Restraint/Seclusion  
Administration Policy

Document Number: MHC-ADMIN-02-1044

General Description
Purpose: Meridian Health strives to:

A. Create a physical, social and cultural environment that limits restraint/seclusion use.
B. Provide guidelines for the clinical appropriateness, safe application, monitoring, and discontinuation of restraints as soon as the patient meets criteria for release.
C. Provide an organizational approach to the use of restraints that protects the patient’s health and safety while preserving the patient’s rights, dignity and well-being.

Scope:

All clinical departments and patient care areas of Meridian Hospitals Corporation and its facilities including: JSUMC, OMC, RMC, BCH, SOMC and K. Hovnanian Children’s Hospital.

Policy:

In order to protect patients; all patients have the right to be free from restraints or seclusion imposed as a means of coercion, punishment, discipline, convenience or retaliation by staff.

The use of restraints or seclusion is an exceptional event, not a routine response to a condition or behavior. Restraints or seclusion are initiated only after alternatives have been attempted and have proven to be unsuccessful. Restraints or seclusion are used to prevent serious disruption of treatment, to prevent imminent harm to the patient, staff members or others or to prevent damage to the physical environment.

A comprehensive, individualized patient assessment inclusive of, but not limited to, toileting needs, medication review, pain management, etc. will be performed to determine the safety and protective needs of patients prior to the application of restraints. The use of restraints or seclusion must be in accordance with the order of an LIP (defined below).

Patients, family members and significant others when appropriate, will receive education on the need for restraint use at the time of application and criteria for removal.
Indication for use:

There are two categories of situations under which the use of restraints or seclusion may be considered:

2. Behavioral: Threat of violence or self-destructive behavior.

Each situation is discussed below.

Definitions:

I. Types of restraints:

A. Physical Restraint: Any manual method, physical device, material or equipment attached or adjacent to the patient’s body, with or without the patient’s consent, that:
   • Prevents free bodily movement to a position of choice,
   • Restricts his/her freedom to move his/her arms, legs, body or head freely,
   • Restricts normal access to his/her body,
   • He or she cannot easily remove in the same manner in which it was applied.

   NOTE: Devices or practices that serve multiple purposes such as Geri Chair with locked tray or 4 raised side rails constitute a restraint when they restrict a patient’s movement and cannot be removed by the patient.

B. Drug Used as Restraint: A drug or medication used to control behavior or to restrict the patient’s freedom of movement that is not a standard treatment or dosage for the patient’s medical or psychiatric condition. DRUGS ARE NEVER TO BE USED AS A RESTRAINT.

C. Seclusion as a Restraint: The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff member or others. SECLUSION CAN ONLY BE USED ON THE BEHAVIORAL UNITS AT JSUMC AND RMC. Restraints and seclusion are not to be used simultaneously.

D. Therapeutic Hold: Holding a patient in a manner that restricts his/her movement without the patient’s consent.
II. Exceptions to the Restraint Definition:

- **Positioning or Securing Devices** – devices used with the patient’s consent to maintain position, limit mobility or temporarily immobilize during medical, dental, diagnostic or surgical procedures.

- **Age or developmentally appropriate safety devices** – devices (such as stroller, safety belts, swing safety belts, high chair lap belts, raised crib rails and crib covers) which a safety conscious childcare provider would utilize to protect an infant, toddler or preschool-aged child.

- **Law enforcement Restraint Devices** – i.e. handcuffs are not considered a restraint.

III. Alternatives to Restraints:

Alternatives must be considered and documented as to effectiveness or lack thereof. Alternatives to restraints include, but are not limited to:

- Providing companionship/supervision
- Changing or eliminating treatments when feasible
- Modifying the environment
- Reality orientation and psychosocial interventions
- Offering diversionary/physical or structured activities
- Behavior modification

IV. Episode:

Each time an order is written for restraint.

V. Licensed Independent Practitioner (LIP) is an independent practitioner licensed by the State of New Jersey, including a physician, nurse practitioner (NP), clinical nurse specialist (CNS) and licensed physician assistant (PA).

