CRENSHAW
COMMUNITY HOSPITAL

Education Department

September 30, 2023

Revised Restraint Policy 2023

Please review this document along with the new "Restraint Packet," the policy package of documents and forms to be used together for any restraint or seclusion incident.

Major Points

1. The restraint policy has been revised and updated to be consistent with Federal and State guidelines.
2. All forms have been updated, including order forms, debriefing forms, face-to-face assessment forms, and monitoring forms, as well as Quality Initiative forms. No other previous forms are to be used.

Core Principles: Patients have a right to be restraint-free. Restraints and/or seclusion will only be used as a last resort, having failed at all attempts of less invasive interventions to prevent harm to the patient or harm to others. The updated forms will make it more clear to staff what is to be performed and documented for all restrained and/or secluded patients. Federal and State guidelines are extensive, and there are no unnecessary forms included in the restraint pack. The purpose of the revised policy is not intended to make it easier to restrain or seclude a patient, but to comply with all regulations and maintain patients' rights, dignity, and safety.

Overview of specific changes

1. All Registered Nurses responsible for the patient in restraints and/or seclusion must have been trained in the new facility policy and restraint processes prior to working with restraints or seclusion.
2. Restraints and/or seclusion can only be initiated for behavior that is an immediate threat of self-harm or injury to others, not for non-compliance.
3. A patient may be restrained and/or secluded for a maximum of 4 hours per physician order. Any patient requiring more time than 4 hours must have a new physician order.
4. The maximum amount of time a patient may be restrained or secluded continually will be 12 hours. It is expected that 12 hours is enough time that a suitable and effective solution to improve the patient's mental state will be implemented.
5. Caution must be used when giving medications outside their normal intended usage and dosage, as this could be considered Chemical Restraints, and requires Violent Restraint policy documentation.
6. All monitoring of a restrained or secluded patient will be performed and documented by a trained Registered Nurse. Mental Health Techs will only be able to collect vital signs or assist the Registered Nurse, while the RN is present with patient.

7. "Time Out" – A patient may be placed in Time-Out but must be physically capable of leaving the area. Placing the patient behind a locked or closed door implying that it is locked will be considered Seclusion.
8. Seclusion is considered a "Violent Restraint" for purposes of documentation.
9. A patient placed in emergency restraints or seclusion will have a Face-to-Face Assessment done within one hour of initiation, documented using the Face-to-Face form in the restraint packet. The results of this assessment will be reported to the physician or physician designee as soon as possible.
10. An order from the physician or physician designee for restraints or seclusion must be in the patient's chart within one hour of initiation.
11. A patient placed in restraints for a 4-hour period that meets criteria for discontinuation in less than 4-hours automatically discontinues the order. If the patient then later requires restraints or seclusion, a new order must be obtained, as well as a new Face-to-Face assessment, using a new restraint packet.
12. If a patient falls asleep while restrained or secluded, by practical observation, the patient is no longer violent, and restraints must be removed. If the patient awakens and becomes violent again, a new order for restraints must be obtained.
13. The entire restraint/seclusion event will be documented appropriately per policy and will be reviewed by Quality and Risk Management for compliance issues as well as areas of potential improvement.
14. No shortcuts to interventions, monitoring or documentation will be allowed. It is the responsibility of the staff working with the restrained patient to ensure compliance with policy requirements.
15. Because of the risk of harm to the emotional or physical health to the patient, restraints and/or seclusion will only be used as a very last resort in extreme cases, where the patient is at immediate risk of self-harm or injury to others, and will be discontinued immediately as soon as the patient is no longer exhibiting behavior that includes potential self-harm or injury to others.

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Crenshaw Community Hospital Policies and Procedures	Policy Number AHW.400.0052	Effective Date 10/2012
	Revision Date 9/15/23	Review Date
Manual: Administrative (House Wide) Title: Restraints and Seclusion	Chief Of Staff Administrator	

Purpose:
Crenshaw Community Hospital strives to protect the rights and dignity of all patients by seeking a restraint-free environment while emphasizing both the physical and emotional wellbeing of our patients. Restraints/Seclusion will be used only when clinically justified and when other less restrictive alternatives have proven ineffective. Restraints or seclusion will not be used as a means of coercion, threat, punishment, staff retaliation or for staff convenience, nor will restraint or seclusion be used as a substitute for adequate staffing. Reduction of risks associated with restraint use will be accomplished through preventative strategies, innovative alternatives, process improvement, planning, education, and allocation of resources.

Policy and Procedure:

A. **Definitions**
   1. **Attending Physician**: The covering physician with **primary** responsibility for the care and treatment of the patient.
   2. **Chemical Restraint:** A drug or medication when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is **NOT** a standard treatment or dosage for the patient's condition.
      - Standard treatment or dosage is defined as and must meet **ALL** of the following:
         - Used within the parameters of the FDA as defined by the medication label;
         - use of drug follows national practice standards;
         - use of drug for treatment is based on physician assessment of the symptoms, clinical situation, and knowledge of the expected/actual response to the medication.
      - The use of medications that do not meet all components of standard treatment or dosage as defined above are considered **chemical restraints.** NOTE: In addition to "standard treatment", if the overall effect of a drug or medication is to improve the patient's ability to effectively or appropriately interact with the world, the drug or medication is not considered a restraint.
      - Routine use of chemical restraints is not permitted.

- If and when chemical restraints are utilized, violent/self-destructive restraint requirements will apply.

