JACKSONVILLE MEMORIAL HOSPITAL ADMINISTRATIVE POLICY MANUAL

POLICY NUMBER: 9000-035A
DEPARTMENT: Administration
CATEGORY: General/Safety
SUBJECT: Restraints and/or Seclusion for Violent Behavior
EFFECTIVE DATE: November 19, 2021
SUPERSEDES: April 23, 2019

Policy:
All patients have the right to be free from restraints and to receive care in a safe place. Restraints and/or Seclusions may be implemented only when alternative measures are not sufficient to prevent a patient from harming self, other patients, or staff.

Purpose:
To promote a minimal restraint environment that protects the rights, dignity, and wellbeing of patients, while protecting the patient from harming himself/herself, other patients or staff. This policy is consistent with the requirements of the State of Illinois Mental Health Code.

Introduction

This policy applies to:

1. All hospital patients, regardless of location.
2. Patients who exhibit severely aggressive, violent, or destructive behavior that poses an imminent danger to self or others.
3. Restraint or seclusion used to ensure the immediate physical safety of the patient, staff member, or others.

This policy does not apply to:

1. A time-out when the individual is restricted for 30 minutes or less from leaving an unlocked room and when it is used consistently with the individual's treatment plan with which they are in agreement.
2. Instances in which an individual is limited to a designated area consistent with their plan of care.
3. Forensic and correction restraints such as handcuffs used for security purposes.
4. Positioning or securing devices used to maintain position, limit mobility or temporarily immobilize the patient during a medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes (for example, surgical positioning, IV arm boards, radiotherapy procedures, protective of surgical and treatment sites in pediatric patients).
5. Drugs or medications that are used as part of a patient's standard medical or psychiatric treatment and are administered within the standard dosage for the patient's condition, including PRN doses prescribed to calm a patient who is anxious.

In no event shall restraint and seclusion be utilized to punish or discipline a recipient, nor is a restraint or seclusion to be used as a convenience for the staff.

Although restraint/seclusion is considered an emergency measure, the least restrictive intervention should be used in managing the violent patient. Non-physical interventions are the first choice as an intervention, unless safety issues demand an immediate physical response (see Appendix A for de-escalation measures).

Definitions

1. **Restraints** are defined as:
    a. 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.
    b. A drug or medication when it's used as a 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.
2. The use of force to medicate a violent patient is considered a restraint for violent behavior. This requires a physicians' order and a face-to-face evaluation by a physician within one hour. If the patient requests to be held still for an injection or procedure, it is not considered a restraint.
3. **Violent behavior** is defined as behavior that jeopardizes the physical safety of the patient, staff, or others.
4. **Seclusion** is the involuntary confinement of a person alone in a locked room or area from which the person is physically prevented from leaving. It is also considered seclusion if a patient is in an unlocked room and staff are physically intervening to prevent the patient from leaving the room or the patient perceives that they cannot leave the room. Seclusion is not used outside of the Emergency Department.

Orders

1. The use of restraint and/or seclusion requires an order from a physician or Allied Health Professional (APN or PA credentialed through the Medical Staff Office) with competency in monitoring, assessment, and care of the restrained patient. In an emergent situation, the RN responsible for the patient may initiate the use of restraint/seclusion prior to contacting the physician.
2. The order must state events leading up to the need for and purpose of restraint/seclusion, length of time for which restraint should be applied, and clinical justification for the intervention.
3. A face-to-face evaluation by a physician, APN, or PA occurs within one hour after the initiation of the restraint/seclusion.
    a. The physician, APN, or PA conducting the face-to-face evaluation documents the situation leading to restraints, psychological and physiologic condition, and continued need for intervention.
    b. If a patient's violent or self-destructive behavior resolves and the restraint/seclusion intervention is discontinued before the physician arrives to perform the face-to-face assessment, the assessment is still required within 1 hour after the initiation of the intervention.

4. The attending physician guides the plan of care and can assist in determining any needed changes in subsequent treatments. The attending physician notification is documented in the medical record. For orders obtained in the Emergency Department, the ED physician is considered the attending physician.
5. Continued restraint/seclusion use requires a new order:
    a. Every 4 hours for adults
    b. Every 2 hours for children and adolescents age 9-17
    c. Every 1 hour for children under 9 years of age
6. A face-to-face evaluation of the patient by the physician, APN, or PA to document continued need for restraint/seclusion and changes in the treatment plan is required <u>every other</u> time a renewal order is needed:
    a. Every 8 hours for adults
    b. Every 4 hours for children and adolescents age 9-17
    c. Every 2 hours for children under 9 years of age
7. If restraint/seclusion has been discontinued for a patient, a new order is required before reinitiating.
8. A seclusion order must be written (in addition to the restraint order) for patients who are concurrently restrained and secluded.

Care and Management

1. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized.
2. After the restraint/seclusion has been initiated, a staff member trained in the use of restraint/seclusion provides continuous observation.
3. If a restraint is imposed upon a patient whose primary mode of communication is sign language, the patient is permitted to have his hands free from restraint for brief periods each hour, except when such freedom may result in physical harm to the recipient or others.
4. When restraints are initiated, the RN overseeing the plan of care notifies one of the following regarding the application and reason for restraint. This notification is documented in the medical record.
    a. The patient, or if a minor, the parent or guardian.
    b. A person, persons, or agency designated by the patient for such notice.
    c. The Guardianship and Advocacy Commission if the patient has so designated.
5. The RN informs the patient of the reasons for restraints and the goals and/or behavior desired in order for the restraints to be removed. Restraint/seclusion will be discontinued at the earliest possible time and will be removed as soon as patient meets and maintains behavioral expectations.
6. The patient will be dressed in hospital scrubs or gown. The nurse caring for the patient checks the patient's garments for contraband and potentially harmful objects.
7. A minimum of two restraints are required. They must be applied to opposite extremities (i.e. left wrist/right ankle), never to both arms, both legs, or extremities on the same side. A patient is never restrained with only one restraint. The patient must be in the supine position with head of bed elevated 45 degrees to allow adequate chest excursion.
8. Always secure restraints to the bed frame. The side rails should be free of any restrictions.

