MH PATIENT CARE POLICY/PROCEDURE

RESTRAINT AND/OR SECLUSION FOR VIOLENT BEHAVIORS

March 2025

SCOPE:

This policy applies to Decatur Memorial Hospital (DMH), Jacksonville Memorial Hospital (JMH) and Springfield Memorial Hospital (SMH).

OBJECTIVE:

Memorial Health is committed to promoting 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.

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 encouraged to attempt to self-regulate for 30 minutes or less from leaving an unlocked roomand when it is used consistently with the individual's treatment plan with which they agree.
2. Instances in which an individual is limited to a designated area consistent with their plan of care.
3. 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).
4. Drugs or medications that are used as part of a patient's standard medical or psychiatric treatmentand are administered within the standard dosage for the patient's condition, including PRN doses prescribed for 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.

DEFINITIONS:

Restraints:

1. Any method, physical or mechanical device, material or equipment that immobilizes or reduces theability of a patient to move his or her arms, legs, body, or head freely.

2. 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.

3. The use of **force to medicate** a violent patient is considered a restraint for violent behavior. If the patient requests to be held still for an injection or procedure, it is not considered a restraint.

Violent behavior: behavior that jeopardizes the physical safety of the patient, staff, or others.

Seclusion: 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 or Psychiatric Units at Springfield Memorial Hospital. Seclusion is not used outside of the Emergency Department or Intensive Care Units at Decatur Memorial Hospital and Jacksonville Memorial Hospital.**

POLICY:

1. Orders:

   A. 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 training 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.

   B. Each type of restraint placed requires an order.

      i. 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.

C. A face-to-face evaluation by a physician, APN, PA, or trained psychiatric charge nurse occurs within one hour after the initiation of the restraint/seclusion.

   i. The physician, APN, PA, or trained psychiatric charge nurse (if applicable) conducting the face-to-face evaluation documents the situation leading to restraints, psychological and physiologic condition, and continued need for intervention.

   ii. Colleagues should contact the 5A/G charge nurse (SMH only) to complete the initial face to face evaluation and required documentation on all inpatient units (excluding ED).

   iii. If a patient's violent or self-destructive behavior resolves and the restraint/seclusion intervention is discontinued before the physician, APN, PA, or trained psychiatric nurse arrives to perform the face-to-face assessment, the assessment is still required within 1 hour after the initiation of the intervention.

D. Each original restraint/seclusion order, if placed by a resident, APN, or PA requires the attending physician to be notified within 1 hour.

   i. The attending physician works for the attending service that is currently overseeing and coordinating the overall care of the patient (i.e. this is not a consulting attending physician).

   ii. The attending physician notification is documented in the medical record. For orders obtained in the Emergency Department, the ED physician is consideredthe attending physician.

E. Restraint/seclusion renewal orders may be placed by a physician, resident, APN, or PA according to the following frequencies:

   i. Every 4 hours for adults

   ii. Every 2 hours for children and adolescents age 9-17

   iii. Every 1 hour for children under 9 years of age

F. A face-to-face evaluation of the patient by the physician, APN, or PA working for the patient's attending service must document continued need for restraint/seclusion and changes in the treatment plan every 24 hours.

G. If restraint/seclusion has been discontinued for a patient, a new order is required before reinitiating.

H. On psychiatric units, restraint/seclusion may be employed during all or part of one 24-hour period, the period commencing with the initial application of the restraint. However,once restraint/seclusion has been employed during one 24-hour period, it shall not beused again on the same recipient during the next 48 hours without the prior written authorization of the psychiatric

medical director.

I. A seclusion order must be written (in addition to the restraint order) for patients who are concurrently restrained and secluded.

2. Care and Management

A. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. **Do not attempt violent restraint application alone.**

B. After the restraint/seclusion has been initiated, a staff member trained in the use of restraint/seclusion provides continuous observation.

C. 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.

D. 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.

i. The patient, or if a minor, the parent, or guardian.

ii. A person, persons, or agency designated by the patient for such notice.

iii. The Guardianship and Advocacy Commission if the patient has so designated.

E. The RN informs the patient of the reasons for restraints and the goals and/or behavior desired 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.

F. The patient will be dressed in hospital scrubs, gown, or paper scrubs. The colleague caring for the patient checks the patient's garments for contraband and potentially harmful objects.

G. When applying four-point restraints, to mitigate positional risk, position the patient and elevate the head of the bed to a position that allows for full lung expansion, taking into account medical co-morbidities. Avoid pressure to chest, head, or abdomen. Do not restrain a patient in a prone position or apply wrist restraints with arms secured above the patient's head.

