who are suffering from serious mental illness to improve their level of functioning so that they can more actively participate in their treatment.
    - Therapeutic doses of anti-anxiety medications to calm the patient who is anxious.

- Appropriate doses of sleeping medication prescribed to treat insomnia
- Appropriate doses of analgesic medication for pain management

Note: Agitation in and of itself is not an emergency situation that warrants medication of the patient (i.e. chemical restraint) over and above the patient's objection. Medication used against a patient's wishes/objections to control actions or behavior is considered a restraint. A patient has a right to refuse medications.

Seclusion:

The involuntary confinement of a person alone in a room or an area where he/she is physically prevented from leaving the room. Seclusion can only be used in emergency situations if needed to ensure the immediate safety of the patient exhibiting violent or self-destructive behavior (and others) and less restrictive interventions have been determined to be ineffective. (Used in the emergency department.)

Seclusion outside of the ED (i.e. an inpatient unit) is only used in an emergency situation in which safety of the individual or staff is of primary concern. The Administrative Supervisor is immediately notified as is the LP to obtain approval and an order for the use seclusion.
The goal is to eliminate the need for seclusion as soon as possible.

Medical/Surgical Restraint:

These standards will apply to situations when restraint is used to directly support healing. The use of restraint is meant to prevent the patient from jeopardizing their safety during the course of medical/surgical treatment. Ex: Medical device protection.

Interpretive guideline: In acute medical and post-surgical care, a restraint may be necessary to ensure that an intravenous line or monitoring device remains intact or to prevent the person who is incapacitated with a hip fracture from walking before medically appropriate. Agitation in and of itself is not an emergency situation that warrants medication of the patient (i.e. chemical restraint) over and above the patient's objection.

Behavioral Health Restraints:

These standards will apply to those situations that restraint is needed in an emergent situation to protect a patient from injuring himself or others because of an emotional or behavioral disorder. The patient may be increasingly delusional, combative or violent towards self or others and non-physical interventions have failed and/or are not feasible.

Interpretive guideline: If the intervention is undertaken because of an unanticipated outburst of severely aggressive or destructive behavior or one that poses an imminent danger to patient or to others, behavioral restraint standards apply. Agitation in and of itself is not an emergency situation that warrants medication of the patient over and above the patient's objection (i.e. chemical restraint.)

Restraint Episode:

The time between initiation and discontinuation of the restraint or seclusion within the specific time-limited order or event.

Prolonged Restraint:

Restraint of a patient longer than 5 calendar days is considered prolonged restraint.

Licensed Provider (LP):

Any individual permitted by law and the organization to provide care and services, within the scope of the individual's license, and consistent with the individually granted clinical privileges. This includes the primary physician/attending responsible for the patient's ongoing care while hospitalized, and the provider coverage on call for the attending physician. This may include a credentialed physician assistant (PA) or Nurse

Practitioner (NP).

Alternative Interventions:

Measures which modify the environment; enhance interpersonal interaction or provide for a proactive/self-care approach to care so as to minimize or eliminate a problem behavior which places the patient at risk for injury to self or others. The staff is encouraged to use creativity in their approach to reduce or eliminate restraint. The following are suggestions:

- Ambulation/PT consult
- Assess/treat pain
- Bed alarm
- Correct visual/hearing deficits
- Diversional activity/therapeutic activity such as music, simple tasks, and picture books.
- Camouflaging tubes
- Calming techniques
- Sleep/hygiene
- Provision of personal needs
- Hallway monitoring with frequent observation
- Relocation of room/unit Place in high observation area, access to call bell or bed/chair alarms, assess for appropriate seating, safe bed exit, decrease stimulation, night lighting (or increased lighting), and environmental temperature.
- Review/adjust medications
- Family involvement/notification
- 1:1 supervision
- Discontinue any unnecessary tubes/drains
- Reclining chair

Timeout:

This is not considered seclusion. Timeout is an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses.

Report of Death:

The hospital must report each death to CMS that occurs while a patient is in restraints or seclusion and within 24 hours after the patient has been removed from restraint or seclusion, regardless of whether the death was due to a restraint *See Exceptions Under Procedure pg #7.