3. **Episode:** The time period beginning with the initiation of restraint/seclusion to discontinuation based on assessment and resolution of symptoms precipitating that event or expiration of the time-limited order.
4. **Face-To-Face Evaluation:** A physical and behavioral assessment inclusive of a comprehensive review of the patient's condition to determine if medical factors are contributing to the violent/self-destructive behavior. The evaluation must be conducted by a qualified licensed practitioner within the scope of their practice.
5. **Licensed Independent Practitioner:** Any individual who is permitted by law and the hospital to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges as defined by laws, rules and regulations.
6. **Qualified Registered Nurse:** A Registered Nurse who has been trained in the initiation, monitoring and discontinuation of restraints or seclusion, and is competent in the care of the psychiatric patient.
7. **Restraints:** 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, including the application of physical force alone; or a drug or medication when it is used for restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. For example: Physical restraints include manual hold and 2/4 point physical immobilization.
   a. Non-violent restraint usage is defined as a circumstance where the patient is attempting to seriously interfere with medical treatment or devices thus adversely affecting the direct support of medical healing.
   b. Violent/Self-destructive restraint usage is defined as behavior that jeopardizes the **immediate** physical safety of the patient, a staff member, or others.
8. **Seclusion:** Involuntary confinement of a person in a room or area where a person is physically prevented from leaving. This area may be secured by a door that is held shut, locked, or physically blocked by a staff person or for which exit is blocked by intimidation or implication that the patient cannot leave. If a patient has been placed in a room for a time out and not told that the exit door is not locked, this is considered seclusion.
9. **Time Out:** The "voluntary" confinement in which a patient is placed alone in a room or area for an agreed upon time frame and is placed under close observation but is physically able to leave the room or area. Therefore, time out is not considered restraint or seclusion.
10. **Behavioral Emergency:** A situation in which it is necessary to restrain or seclude a patient to prevent any of the following:
    a. Harmful acts involving the patient to self:
       i. Imminent probable death
       ii. Suicide

iii. Serious bodily injury

b. Imminent physical or emotional harm to others because of at least the following:
   i. Threats
   ii. Attempts or other acts the patient overtly or continually makes or commits.
   iii. Preventative, de-escalative, or verbal techniques have proven ineffective at diffusing the potential for injury.
c. These situations may include aggressive acts by the individual, including serious incidents of shoving or grabbing others over their objections.

The following exclusions apply to this policy and are not considered restraints:

11. 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 protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.
    a. An IV arm board used to stabilize an IV line but does not immobilize the entire limb thus allowing the patient to access his/her body.
    b. Age and/or developmentally appropriate safety interventions such as stroller, safety belts, highchair, lap belts, raised crib rails, crib covers, and swing belts which are routinely used outside a health care setting to protect an infant, toddler, or preschool child.
    c. A drug or medication used for standard treatment or dose to treat a patient's medical condition. (See Chemical Restraints)
    d. Mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility.
    e. A medically necessary positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize the patient during a procedure.
    f. **Bed Rail Exceptions:** The use of four bedrails in clinical situations requiring the use of a lateral rotation bed for treatment purposes; use of a stretcher during treatment or transport; with the use of bed pads for seizure precautions; and during the recovery period immediately following the use of anesthesia.
    g. **Forensic Restrictions/Restraints:** The use of handcuffs or other restrictive devices **applied by law enforcement officials** who are not employed or contracted by the hospital for purposes of custody, detention, and public safety (the hospital is still responsible for assessment and provision of safe and appropriate care of these patients).

B. Governing Principles:

Prevent, reduce or eliminate the use of restraint whenever possible by:

1. The determination of the type of intervention: Application and use of restraint intervention cannot be diagnosis or location dependent. Restrictions of a patient's freedom can be initiated for two reasons:
   a. Violent/Self-destructive behavior
   b. Non-Violent
2. The application of a comprehensive individual assessment of patient necessity
3. The rationale that the patient should be restrained because he/she "might" fall does not constitute an adequate basis for using a restraint.
4. Seeking alternatives to restraints whenever possible. Restraint use will never be the first-choice solution.
5. Limiting the use of restraints to situations where there is a risk of the patient interfering in medical treatment or to keep the patient from harming themselves or others as a result of violent/self-destructive behaviors.
6. The application of the least restrictive method of restraint.
7. The provision of safe application, monitoring of patient needs, and removal of the restraint/seclusion by staff members who have been identified, trained, and deemed competent to safely and effectively perform these responsibilities.
8. Discontinuation of the restraint/seclusion immediately if the patient's condition no longer warrants the use of the restraint.
9. In extreme cases of imminent danger to the patient or to others by the patient, simultaneous restraint and seclusion use is only permitted if the patient is continually monitored:
   a. Face-to-face by an assigned, trained staff member or by trained staff using video equipment. This monitoring shall be in close proximity to the patient with capability of immediately addressing any situation that may arise.
   b. The patient will receive close observation while in restraints and/or seclusion with the appropriate documentation completed.