9. Debriefing can be helpful in reducing the recurrent use of restraint and seclusion. Staff who were involved in the episode and who are available may participate as warranted.
10. When needed, RN may request a Level I security presence for patients displaying disruptive behavior.

Observation and Documentation

1. Initial nursing documentation includes: description of specific patient behaviors, least restrictive measures utilized, attempts at alternatives to restraints, type of restraint used, and patient's response to restraint.
2. Document the event and the number of staff required to restrain the patient in the medical record.
3. Every 15 minutes: assessment of behavior and emotional status is documented.
4. Every 30 minutes for restrained patients: circulation, discoloration, swelling, movement of extremities, and distal pulses are assessed and documented.
5. Every 2 hours and more often as needed:
    a. The RN supervising the care of the patient documents a comprehensive physical and psychological assessment while the patient is secluded or restrained. Interventions to correct or alleviate ill effects from restraint/seclusion are documented. The nurse determines that the restraint does not pose an undue risk to the patient's health in light of the physical or medical condition.
    b. Restraints are rotated and/or patient re-positioned. Only one restraint is removed at a time and range of motion is performed.
    c. Vital signs are assessed and documented and more often as necessary.
    d. Intake of fluid and food is documented. Fluids are offered. Elimination is offered.
6. The frequency of assessment and monitoring should be individualized. There may be circumstances where it is inappropriate to awaken a sleeping patient every 2 hours to take the patient's vital signs. Similarly, the patient may require monitoring and patient assessment more frequently than every 15 minutes to ensure the patient's safety.
7. Patient's plan of care includes restraint/seclusion interventions.

Reporting Deaths Related to Restraint:

Staff will promptly notify the Director of Quality & Safety or the Administrator on Call of:

1. The death of any patient in restraints or seclusion (with the exception of soft, non-rigid, cloth-like wrist restraints).
2. The death of any patient within 24 hours of the end of an episode of restraint or seclusion.
3. The death of any patient known to the hospital within one week after restraints or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restriction of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.
4. The Director of Quality & Safety will notify the Centers for Medicare and Medicaid Services (CMS) of each death referenced in this paragraph by telephone no later than the close of business the next business day following knowledge of the patient's death.

The Director of Quality & Safety or her designee will document in the patient's medical record the date and time the death was reported to CMS.

When no seclusion has been used and when only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the death will be recorded within seven days of the death of the patient. This log will include any death that occurred within 24 hours after a patient has been removed from such restraints, within seven days of the date of death of the patient.

Staff Training and Competence

1. Staff with direct care responsibilities will receive education as part of orientation and annual competency validations. Content will include:
    a. Application, monitoring, assessment and care of patients in restraints
    b. Techniques to identify triggers for restraints
    c. Non-physical interventions
    d. Choosing the least restrictive intervention
    e. Signs of physical and psychological distress
    f. Indications that restraints are no longer necessary
2. Physicians ordering restraints will have a working knowledge of the policy & procedure regarding use of restraints.

This policy has been reviewed and approved by:

Leanna Wynn, RN, MBA, MSN
Affiliate Vice President & Chief Nursing Officer

Scott Boston, MD
President & CEO

MMC Approved: July 2015

Implemented at PAH: 6/10/2016
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Revised: 11/19/2021

APPENDIX A

De-Escalation Measures

Below are some helpful tips and recommendations for de-escalating an individual.

First, ask yourself:

1. Is the individual an actual threat to your safety and capable of inflicting harm?
2. Is the threat of harm imminent?
3. What is the mental status?
    A. Is the person delirious, confused, or disoriented?

Be aware of your non-verbal behavior:

1. Keep a relaxed, open, and positive body language
2. Maintain smooth, slow, and still body movements
3. Maintain a well-balanced stance and comfortable distance
4. Convey a neutral, interested facial expression

Be aware of your verbal communication:

1. Keep your tone, loudness, and pitch low enough to make the individual have to concentrate to hear you speaking **(Do not raise your voice)**
2. Do not express disapproval or scold the person
    A. This can escalate the situation
    B. Strive for neutrality

Objectives:

1. Communicate sincere interest and respect in helping the individual
2. Listen carefully, take your time
3. Allow the person to keep as much control as possible and solve the problem together
4. Offer choices **(Do not give ultimatums)**

Communication Recommendations:

1. One team member should speak to the person in distress
    A. This keeps the individual centered
2. If needed, tell the person why his/her behavior is disturbing
    A. “When you are talking loudly, it can upset other people.”
    B. “At Memorial, we must ensure that our environment is calm and safe for everyone, when you talk like this, people do not feel as safe around you.”

3. Set limits if needed, but wait for additional team members or security for support
    A. Contact security discretely
        i. Have another team member make the call **(Security #479-5536)**
4. Other members of the team should arrive quietly and support the team member talking to the individual in distress
    A. The quiet additional presence of staff can do two things:
        i. Diffuse the situation
        ii. Provide extra support if the situation continues to escalate

What to do if the person grabs you:

1. Breathe, relax, and don't overreact.
2. Do not fight force with force. Move with the person.
3. Team members may need to assist you to help be released from the individual.