One Week Rule:

The hospital has to report any death to CMS that occurs within one week after restraint or seclusion where it is reasonable to assume that the restraint or seclusion contributed to the death either directly or indirectly regardless of the type(s) of restraint used on the patient. “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.

Ligature Risk:

Anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. They can include but are not limited to hand or shower rails, door handles/knobs, door hinges, shower curtains, exposed plumbing/pipes, water fountains, soap and paper towel dispensers on walls, power cords on medical equipment or call bell cords, light fixtures or projections from ceiling, toilets or toilet seats.

Addendums, Diagrams & Illustrations

See Next Page(s)

Appendix A: Restraint Table

Behavioral Management	**Acute Medical / Surgical**
Definition: An emergency situation involving the use of physical/chemical restraint or seclusion when violent or aggressive behavior places the patient, staff or others in imminent physical danger. Restraint for behavioral management can be used on any clinical unit.	**Definition:** A restraint used to promote medical/surgical healing.

Elements of Restraint	**Behavioral Health**	**Medical/Surgical**
Initiation of restraint order.	RN may initiate prior to order, LP must be immediately notified, order needs to be obtained immediately (within a few minutes) &LP assessment within 1 hour. The assessment must occur after the application of restraints and timed as such.	RN may initiate prior to order but order must be obtained immediately (within a few minutes) The LP must be immediately notified.
Notification to attending physician/covering attending	As soon as possible	As soon as possible
Order Documentation:	**Verbal or written.** May not be prn or per standing order or protocol. Behavioral Health Restraint Order Form (Doc #3019)	**Verbal or written.** None may be prn or per standing orders or protocol. Restraint Order Form Med Surgical (Doc #3019A)
Maximum **length** of order.	18 yrs & older - 4 hours 9-17 yrs - 2 hours < 9 yrs - 1 hour **Note:** If restraint is discontinued a new order is required if restraints reapplied	One calendar day **Note:** If restraint is discontinued a new order is required if restraints reapplied
Face to Face evaluation by LP on initiation Documentation:	**Within one hour** Behavioral Health Restraint Order Form (Doc #3019)	**A. Within 1 hour of application of emergency restraints; otherwise,** **B. Within 24 hours** Restraint Order Form Med Surgical (Doc #3019A)
Re-evaluation Order Cycle: Face to Face by the LP Documentation:	• **Within 1 hour after initiation** • **With each time-limited order** Physician Progress Note/Order When the patient is no longer a danger to self or others is when the restraint should be discontinued.	**Every calendar day** Physician Progress Note/Order
Initial Assessment by RN: Subsequent Assessment/Documentation:	Circulation, respiratory, skin at site and dignity/safety/ environment/ psychological status Continuous Face to Face observation by assigned staff. Q 15 minutes assessment documented on Restraint Documentation Record (Doc #5307)	Circulation, respiratory, skin at site and dignity/safety/ environment/psychological status Minimum Q 2 hours. Documentation on Restraint Documentation Record (Doc #5307)
Nursing documentation on Restraint Documentation Record (Doc #5307)	Narrative Note on initiation, discontinuation and any significant change in condition	Narrative Note on initiation, discontinuation and any significant change in condition.

Appendix B: Restraint Reference Guide

Restraint Champions:

SWAT
CNSs
Nursing Supervisors

Restraint Champion Responsibilities:

- **To assist in making sure it is a restraint**
- **To make sure the documentation is correct**
  (see next page for list of what to document)
- **To remind staff a resource binder exists on all units**
- **Notify the Nurse Manager of the unit the restraints are on either in person or by e-mail**
- **To complete the restraint audit form (#360)**
  (Day & Night Charge RNs complete it in the ICU)

Documentation to be completed:

- Licensed Provider Order (**#3019** or **#3019A**)
  - Notify provider & obtain initial restraint order within a few mins (≤ 10 mins per Crouse)
- Nursing Documentation (**#5307**)
- Care plan initiated in Soarian when applied
- Care plan completed in Soarian when discontinued
- Audit Tool completed (**#360**)
  - give to Nurse Manager when complete so they can review and give to QI
  - if something was documented incorrectly, also provide a copy of the documentation/order