C. Ordering & Face-to-Face Evaluation

1. The least restrictive method of restraint will be implemented when safety or medical needs cannot be met through alternative measures.
2. Restraint orders will never be written as a standing or PRN order.
3. In non-emergent situations, a LIP must provide an order for restraints prior to initiation.
4. In emergency application situations, a RN may initiate application when less restrictive interventions have either been exhausted or have been determined to be effective to protect the patient and/or others. Documentation of less restrictive attempts that failed must be documented. An order is still required and must be obtained immediately; **not to exceed 1 hour from initiation.**
5. **No order for restraints or seclusion may exceed four (4) hours.**
6. An authorized LIP must provide a new order for each 4-hour episode of restraint. If the attending LIP is not the ordering LIP, he/she must be notified as soon as possible of the initiation of restraint and to obtain a new order. Notification must be documented in the patient's record. If the restraint requires a more restrictive intervention, a new order reflecting the more

restrictive intervention is required. Once the restraint is discontinued, ending the episode, a new order is required for reapplication.

7. When restraint or seclusion is terminated **before** the time-limited order expires, a new order must be obtained to **reapply** the restraint or seclusion, even if a previous order's time limits have not expired.
8. All staff who have direct contact with a patient in restraints or seclusion must have annual education and training in the proper and safe use of restraint and seclusion application and techniques and alternative methods for handling behavior, symptoms, and situations.
9. The following guidelines regarding ordering and evaluation are specific to **Non-Violent Restraints:**
   - When a restraint is used for circumstances where the patient is attempting to seriously interfere with medical treatment or devices thus adversely affecting the direct support of medical healing, the registered nurse may initiate the emergency use of restraint.
   - A non-violent restrain order must be renewed every 24 hours.
10. The following guidelines regarding ordering and evaluation are specific to **Violent/Self Destructive Restraints:**
    - When a restraint or seclusion is used for the management of violent and/or self-destructive behavior that jeopardizes safety, the registered nurse immediately notifies the LIP to obtain an order. The LIP performs a face-to-face evaluation within 1 hour of initiation of restraint or seclusion and authenticates the verbal order, including date and time of the authentication.
    - **Renewal Orders** for the restraint are subject to the following time limits, and the LIP renewal must occur **every 4 hours** for adults 18 years or older

D. Seclusion Specific

a. Appropriate Initiation of Patient Seclusion

i. Seclusion may be used in an emergency situation for patients who exhibit behaviors that indicate they are at high and imminent risk of physical or emotional harm to others or themselves.

ii. Patient seclusion shall be initiated only as an intervention of last resort following attempts to intervene in a less restrictive manner, after preventative, de-escalation or verbal techniques have proven ineffective at diffusing the potential for harm

iii. Seclusion should be used for the shortest period of time necessary to enable the patient to effectively cope with his or her environment.

iv. The rights of the patient shall be preserved at all times during the use of seclusion in a compassionate manner while maintaining the patient's dignity as much as possible, while providing for the safety of others.

b. **Inappropriate use of Seclusion:** Seclusion should not be used as punishment, for the convenience of staff or others, of as a substitute for effective treatment or socialization.

c. **Implementation of Seclusion:**

   i. Seclusion shall be initiated in a way that avoids undue physical discomfort, harm or pain.
   ii. Only the minimal amount of physical force that is reasonable and necessary shall be used to implement seclusion.
   iii. PRN orders shall not be used to order or authorize seclusion.
   iv. Each use of seclusion shall be prescribed by a physician
   v. Patients placed in seclusion shall have a protected, private, observable environment that safeguards their personal dignity and well-being.
   vi. The decision to seclude a patient shall be made by the Psychiatrist to determine whether the behavior requires seclusion.
   vii. When a physician is not available after conducting a face-to-face assessment of the patient to determine whether the behavior requires seclusion, the decision to seclude a patient shall be made by a clinically experienced Mental Health Competent RN in an emergency situation.
   viii. The RN shall obtain and document a physician's verbal order by phone no later than one (1) hour following initiation of seclusion. If the RN is unable to reach the physician for an order, the physician's designee shall be consulted to obtain the verbal order.
   ix. The order shall accomplish the following:
      1. The specific procedure and type of restraint that maximizes the patient's safety, health and well-being.
      2. The date, time of day and maximum length of time the procedure may be used, not to exceed four (4) hours.
      3. The specific behaviors which constituted the emergency
      4. The specific release behaviors the patient shall demonstrate before seclusion shall be discontinued.
   x. Staff who initiate the seclusion should document in the patient's chart the use of all alternative strategies which were attempted before the use of seclusion. When alternative strategies have not been used, the rationale shall be documented for this omission.
   xi. As soon as is feasible after seclusion has been implemented, the RN shall discuss at least the following with the patient:
      1. The specific behaviors that necessitated the seclusion
      2. How the individual's behavior continues to meet the criteria
      3. The behaviors that must be demonstrated in order to be released from seclusion.
      4. The patient's suggestion regarding staff actions that can assist the individual in gaining release from seclusion.
      5. If the patient appears to not understand this explanation, staff must make further attempts to re-explain every 15 minutes until understanding is reached. Staff must

document all attempts at explanation including patient response.

xii. No staff member shall enter the seclusion room alone.

xiii. Staff shall monitor the patient directly or by video monitor at least every 15 minutes, or more often as indicated.

xiv. Continuous observation shall be required when a patient in seclusion has been administered psychoactive medications on an emergency basis and during mealtimes.

xv. While in seclusion, the patient shall be allowed the following:

1. Bathroom privileges at least once every two (2) hours, or more often as indicated.
2. An opportunity to drink water or other appropriate liquids every two (2) hours, or more often as indicated.
3. A bath at least once daily, or more often as indicated.
4. Regularly prescribed medications, unless otherwise ordered by the physician.
5. Regularly scheduled meals and snacks served on serve-ware appropriate for safety.
6. An environment free of safety hazards.
7. An adequately ventilated, heated/cooled room appropriate for seasonal weather.
8. An appropriately lighted room – lights must remain on at all times but should be dimmed for patient comfort as appropriate.
9. The patient must be protected from assault by others while in seclusion.