H. Always secure restraints to the bed frame. The side rails should be free of any restrictions.

I. Locked restraints are obtained from the psychiatric unit by contacting the psychiatric unit Charge Nurse (SMH) or the Emergency Department (DMH). Inpatient units will receive 2 sets of keys to the locked restraints. The nurse assigned to the patient should carry one set and the other set will remain with

the staff member sittingwith the patient who is restrained.

J. 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.

K. When needed, nurse may request a security presence for patients displaying disruptive behavior.

3. Discontinuation of violent restraints
   A. Once deemed safe to begin removal of restraints, begin by removing one restrained extremity. Stay with the patient to assess continued desired behavior before removing another restrained extremity. Then remove the second restraint on the opposite limb and extremity of the patient (i.e. remove left wrist then right ankle). Do not remove restraint so that it leaves only both arms, only both legs, or extremities on the same side restrained at the same time. A minimum of two restraints are required applied to opposite extremities until restraints are discontinued.
4. Observation and Documentation:
   A. Document the event and the number of staff required to restrain the patient in the medical record.
   B. 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.
   C. Every 15 minutes: behavior and emotional status are monitored and documented.
   D. Every 30 minutes for restrained patients: circulation, discoloration, swelling, movementof extremities, and distal pulses are monitored and documented.
   E. Every 2 hours and more often as needed:
      i. 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 RN determines that the restraint does not pose an undue risk to the patient's health in light of the physical or medical condition.
      ii. Restraints are rotated and/or patient re-positioned. Only one restraint is removed at a time and range of motion is performed.
      iii. Vital signs are assessed and documented and more often as necessary.
      iv. Intake of fluid and food is documented. Fluids are offered. Elimination is offered.

F. 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 takethe 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.

G. Patient's plan of care includes restraint/seclusion interventions.

PATIENT DEATHS AND RESTRAINTS:

1. The Nurse responsible for completion of the Expiration Record will document if the patient died while in restraints, within 24 hours of removal of restraints or within one week after restraints were used.
2. Nursing Outcomes Improvement (SMH) or Quality & Safety (DMH, JMH) will record in an internal log the following data for internal performance improvement and external reporting.
   A. The death of any patient while in restraint or seclusion.
   B. The death of any patient within 24 hours after the patient has been removed from restraint or seclusion.
   C. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.
   D. '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.
   E. The internal log will include date and time of death, patient's name, date of birth, name of attending physician or other licensed independent practitioner (LIP) responsible for care of the patient, medical record number, primary diagnosis(es), cause of death, and types of restraint used.
   F. Entries into the internal log will occur within 7 days of the patient's death.
      i. An entry will be made in the electronic medical record indicating inclusion in the internal log.
   G. Deaths will be reported related to all restraints except for non-violent, soft, non-rigid, cloth-like wrist restraints to the Centers for Medicare and Medicaid (CMS).
      i. This will occur no later than the close of the next business day following knowledge of the patient's death.
      ii. A standardized form provided by CMS will be used to submit the required reports to the CMS Regional Office.

iii. The date and time the death was reported to CMS will be documented in the medical record.

3. Staff Training and Competence

A. Staff with direct care responsibilities will receive education as part of orientation and annual competency validations. Content will include:

i. Application, monitoring, assessment, and care of patients in restraints

ii. Techniques to identify triggers for restraints

iii. Non-physical interventions

iv. Choosing the least restrictive intervention

v. Signs of physical and psychological distress

vi. Indications that restraints are no longer necessary

B. Physicians ordering restraints will have a working knowledge of the policy & procedure regarding use of restraints.

C. Psychiatric charge nurses performing face-to-face evaluations will receive training prior to being authorized to conduct the evaluations and annually thereafter.

February 26, 2023: This document replaces the following documents:

DMH Restraints and Seclusion Policy

JMH Restraint and/or Seclusion for Violent Behaviors

SMH Restraint and Seclusion for Violent Behaviors

APPROVAL:

This policy has been reviewed and approved by:

MH CNO Council

Approval & Revision Dates:

Effective September, 2022
Revised November, 2022
Revised May 2023
Revised May 2024
Revised August 2024
Revised October 2024
Revised March 2025

REFERENCES:

The Joint Commission (2024). Joint Commission Resources E-dition Hospital Standards. EPs 11. PC.01.01.01., PC.03.05.01., PC.03.05.03.,PC.03.05.05.,PC.03.05.07., PC.03.05.09., PC.03.05.11., PC.03.05.15., PC.03.05.17., PC.03.05.19.