Reminder:

Neoprene Cuffs are kept with Security

Related Documents:

- **Medical/Surgical Restraint Order Form (#3019A)**
  - Used for medical device protection (Ex: Pt. is attempting to pull out ETT)
  - Order renewal is every calendar day

- **Behavioral Health Restraint Order Form (#3019)**
  - Used if patient is aggressive/violent towards self/others
  - All chemical restraints and/or physical holds are behavioral
  - Order renewal is 1 hour after initiation, then with each time-limited order

- **Restraint Documentation Record (#5307)**
  - All nursing documentation is completed on this form
  - Only fill out the debriefing section for behavioral health restraints

- **Restraint Data Collection Sheet (Audit Tool) (#360)**
  - To be completed by day and night charge nurse in ICU/NSU
  - To be completed by restraint champion in Med-Surg/OB

- **Reporting of Death in Restraint to CMS (#7424)**
  - Complete if patient had any form of restraints in the last 24 hours prior to death
  - Return to Nurse Manger so they can give to QI
  - QI must report to CMS within 1 week of the patient's death

- **Daily 1:1 Safety Watch Observation Form (#8053)**
  - If a patient is on a 1:1- make sure doc #8053 "Daily 1:1 Safety Watch Observation Form" is filled out q shift and placed in the patient's chart when completed

- **Patient's Rights, Capacity & Detention of (#8585)**
  - created by legal as a reference for frequently asked questions about keeping patients that want to leave AMA

Definitions:

Chemical Restraint:

- A medication used to restrict a person's freedom of movement or to manage or control aggressive behavior in an emergent situation that is not a part of standard treatment for the patient's medical or psychiatric condition.
- Medications that are part of the patient's regular medical regimen (including PRN medications) are not considered drug restraints, even if the purpose is to control ongoing behavior:
    - Therapeutic doses of psychotropic medication for patients who are suffering from serious mental illness to improve their level of functioning so that they can more actively participate in their treatment.
    - Therapeutic doses of anti-anxiety medications to calm the patient who is anxious.
    - Appropriate doses of sleeping medication prescribed to treat insomnia
    - Appropriate doses of analgesic medication for pain management

Note: Agitation in and of itself is not an emergency situation that warrants medication of the patient (i.e. chemical restraint) over and above the patient's objection. Medication used against a patient's wishes/objections to control actions or behavior is considered a restraint. A patient has a right to refuse medications.

Physical Hold:

Holding a patient in a manner that restricts the patient's movement against the patient's will.
Ex of one- physically holding a patient to administer a psychotropic medication
Ex of **Not** one- part of procedural care like stabilizing an arm for IV or NGT placement

Imminent Risk: Patient has a current plan & immediate ability to be suicidal &/or homicidal.