xvi. The patient's right to retain personal possessions and personal articles of clothing shall be suspended during seclusion when necessary to ensure the safety of the patient and others. This includes any item that could be used to inflict personal injury or injury to others. If patient's clothing must be withheld, then appropriate clothing must be provided by staff.

xvii. Visitation shall not be permitted while the patient is in seclusion, except for the patient's attorney or a representative from the Alabama Department of Public Health or Mental Health.

d. Renewal Order

i. When the original order is about to expire and the clinically experienced RN has evaluated the patient face-to-face and determined the continuing existence of an emergency, the RN shall contact the physician for renewal of the order for patient seclusion.

ii. Seclusion shall not be ordered or continued for more than twelve (12) consecutive hours.

iii. The physician or physician designee shall see a secluded patient face-to-face with one (1) hour of the initiation of seclusion and as frequently as necessary to monitor any changes in the patient's physical or mental status.

e. Removal from Seclusion and Documentation

i. There shall be RN documentation to clinically justify the continued use of seclusion.
ii. The decision to release a patient from seclusion shall be made by a clinically experienced mental health competent RN or by direct psychiatrist orders.
iii. When staff members determine that the release behaviors described in the written order have been exhibited by the patient, the patient shall be evaluated by a clinically experienced mental health nurse or by the physician for feasibility of release from seclusion.
iv. The determination for release shall be based on current behavior only.
v. Staff shall immediately release a patient who has been evaluated and determined to meet release criteria.
vi. Immediately following release, a staff member shall:
    1. Take appropriate action to facilitate the patient's reentry into the social milieu by providing the patient with transitional activities and an opportunity to return to the unit's ongoing activities.
    2. Continuously observe the patient for at least fifteen (15) minutes after removal.
    3. Document observations in the chart of the patient's behavior during this transition period.

f. Emergency Health Situations

i. When an emergency health situation occurs, the patient shall be released from seclusion as soon as possible as dictated by the emergency.
ii. When the specific conditions that required the initiation of seclusion still exist after the emergency has been resolved, a physician shall conduct a face-to-face examination of the patient to determine whether seclusion shall be renewed without adverse effects.

g. Seclusion Patient Who Falls Asleep

i. When a patient appears to fall asleep in seclusion, the clinically competent RN shall assess the patient to determine whether the patient is actually asleep.
ii. When the patient is determined to be asleep, the clinically competent RN shall instruct authorized staff to immediately unlock the seclusion room door.
iii. Authorized staff shall maintain continuous face-to-face observation until the patient is awake and re-evaluated by the clinically competent RN.

iv. The clinically competent RN shall assess the patient upon his or her awakening for evidence of behaviors requiring seclusion.
v. When the patient exhibits behaviors requiring seclusion upon awakening, the clinically competent RN shall obtain a new physician's order for seclusion.

h. Seclusion Staff Routines

i. At each shift change, from information presented by the outgoing shift to the incoming shift, the following information should be documented by both shifts:
    1. Circumstances regarding the time the seclusion was initiated
    2. The current status of the individual's physical, emotional and behavioral condition
    3. Medication administered
    4. Time and type of care needed
ii. Staff shall remain current with procedures to ensure the proper management of patients in seclusion during evacuation of the unit during drills or disasters.
iii. Staff shall notify the patient's legal guardian or family member of each seclusion episode **if appropriate.**
iv. Uses of seclusion in an emergency situation shall be reported daily to the Director of Nursing and appropriate action shall be implemented to correct unusual or unwarranted utilization patterns.
v. For each use of emergency seclusion, the Utilization Review Nurse shall be responsible for maintaining a central file containing, at minimum, the following information:
    1. Patient name and medical record number
    2. Age, Gender, and race
    3. Date/time/shift, and day of week
    4. Date and time seclusion started.
    5. Date and time seclusion discontinued.
    6. Total time patient was in seclusion
    7. Injuries occurring during seclusion
    8. Name and credentials of staff involved in the initiation of seclusion
vi. An Occurrence Report shall be completed for each episode of seclusion and shall become a part of the CQI Program
vii. The Multidisciplinary Treatment Team shall review alternative strategies for dealing with a patient's behaviors necessitating the use of seclusion more often than twice in a hospital admission or in a thirty (30) day period, whichever is shorter.
viii. When the number of seclusion incidents has not reduced, the treatment team shall consult with the Medical Director or Designee to explore alternative treatment strategies.

E. **Patient Monitoring & Assessment:**

Non-Violent: Patients placed in non-violent restraints will be periodically assessed, monitored, re-evaluated, and at a minimum, have documentation recorded in the chart at the following intervals by trained staff member:

Vital Signs consisting of pulse rate and rhythm, respiratory rhythm and rate, and blood pressure, are to be assessed as quickly as possible as determined by the patient's needs and situation; not to exceed every 4 hours.