The following LIPs may initiate/discontinue restraint orders in accordance with this policy:

- MD
- DO
- NP/CNS (as per hospital privileges)
- PA (as per hospital privileges)

**General Considerations:**

A. Contraindications to Restraints
Restraints may be contraindicated when precluded by the patient’s clinical condition as determined by the LIP or RN. Examples include: psychological distress, fractured limbs, open wounds, pregnancy and elevation of intracranial pressure.

B. Restraints not to be used as Punishment

Restraints are not to be used as punishment, coercion, discipline, retaliation or as a convenience to staff, or for forensic cases.

C. Progressive Range of Restraining Procedures

Restraints may be used to protect the patient or others from harm only when less restrictive interventions have been determined to be ineffective. A progressive range of procedures must be used from the least restrictive to the most restrictive. Prior to application of restraints/seclusion, the patient’s belongings are inspected for any potentially dangerous objects, e.g. lighters, pocketknives. Only an LIP (or RN in an emergency) may initiate restraints or seclusion and he or she must be present to monitor and evaluate the application. Ancillary personnel such as PCAs, LPNS, security and other qualified clinical staff may participate in the application under the direction of an LIP or an RN.

D. Removal of Restraints

Restraints must be discontinued at the earliest possible time regardless of the length of time identified in the order. LPNs, PCAs, Security and other clinical staff are able to physically remove restraints or discontinue seclusion as appropriate under the directions of an LIP or an RN. As early as feasible, the patient/family should be made aware of the rationale and criteria for removal or discontinuation.

E. Commonly Used Types of Restraints include, but are not limited to:

- Mitts
- Lap Buddy
- Elbow Immobilizers
- Geri Chair with Locking Tray
- Full Side Rails
- Soft Limb
- Locked
- Enclosed/Net bed

F. Use of Locked Restraints

- May only be used with the extremely agitated patient who requires physical control.
• The RN and/or security officer is responsible for applying the locking restraint, utilizing the two-finger check to ensure the integrity of the extremity, and for the initial locking of the device. The RN and/or security officer is responsible for securing the extremities to be restrained as well as securing the device to the stretcher or bed.

• The RN is responsible for documentation on the Restraint Flow Sheet.

• Keys must be maintained in a location that is easily accessible to the RN, caregivers and Security. Location must be documented on the flow sheet.

• When locked restraints are discontinued, nursing is responsible to notify Security of discontinuation.

Procedure for Use of Restraints for Non-Behavioral (Disruption of Treatment) and Behavioral (Threat of Violence or Self-Destructive Behavior)

A. Application:

1. An RN may initiate restraints in an emergency situation:
   a. Following a clinical assessment
   b. When alternatives and less restrictive interventions have been tried and determined to be ineffective.

2. The RN must notify an LIP immediately when restraints have been applied to obtain an order and for a face-to-face evaluation to be completed within one hour.

B. Orders

When ordering restraints, the LIP shall utilize the Restraint Order Sheet, or enter the order directly into the computer. All Restraint Orders must be entered into the computer ASAP.

Orders for the use of restraint must never be written as a standing order or as a PRN order.

Orders must include:
1) Indication for use – Non-behavioral (disruption of treatment) or Behavioral (Threat of violence or self-destructive behavior)
2) Type of restraint
3) Number of Extremities
4) Length of Time: The restraints may only be ordered for a time limit of:

Non-Behavioral (Disruption of Treatment)
· Every 24 hours

Behavioral (Violent and Self-Destructive):
· Every 4 hours for patients ages 18 and over
· Every 2 hours for patients ages 9 through 17
· Every 1 hour for patients under 9 years of age

5) Criteria for Removal

. When agitation is decreased
. When the patient is able to verbalize the behavior leading to restraint/seclusion and the expectation for release
. When the patient is in control of behavior and is no longer a harm to self or others
. Other, individualized criteria

6) Signature, Date and Time by Physician or other LIP

7) If the restraint is ordered by anyone other than the attending physician, then the attending physician must be notified as soon as possible, but no later than 24 hours of the restraint use.