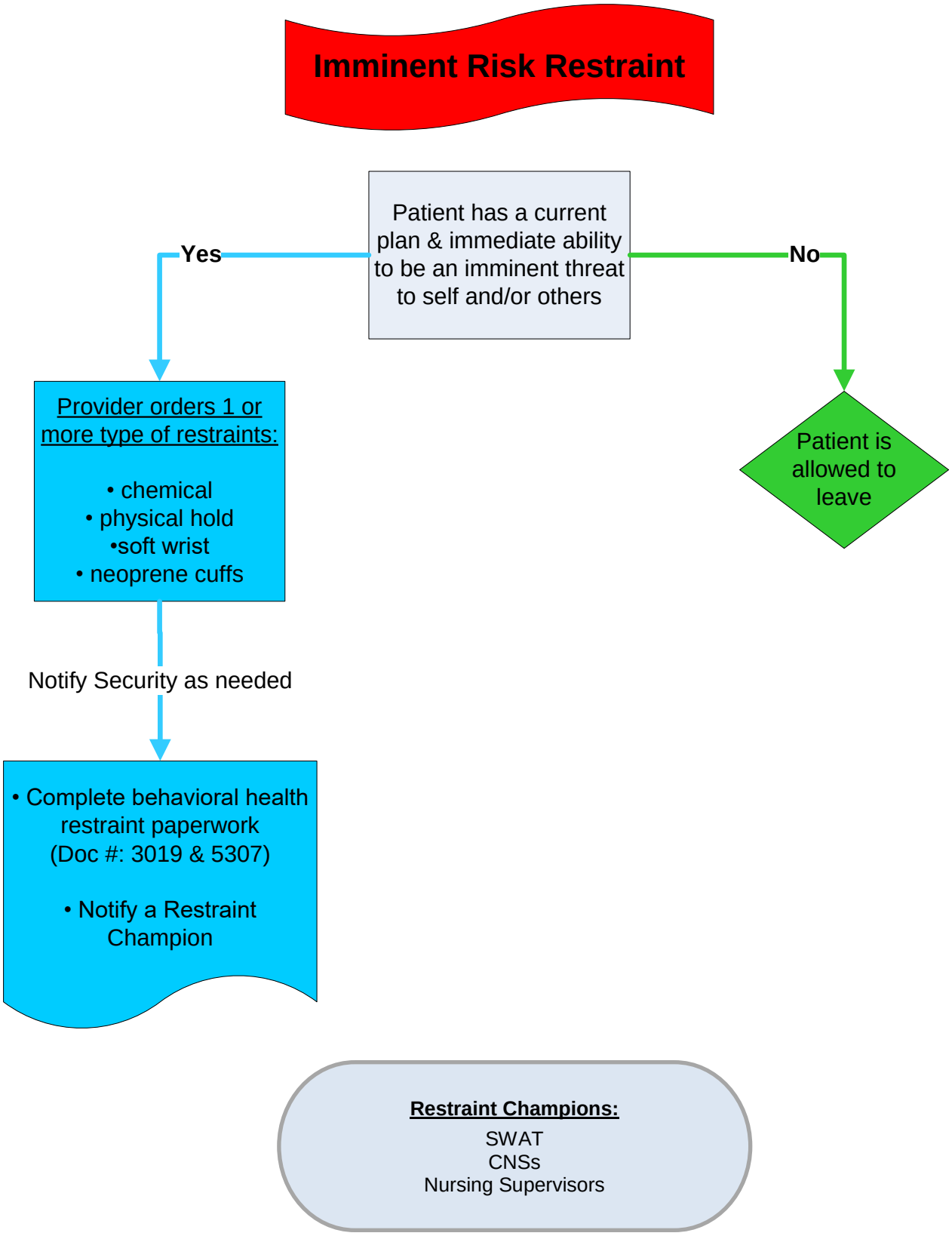
Enabled: Patient is calm and able to participate in their care; cooperative