Every two (2) hours and as needed:

- Mental Status/Level of distress/Agitation
- Circulation Checks
- Fluids/nutritional needs
- Assistance with toileting
- Release of restraints and range of motion
- Skin integrity status for injury
- Repositioning
- Hygiene needs, comfort, warmth and emotional needs
- Evaluation of alternatives or less restrictive method
- Evaluation for removal
- Response to intervention

Violent/Self-Destructive: Ongoing assessment and monitoring will be conducted by a trained staff member. A patient in **restraints or seclusion** will be continuously observed for the first hour. After the first hour, at intervals no greater than every 15 minutes, the patient will be assessed and re-evaluated related to the discontinuation of restraint or seclusion. After the first hour a patient in seclusion may be monitored through simultaneous continuous video with direct visual observation of the patient every 15 minutes. Documentation of Restraints/Seclusions will be performed by the assigned staff using the appropriate forms and scanned into the patient's medical record.

Simultaneous Restraint and Seclusion for the Violent/Self-destructive patient: Continuous observation and monitoring by a staff member in close proximity to the patient is required with the simultaneous use of restraint and seclusion. This may be accomplished by face-to-face observation and/or video equipment. In the event video equipment is not utilized, staff will perform the monitoring in close proximity to the patient. Assessment guidelines for the patient with violent/self-destructive restraint apply.

Vital Signs consisting of pulse rate and rhythm, respiration rate and rhythm, and blood pressure, are to be assessed as quickly as possible as determined by the patient's needs and situation; not to exceed every 4 hours.

Violent/Self-Destructive Assessment Frequency and Content
Every hour (and as needed):

- Mental status/Level of distress/Agitation
- Fluid/nutritional needs
- Assistance with toileting
- Release of restraints and range of motion
- Skin integrity
- Injury
- Repositioning
- Hygiene needs, comfort, warmth and emotional needs
- Evaluation of alternative or less restrictive method
- Evaluation for removal
- Response to intervention

Every 15 minutes:

- Circulation
- Respirations
- Mental Status

F. Discontinuation

Restraint use will be discontinued at the earliest possible time, regardless of the length of time identified in the order. Discontinuation of the restraint must occur as soon as the patient's condition no longer meets criteria warranting the use of the restraint.
Trial releases are not allowed. Either a patient needs to be restrained/secluded or they don't. Only a physician or RN can determine if a patient can be removed from restraints using the following criteria as guidance.

Criteria to remove **a Non-Violent restraint are**:

- Cognitive status improved and no longer interferes with medical care
- No interference with medical devices, tubes, dressings, etc.
- Medical devices, tubes, dressings, etc., removed
- Responds to safe limit settings
- Follows commands
- Dangerous behavior no longer present/patient oriented
- Alternatives identified
- Restraints are determined to be more harmful than helpful

Criteria to remove a **Violent/Self-Destructive restraint:**

- Patient is no longer a threat to self and/or others

G. Documentation Requirements

The following documentation shall be included in the medical record:

Documentation Required	Medical Record Location
The patient's condition or symptom(s) that justify the use restraint.	Attached Medical Record Forms and/or Electronic Medical Record
Any alternatives and/or strategies attempted	Attached Medical Record Forms and/or Electronic Medical Record
Type of restraint used (manual hold, 2 or 4 points, seclusion)	Attached Medical Record Forms and/or Electronic Medical Record
The patient's response to the intervention(s) used, including the rationale for continued use of the intervention	Attached Medical Record Forms and/or Electronic Medical Record
Individual patient assessments and reassessments (See section D for frequency & content)	Attached Medical Record Forms and/or Electronic Medical Record
Related patient/family education	Attached Medical Record Forms and/or Electronic Medical Record
Related patient/family notification (as warranted)	Attached Medical Record Forms and/or Electronic Medical Record
Revisions to the Plan of Care	Patient Individualized Plan of Care
Orders for the use of restraint by an authorized LIP	Physicians' Orders
Notification of the use of restraint to the attending LIP (as required)	Physicians' Orders
Notification to CMS of death associated with the use of restraints	Facility Specific Permit to Release a Body Form
Face-to-face evaluations (*Violent/Self-destructive)*	Progress Notes

**NOTE = Violent/Self-destructive monitoring will be documented on Violent/Self-destructive restraint flowsheet (paper-format).*

G. Family/Patient Participation in Care: Crenshaw Community Hospital recognizes the role of the patient's family in the recovery process and the role which family can play in minimizing the use of restraints. Care planning involving the patient and family is an integral part of this recovery process. When practical, efforts will be made to discuss the issue of restraint with family members. In cases where the patient has consented to keep family or authorized representative informed regarding his/her care, staff should attempt to notify them of the use of restraint. For those patients unwilling to provide consent, no attempt at family/authorized representative will be made.

H. Competency of Staff

Direct care staff will receive training in behavioral de-escalation, application, removal, observation, assessment, and evaluation of the use of restraining devices or seclusion. Only staff members who are deemed competent to do so will initiate restraint and provide care/monitoring for these patients. If care is required by a staff member not

authorized to remove, apply, or manage restraints, this role will be delegated to a competent individual.

Restraint training will take place at orientation and on an annual basis thereafter. Competence will be documented in staff education records. The facility will designate training content for "appropriate staff" with staff serving higher risk populations receiving more in-depth training for population needs. Physicians authorized to order restraint and seclusion will have a working knowledge of the Crenshaw Community Hospital policy regarding its use.