C. Evaluation by the LIP

1. Within one (1) hour of receiving the initial order, the LIP shall respond and conduct a face-to-face evaluation of the patient and document in the medical record:

   a. A description of the patient’s behavior and immediate situation that warranted the use of restraint.
   b. Alternatives or other less restrictive interventions attempted (as applicable).
   c. An assessment of the patient’s medical and behavioral condition.
   d. The patient’s response to the intervention(s) used, and the rationale for the continued use or termination of the intervention.

2. Following the initial evaluation, the patient must be evaluated face-to-face by an LIP at least once every 24 hours and changes in the patient’s clinical status must be recorded. A new order must be obtained if restraint usage continues beyond the time limited order; however the face-to-face evaluation is only required every 24 hours.

   a. For example, if a behavioral restraint is ordered at 10pm the initial face-to-face evaluation must be conducted by 11pm. At 2am the initial order expires but the patient’s behavior warrants continued restraint use and a new order is obtained. A face-to-face evaluation is NOT necessary at this time. If restraints are continued a face-to-face evaluation is only required every 24 hours, i.e. 10pm the next day.
3. If restraints are discontinued and the patient has to be restrained again, a new order must be written and the LIP must assess the patient within an hour.

D. Nursing Care while Patient is Restrained

Upon initiating restraints, a comprehensive individualized patient assessment will be performed inclusive of the behavior necessitating the restraint use.

Each assessment and nursing intervention should be made as follows:

**Every 2 hours:**
- Mental status
- Cognitive function
- Current behaviors indicating need for restraints
- Circulation and skin assessment
- Release of restraints for skin care and range of motion
- Patient comfort needs inclusive of:
  - Fluids and Nutrition offered
  - Repositioning
  - Toileting
- Decision making with re-evaluation for the continuing need for restraints

**Every 4 hours:**
- Ambulation if clinically feasible

**Every 12 hours:**
- Vital Signs (perform more frequently based on the patient’s condition)

**Every 24 hours:**
- Hygiene needs

**Visual observation:**

**For Non-Behavioral restraint use (Disruption of Treatment)**
- Based on nursing assessment, visual observation will be continuous or periodic and will be documented at a minimum of every 2 hours.

**For Behavioral restraint use (Threat of Violence or Self-Destructive Behavior)**
The patient in behavioral restraints must be monitored by an assigned team member and will be documented every 15 minutes.

E. Plan of Care

Use of restraints or seclusion must be in accordance with the written modification to the patient's plan of care.

F. Removal Guidelines

Restraints may be removed and/or discontinued in accordance with the original order. The restraint must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

Time of removal and behavior that supports removal should be documented on the Restraint Flow Sheet.

G. Reapplication

If a patient is recently released from restraints and exhibits behavior that can only be handled by the reapplication of the restraints, the RN may initiate restraints. This initiation is considered a new episode and as such the LIP must be notified immediately to respond within the hour for a new order and face-to-face evaluation.

H. Notification of Patients in Restraints

Clinical Leadership, i.e. Charge Nurse, Nurse Manager and/or Nursing Supervisor is notified daily of patients in restraints.

Security should be notified for any application/removal of behavioral restraints.

I. Notification and Education of Patient’s Family/Guardian/Significant Other

If the patient consents, the patient’s family, guardian or significant other will be notified of the need or reason for the use of restraints as soon as possible but no longer than 24 hours after application. The notification, or refusal by the patient, will be documented on the flow sheet.

J. Documentation

Documentation will include, but is not limited to the following:

- Order
- Face-to-Face Evaluation by Physician/LIP
- Flow Sheet: All sections must be completed on an ongoing basis.
- The Plan of Care must be modified to reflect the use of restraints.

Other Considerations

A. Performance Improvement
Data will be collected on the use of restraints and seclusion to monitor and improve the process. Performance Improvement processes will seek to identify opportunities to reduce the risks associated with restraints use through preventive strategies, innovative alternatives and process improvements.