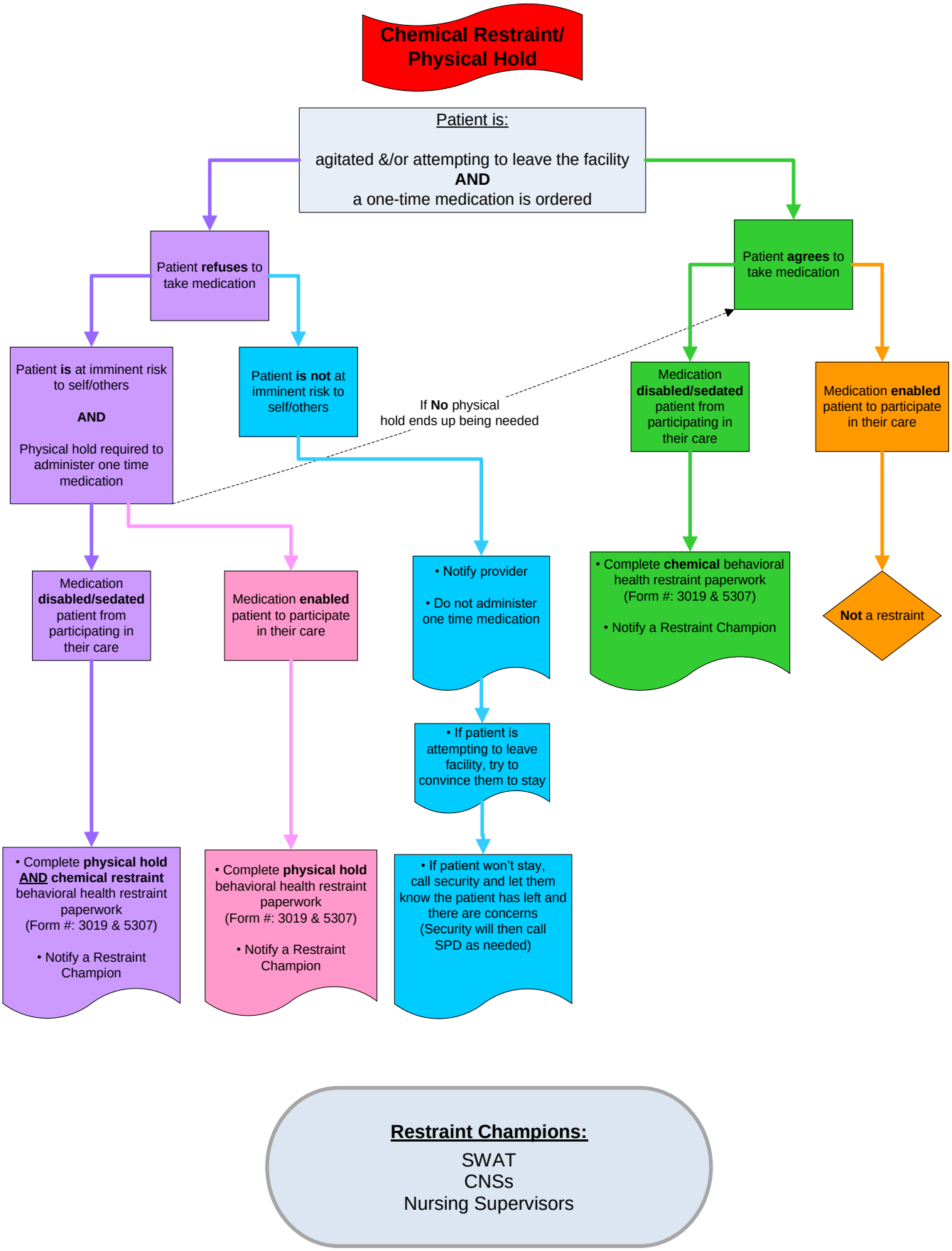
Disabled: Patient is unable to participate in their care and movement is restricted

Sedated: Patient is unarousable

One-time Medication: not a scheduled or prn order (Ex: Haldol, Ativan, Geodon)

SPD: Syracuse Police Department


Imminent Risk Restraint
Patient has a current plan & immediate ability to be an imminent threat to self and/or others
Yes
No
Provider orders 1 or more type of restraints:
• chemical
• physical hold
•soft wrist
• neoprene cuffs
Patient is allowed to leave
Notify Security as needed
• Complete behavioral health restraint paperwork (Doc #: 3019 & 5307)
• Notify a Restraint Champion
Restraint Champions:
SWAT
CNSs
Nursing Supervisors


Chemical Restraint/ Physical Hold
Patient is:
agitated &/or attempting to leave the facility
AND
a one-time medication is ordered
Patient refuses to take medication
Patient agrees to take medication
Patient is at imminent risk to self/others
AND
Physical hold required to administer one time medication
Patient is not at imminent risk to self/others
If No physical hold ends up being needed
Medication disabled/sedated patient from participating in their care
Medication enabled patient to participate in their care
Medication disabled/sedated patient from participating in their care
Medication enabled patient to participate in their care
• Notify provider
• Do not administer one time medication
• Complete chemical behavioral health restraint paperwork (Form #: 3019 & 5307)
• Notify a Restraint Champion
Not a restraint
• If patient is attempting to leave facility, try to convince them to stay
• Complete physical hold AND chemical restraint behavioral health restraint paperwork (Form #: 3019 & 5307)
• Notify a Restraint Champion
• Complete physical hold behavioral health restraint paperwork (Form #: 3019 & 5307)
• Notify a Restraint Champion
• If patient won't stay, call security and let them know the patient has left and there are concerns (Security will then call SPD as needed)
Restraint Champions:
SWAT
CNSs
Nursing Supervisors