I. Death Reporting

Hospitals must report deaths associated with the use of restraints or seclusion. Nursing staff will contact the Nursing Supervisor/Quality Director and/or Risk Manager or designee. Nursing staff and the Nursing Supervisor/Quality Director will collaborate to ensure completion of the entity's required forms (i.e. Permit for removal of the body, incident report, death reporting worksheet, etc.) The Nursing Supervisor/Quality Director is responsible for contacting the Director of Nursing. The notification must include, but not limited to:

1. Name of the Patient
2. Medical Record Number
3. Date & Time of Death
4. Date and Time of Restraint Removal

The Hospital must report the following to CMS:

- Each death that occurs while a patient is in restraint or seclusion
- Each death that occurs within 24 hours after a patient has been removed from restraint or seclusion
- Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death.

Each death must be reported to CMS electronically no later than the close of the next business day following knowledge of the patient's death. There must be documentation in the patient's medical record of the date and time that the death was reported to CMS.

J. Quality Improvement

Crenshaw Community Hospital is committed to reducing the risk associated with restraint and seclusion use by using performance improvement methodology to identify preventive strategies and innovative alternatives. Prevalence of restraint use is monitored to assure the incidence of use remains low. Appropriate investigation and action shall be taken when indicated as a result of prevalence identifying a shift in usage and/or identification of opportunities to improve.

The major objectives of restraint usage evaluation are:

1. Decrease the use of restraint(s)
2. In situations where restraints may still be warranted, assure the use is appropriate and that the least restrictive interventions are used.
3. Assure requirements of this policy are followed.

CRENSHAW COMMUNITY HOSPITAL

Patient label

Seclusion / Restraint Face-to-Face Assessment

A Face-to-Face Assessment must be completed within one hour of the initiation of a restraint or seclusion, and a Face-to-Face must be repeated every other renewal of the order thereafter. Trained Registered Nurses may perform the Face-to-Face Assessment for restraints.

Seclusion ☐ **/ Restraint** ☐ **is warranted for the following reasons**: (check all that apply)
☐ Aggressive or violent behavior
☐ Danger of harming self or others
☐ Less restrictive interventions attempted, but unsuccessful.

Patient's medications reviewed: ☐ Yes ☐ No

Patient's reaction to Seclusion / Restraint Intervention (check all that apply)
☐ Calming ☐ Uncooperative ☐ Physical aggression ☐ Verbal Aggression
☐ Other: ____

Patient's medical condition at the time of Assessment:
☐ Complete review of systems assessment performed in Electronic Chart Time performed: ________________

☐ Yes ☐ No Injured during restraint? If yes, describe: ______________________________
☐ Yes ☐ No Circulation normal? If no, describe: ______________________________
☐ Yes ☐ No ☐ N/A If patient diabetic, was blood glucose assessed? If yes, CBG result: __________
☐ Yes ☐ No Change in respiratory status? (color changes, diaphoretic, increased rate, wheezing)
If yes, describe: ______________________________
☐ Yes ☐ No Signs/symptoms of hyperthermia? (confusion / delirium or flushed, hot skin)
If yes, describe: ______________________________

Release Readiness Assessment and Behavior Assessment:

☐ Patient is **READY** to be released from seclusion or restraint because: (check all that apply)
- ☐ Patient verbally contracts with staff to ensure safety of self and others.
- ☐ Patient is calm, quiet, directable, and receptive.
- ☐ Patient able to follow directions necessary for safety.
- ☐ Other: (describe): ______________________________

☐ Patient is **NOT READY** to be released from seclusion or restraint because: (check all that apply)
- ☐ Psychomotor agitation (restlessness, thrashing, quiet pacing, rocking)
- ☐ Suicidal or homicidal ideation or intent
- ☐ Screaming, yelling
- ☐ Threatening to harm self or others
- ☐ Other: describe: ______________________________

☐ Yes ☐ No **Guidance provided in utilizing alternative means to maintain control of behavior**

Additional progress Notes:

____
____
____

Physician / NP Signature: ______________________________ **Date/Time** ________________

If ordering physician is not the attending physician, how was the attending physician notified?
☐ Verbally via telephone ☐ In person

RN completing form: ______________________________ **Date/Time** ________________

CRENSHAW
COMMUNITY HOSPITAL

Patient Label

Behavioral Restraint / Seclusion
Physician Order Form

Date	Time	Orders for Behavioral / Violent Restraint or Seclusion
		Orders that are checked will be implemented. Additions, Deletions, or Modifications of orders must be individually initialed.
		Clinical Reason for Restraint ☐ or Seclusion ☐: ☐ Prevent injury to self ☐ Prevent injury to others ☐ Combative / threatening ☐ Specific behavior: ____
		Time Limit Duration for Order: ☐ Age 18 and older: 4 hours This time limited restaint or seclusion must be renewed by the physician for each event. Seclusion shall not be ordered or continued for more than twelve (12) consecutive hours.
		Least Restricitive Alternatives Attempted: ☐ Provide companionship amd supervision (1:1) ☐ Changing or eliminating bothersome treatments ☐ Frequent reorientation to surroundings ☐ Offering diversionary and physical activities ☐ Reality orientation and psychosocial interventions ☐ Scheduled comfort checks ☐ Verbal Reminders / descalation ☐ Medications offered / tried ☐ Other: ______________________ ______________________________
		Restraint Type: ☐ Mechanical Restraint: Soft Limb ☐ Right Wrist ☐ Right Ankle ☐ Left Wrist ☐ Left Ankle ☐ Chemical Restraint ☐ Seclusion
		☐ Plan of Care for restrained / secluded patient ⊡ Physician or other LIP consulted ⊡ Vital signs on initiation and as indicated ⊡ Face to Face evaluation by trained RN within 1 hour of initiation ⊡ Continuous 1:1 observation every 15 minutes with documentation ⊡ Restraints released every 2 hours ⊡ Re-assessment per policy ⊡ Educate patient on rationale and release criteria ⊡ Complete debriefing after discontinuation
		Restraint / Seclusion to be discontinued if: ☐ Verbally contracts for safety to self and others ☐ Responding to redirection ☐ No longer demonstrates risk for danger to self or others ☐ Responding to alternatives