B. Infection Control
- Maintain standard precautions
- Soiled restraints are to be changed promptly and discarded
- Non-disposable locking restraints are to be sent to the Sterile Processing Department (SPD) for full decontamination after use. The restraints will be identified as “soiled” and delivered to SPD. The restraints will be cleaned in SPD according to manufacturer’s guidelines. After cleaning, the restraints will be identified as “clean” and stored. The integrity of the clean restraints will not be disturbed until time of application to the patient.

C. Reporting Requirements:

1. Clinical Staff:
Identification of any death associated with the use of seclusion or restraint is to be reported as soon as discovered to clinical leadership (i.e., Nurse Manager, Nursing Supervisor, Senior Manager for Nursing Services) and to the Risk Manager. This includes any death that occurs:
- While the patient is restrained or in seclusion
- Within 24 hours after the patient has been removed from restraints or seclusion
- Within one (1) week of restraint removal where it is reasonable to believe that the use of restraint contributed to the death of the patient

2. Administrative Requirements:
Clinical leadership will report the restraint associated death to their administrative liaison as outlined in the administrative policy MHC-ADMIN-02-1173 “Reportable Events to the NJ Department of Health and Centers for Medicare and Medicaid Services”. 
• Both CMS and the NJDOH must be notified of any death that meets the above criteria.

**Exception:**
Any patients’ death which occurs while in soft, cloth-like wrist restraints with no seclusion, or within 24 hours of being removed from such restraints, does not need to be reported to CMS. This event must be recorded within seven (7) days on an internal log that is maintained to record deaths of patients in soft, two-point restraints. This log will be maintained by the administrative supervisor and be made available to CMS immediately upon request. This internal log must include:

  i. Patient’s name  
  ii. Date of birth  
  iii. Date of death  
  iv. Name of attending physician or LIP responsible for the care of the patient.  
  v. Medical Record #  
  vi. Primary diagnosis(es)

However, if there is a death of a patient within one week after use of soft, cloth-like wrist restraints, the CNE /or designee must ensure this death is reported to both the CMS and NJDOH Patient Safety Reporting System when it can reasonably be assumed that the restraint or seclusion contributed to the patient’s death.

3. **Documentation to the Medical Record:**
Administrative staff must document in the patient’s medical record as appropriate;

  i. The date and time the death was reported to CMS and NJDOH  
     OR  
  ii. The date and time the death was entered into the internal log

D. **Staff Education**
All staff with direct patient contact shall have orientation training and periodic ongoing education and training in:

  1. Recognizing behaviors, events and environmental factors that may trigger the need for restraint or seclusion  
  2. The proper and safe use / application of restraints and implementation of seclusion  
  3. Monitoring, assessing and recognizing signs of physical and psychological distress  
  4. Choosing the least restrictive intervention.  
  5. Providing care to a patient in restraints and seclusion
6. Recognizing behavioral changes that indicate restraint or seclusion is no longer necessary
7. Use of first aid techniques and certification in CPR and periodic recertification
8. Choosing alternative methods for handling behavior, symptoms and situations that may have been traditionally treated with the use of restraints.

All LIPs must have a working knowledge of this policy.

Staff education shall focus on emphasizing prevention, the use of alternatives and the correct use of restraints. This training shall be ongoing and include, but not be limited to:

- Annual review
- Competencies
- Mandatory self study
- New employee orientation
- Behavioral Management Training
- De-escalation techniques

The hospital shall document in the staff personnel records that the training and demonstration of competency were demonstrated.

E. Staff Trainers

The individuals providing staff training shall be qualified by education, training and experience in techniques used to handle patient’s behaviors.

Special Notes / Appendix

References
MHS Administrative Policy- Patient Confidentiality
MHS Administrative Policy- Patients Rights
Joint Commission 2011 Hospital Accreditation Standards-Comprehensive Accreditation Manual for Hospitals
Centers for Medicare and Medicaid Services, CMS Guidance Document, December, 2011
New Jersey Hospital Association, Crosswalk, Patient Rights - Restraint and Seclusion, 2011

Related Documents
Revision History
Revision #:
v1
01/06/2006

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v2
04/02/2009
Start new revision level to bring policy in compliance with state Department of Health regulations.

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v3
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