405 ILCS 5/ Mental Health and Developmental Disabilities Code. (ilga.gov)

APPENDIX A

Instructions for Application of

Locked Limb Restraints

Memorial Health

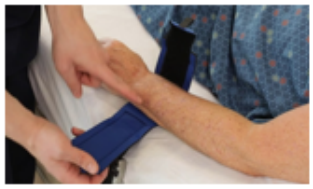
At a minimum, two colleagues need to be present to apply restraints. Do not hesitate to get more help or contact Security. Ensure restraints are unlocked before entering patient's room.

1. One colleague should hold the patient's limb using two hands. When holding down limb, do not apply pressure to joints or lay across chest/neck.

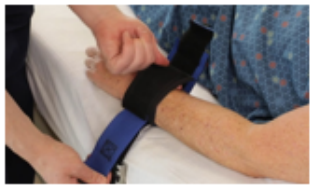
   The other colleague will apply the restraints to all four limbs.

   ** **BLUE** cuffs are for upper extremities and **RED** cuffs are for lower extremities.

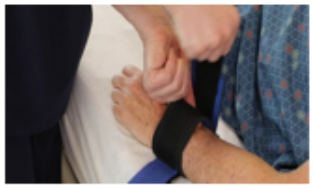
2. Place patient's wrist in **BLUE** cuff.

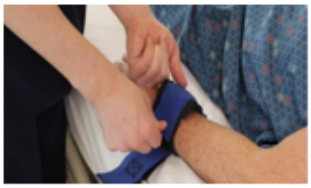


3. Fold inner part of the cuff over wrist. Ensure two fingers fit between cuff and wrist.

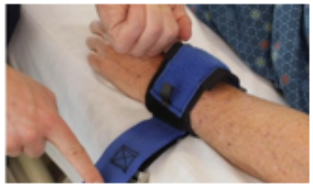


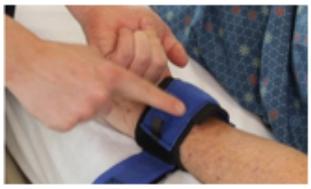
4. Fold black Velcro to black Velcro.





5. Fold black Velcro to black Velcro.

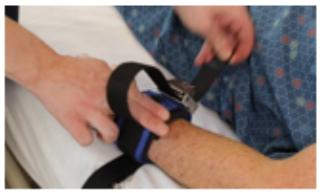




171-0385 02/01/22

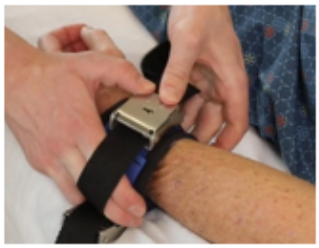
OVER

6 Thread strap through locking buckle.



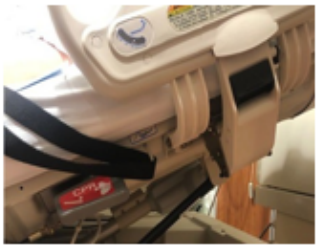
7 Close the buckle to lock the cuff. Use middle and index fingers to support under the buckle. Press thumbs into supported buckle. You should hear a click.

Colleague holding limb should not let go until the restraints are secure or receives a verbal "all clear."



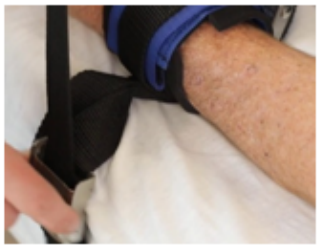
8 Loop long, anchoring strap (at least twice) around bedframe or another non-moveable part of the bed. Do NOT use side rails. Side rails must remain free from restriction.

Be aware of amount of slack on restraint. Restraint should not allow patient to move extremity from bed.



9 Thread strap through locking buckle. Close buckle to lock cuff. You should hear a click.

** Repeat steps 1–9 for remaining three restraints.



APPENDIX B

Posey Twice-as-Tough Cuffs: https://www.tidiproducts.com/hubfs/ifu/restraints-and-restraint-alternatives/posey-tat-cuffs-2790-2790q.pdf

Posey® Twice-As-Tough® Cuffs 2790, 2790Q Application Instructions for Wrist and Ankle

Posey®

Rx ONLY

DESCRIPTION OF PRODUCT: Padded limb restraints with double-security closure. For bed and stretcher use only.

INTENDED USE:
- Patients assessed to be at risk of disrupting life-saving treatments (e.g., chronic tube pulling) or in danger of injury to themselves or to others.
- Follow your hospital's restraint policies and procedures which are in compliance with USA CMS guidelines and state laws, or other governing agencies outside the USA.

CONTRAINDICATIONS:
Do not use this device with someone who has continued highly aggressive or combative behavior, self-destructive behavior, or deemed to be an immediate risk to others or to self. Clinicians may need to use additional interventions in conjunction with restraints.