Date/Time of Verbal Order: ____________________ Name of LIP / RN Signature: ____________________________

Physician's Signature: ________________________ Date/Time: ____

AM Restraint / Seclusion Monitoring Log

patient label

Nursing Manager notified by ______________,RN on (Date)___________at (Time) _________

Implemented by __________________,RN on (Date)______________at (Time) ___________

Discontinued by __________________,RN on (Date)______________at (Time) ___________

*****MUST HAVE RESTRAINT/SECLUSION ORDER FROM MD WITHIN 1 HOUR OF INITIATING*****

Date: ____	RN Check every 15 minutes													RN Check every 1 Hour							RN Initials	VS/Bath
Time	Seclusion or Restraint (S or R)	Cap refill<3 seconds	Pulses palpated	Sensation	Respirations WNL (if rapid, decreased, shallow - ALERT Charge Nurse immediately	Oriented or Disoriented (O or D)	Asleep	Agitated	Threats to self or others	Calm/Cooperative	Yelling	Awake but withdrawn	Meets conditions for discontinuatior	Food consumed	Fluid Consumed	Toilet	Range of Motion	Skin intact	Repostion	Hygiene, comfort, emotional needs	RN Initials	☐Bathing Offered Time:_________ Init: __________ ☐Bathing accepted Time:_________ Init: __________ ☐Bathing refused Time:________ Init: _________
700																						**Vital Signs every 2 Hours**
715																						Temp: _______________
730																						Pulse: _______________
745																						Resp _______________
800																						O2 Sat _______________
815																						BP: _______________
830																						Time: _______________
845																						Initials: _______________
900																						**Vital Signs every 2 Hours**
915																						Temp: _______________
930																						Pulse: _______________
945																						Resp _______________
1000																						O2 Sat _______________
1015																						BP: _______________
1030																						Time: _______________
1045																						Initials: _______________
1100																						**Vital Signs every 2 Hours**
1115																						Temp: _______________
1130																						Pulse: _______________
1145																						Resp _______________
1200																						O2 Sat _______________
1215																						BP: _______________
1230																						Time: _______________
1245																						Initials: _______________
1300																						**Vital Signs every 2 Hours**
1315																						Temp: _______________
1330																						Pulse: _______________
1345																						Resp _______________
1400																						O2 Sat _______________
1415																						BP: _______________
1430																						Time: _______________
1445																						Initials: _______________
1500																						**Vital Signs every 2 Hours**
1515																						Temp: _______________
1530																						Pulse: _______________
1545																						Resp _______________
1600																						O2 Sat _______________
1615																						BP: _______________
1630																						Time: _______________
1645																						Initials: _______________
1700																						**Vital Signs every 2 Hours**
1715																						Temp: _______________
1730																						Pulse: _______________
1745																						Resp _______________
1800																						O2 Sat _______________
1815																						BP: _______________
1830																						Time: _______________
1900																						Initials: _______________

Initials	Signature	Initials	Signature	Initials		Signature

PM Restraint / Seclusion Monitoring Log

patient label

Nursing Manager notified by _____________,RN on (Date)___________at (Time) ________
Implemented by _________________,RN on (Date)_____________at (Time) __________
Discontinued by _________________,RN on (Date)_____________at (Time) __________

*****MUST HAVE RESTRAINT/SECLUSION ORDER FROM MD WITHIN 1 HOUR OF INITIATING*****

Date: _____	RN Check every 15 minutes													RN Check every 1 Hour							RN Initials	VS/Bath
Time	Seclusion or Restraint (S or R)	Cap refill<3 seconds	Pulses palpated	Sensation	Respirations WNL (if rapid, decreased, shallow - ALERT Charge Nurse immediately	Oriented or Disoriented (O or D)	Asleep	Agitated	Threats to self or others	Calm/Cooperative	Yelling	Awake but withdrawn	Meets conditions for discontinuation	Food consumed	Fluid Consumed	Toilet	Range of Motion	Skin intact	Repostion	Hygiene, comfort, emotional needs	RN Initials	□Bathing Offered Time:________ Init: _________ □Bathing accepted Time:________ Init: _________ □Bathing refused Time:_______ Init: ________
1900																						**Vital Signs every 2 Hours**
1915																						Temp: _____________
1930																						Pulse: _____________
1945																						Resp _____________
2000																						O2 Sat _____________
2015																						BP: _____________
2030																						Time: _____________
2045																						Initials: _____________
2100																						**Vital Signs every 2 Hours**
2115																						Temp: _____________
2130																						Pulse: _____________
2145																						Resp _____________
2200																						O2 Sat _____________
2215																						BP: _____________
2230																						Time: _____________
2245																						Initials: _____________
2300																						**Vital Signs every 2 Hours**
2315																						Temp: _____________
2330																						Pulse: _____________
2345																						Resp _____________
2400																						O2 Sat _____________
0015																						BP: _____________
0030																						Time: _____________
0045																						Initials: _____________
0100																						**Vital Signs every 2 Hours**
0115																						Temp: _____________
0130																						Pulse: _____________
0145																						Resp _____________
0200																						O2 Sat _____________
0215																						BP: _____________
0230																						Time: _____________
0245																						Initials: _____________
0300																						**Vital Signs every 2 Hours**
0315																						Temp: _____________
0330																						Pulse: _____________
0345																						Resp _____________
0400																						O2 Sat _____________
0415																						BP: _____________
0430																						Time: _____________
0445																						Initials: _____________
0500																						**Vital Signs every 2 Hours**
0515																						Temp: _____________
0530																						Pulse: _____________
0545																						Resp _____________
0600																						O2 Sat _____________
0615																						BP: _____________
0630																						Time: _____________
0645																						Initials: _____________