APPLICATION INSTRUCTIONS:
Use method a. or b. below to attach straps to frame (repeat steps 1-2 on each side):

1a. Triangulation process; to restrict patient's range of motion: separate the straps and attach at different points along the frame that moves with the patient (Fig. 1) out of patient's reach (do not attach to side rail or head/footboard) (Fig. 2).

1b. To increase patient's range of motion: place the straps together and attach to a single point along a part of the frame that moves with the patient, out of the patient's reach.

2. **2790:** Wrap the connecting strap to the frame by pulling the strap back between the first and second D-ring (Fig. 3).

2790Q: Wrap the connecting strap once around the frame that moves with the patient, out of the patient's reach. Close the quick-release buckle. Listen for a "snapping" sound. Pull firmly on straps to ensure a good connection (Fig. 4).

APPLYING THE CUFFS: (Repeat steps 1-4 for each side):
1. Wrap the neoprene piece around wrist/ankle so the buckle and connecting strap is on the ulnar side of the wrist or lateral malleolus of the ankle. Attach the black hook-and-loop pieces together and pull back the black pull tab on the blue or red fuzzy piece, followed by the blue or red hook-and-loop pieces. The fuzzy piece should be sandwiched between the two pieces of hook (Fig. 5). Be sure to overlap at least one inch (3 cm).

2. Press the hook-and-loop closure together firmly and make sure it adheres securely. Slide ONE finger (flat) between the cuff and the inside of the patient's wrist/ankle to ensure proper fit. (Fig. 6)

Fig. 1

Fig. 2

Fig. 3

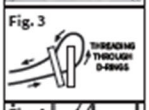


Fig. 4

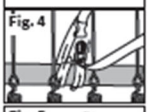


Fig. 5

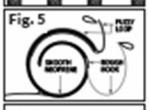


Fig. 6

Fig. 7

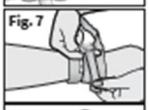
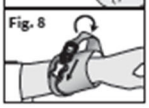


Fig. 8



POSEY TWICE-AS-TOUGH CUFFS:

REF 2790	Double Strap, Regular/blue size
REF 2790Q	Double Strap with Quick-Release Buckles, Regular/blue size

3. **2790:** Pass the end of the limb strap over the top of the cuff and through the two D-rings on the cuff. Bring the strap back over the first ring and through the two D-rings on the cuff. Slide one finger flat between the cuff and the strap.
2790Q: Close the quick-release buckle on the cuff. Insert ONE finger (flat) under the buckle and pull the strap snug, but not so tight as to restrict circulation (Fig 7). Release the quick-release buckle, twist buckle 180°, and reconnect (Fig 8). Listen for a "snapping" sound.

4. Adjust the connecting strap(s) length from the frame to allow desired freedom of movement without compromising patient or caregiver safety. Ensure the remaining strap end(s) are secured and out of the reach of the patient.

PRECAUTIONS:
- A clinical assessment and decision are required when used with monitoring lines or if patient has a wound or dislocated/fractured limb.
- Check the patient regularly to ensure that circulation is not impaired. Serious injury may occur if the cuffs restricts circulation when the limb holder is applied.
- Before each use, check cuffs and straps for cracks, tears, and/or excessive wear or stretch, broken buckles or locks, and/or that hook-and-loop adheres securely as these may allow patient to remove cuff. Discard if device is damaged or if unable to lock.
- ⚠ **WARNING:** Additional or different body or limb restraints may be needed (visit tidiproducts.com):
  - If the patient pulls violently against the bed straps.
  - To reduce the risk of the patient getting access to the line/wound/tube site.
  - To prevent the patient from flailing or bucking up and down and causing self-injury.

BED SAFETY:
Refer to the Food and Drug Administration (FDA), or other governing agencies outside the USA, for the most recent Hospital Bed Safety Guidelines and the bed manufacturer's instructions for use.

EN | Report any serious incident related to device use to TIDI Products and the Member State Competent Authority. | Translations of this document in French, Spanish, Dutch, German, Italian, and Portuguese are located at www.tidiproducts.com/IFU.

ADDITIONAL SAFETY AND LAUNDERING INSTRUCTIONS ON OTHER SIDE.

TIDI Products, LLC • 570 Enterprise Drive, Neenah, WI 54956 USA
Phone: 1.800.447.6739 • International: +1.920.751.4036 • www.tidiproducts.com

EC REP MDSS GmbH Schiffgraben 41 30175 Hannover, Germany

UK CA UK Responsible Person Emergo Consulting (UK) Limited c/o CSBD – UL International Compass House, Vision Park Histon Cambridge CB249BZ United Kingdom

MD CE

TIDI Support Caregivers. Protect Patients.

19253 REV C 2021-07-16