Initials	Signature	Initials	Signature	Initials		Signature

Patient label

Restraint Discontinuation Debriefing Form

To be Completed by Staff Discontinuing Restraint/Seclusion

Date/Time of Discontinuation: ___________________________________

Date/Time of Original Restraint / Seclusion: ___________________________

1. Summary of incident requiring physical management/restraint/seclusion:
   ____
   ____
   ____
   ____
   ____
2. What was the patient's behavioral escalations prior to the restraint/seclusion?

☐ Increasing loudness ☐ Pacing ☐ Arguing with peers ☐ Verbal threats
☐ Demanding ☐ Inciting other patients ☐ Other: ____
____
____

3. What was the trigger or escalation observed leading to immediate restraint/seclusion?
   ____
   ____
4. Was the patient reporting any real or perceived personal need at the time of the incident? ☐ Yes ☐ No If yes, explain:____
   ____
5. Describe the imminent danger to self or others:
   ____
   ____
6. Interventions that were used before physical restraint or seclusion: ☐ Processed with patient ☐ Encouraged use of coping skills identified on IPC ☐Encourage patient to engage in relaxation techniques ☐ Encourage self-time out ☐ Remove from stimuli ☐ Channel feelings into activity ☐ Brought in alternative staff ☐Medication ☐ Staff directed time-out ☐Diversion/redirect attention ☐ Unable to draw upon less restrictive alternatives due to sudden onset of dangerous patient behavior
7. What may have prevented the patient's escalation leading to the restraint/seclusion?

☐ Nothing, all alternatives were exhausted ☐ Earlier intervention ☐ 1:1 intervention with staff ☐ Offering time out ☐ Recognizing signs of escalation sooner ☐ Removing the audience ☐ Engaging patient in activity ☐ Separating patient
☐ Other: ____

8. What could have been done by staff during the restraint/seclusion to make the patient deescalate more quickly, make it end sooner, or be less restrictive? ☐ Not responding to obscenities/insults ☐ Have just one staff talk to the patient ☐ Avoid arguing with the patient ☐ Change staff member talking to the patient ☐ Remove the provoking stimuli ☐ Nothing
9. Did the restraint/seclusion effectively prevent the patient from further harm to self or others? ☐ Yes ☐ No
10. Did the patient receive any physical injuries during the restraint / seclusion? ☐ Yes ☐ No If yes, explain:
    ____
    ____
11. Suggestions for future intervention:
    ____
    ____
    ____

Staff participating in the debriefing:
Name: ______________________________________ Date: ____________ Time: ______
Name: ______________________________________ Date: ____________ Time: ______
Name: ______________________________________ Date: ____________ Time: ______
Name: ______________________________________ Date: ____________ Time: ______

Staff completing debriefing form: _____________________________
Administrative Reviewer: ___________________________________

Patient label if available

Restraint Incident Review Form

To be Completed by Quality Improvement / Risk Management

For Internal Purposes Only, Not to be attached to Medical Record

Date/Time of Restraint / Seclusion: ______________________ Date/Time of Discontinuation: ___________________________

Patient Account# _________________________ ☐ Restraint ☐ Seclusion

Did total time in restraints / seclusion exceed maximum allowed? ☐ Yes ☐ No - Actual Elapsed Time ____________________

☐ Chart has been reviewed and all Restraint Forms have been completed. ☐ Yes ☐ No If no, explain:

____

____

☐ Staff documented acceptable reason for restraint / seclusion. ☐ Yes ☐ No If no, explain:

____

____

☐ Staff documented trigger event for emergent restraint / seclusion. ☐ Yes ☐ No If no, explain:

____

____

☐ Staff documented attempts to deescalate patient to prevent use of restraint / seclusion. ☐ Yes ☐ No If no, explain:

____

____

☐ Face to Face Assessment was performed with one hour. ☐ Yes ☐ No If no, explain:

____

____

☐ MD Order for restraint was acquired within one hour. ☐ Yes ☐ No If no, explain:

____

____

☐ Monitoring the patient was adequate and per policy. ☐ Yes ☐ No If no, explain:

____

____

☐ Did the restraint / seclusion prevent physical harm to patient, staff, or others? ☐ Yes ☐ No If no, explain:

____

____

☐ Staff documented appropriate debriefing when patient was released. ☐ Yes ☐ No If no, explain:

____

____

☐ After reviewing this incident, did staff comply with the restraint policy. ☐ Yes ☐ No If no, explain:

____

____

Based on your review, please list any improvements or changes to the restraint policy and submit to Director of Education.

____

____

____

____

Administrative Reviewer: ____________________________________ Date of Review: ________________________________