Standards for Seclusion/Restraint for Behavioral Management: May 2000

Current Policy	HCFA Rules	JCAHO Standards	Action Plan
	<u>Application:</u> Rules related to restraint/seclusion concern their use in two situations: respectively, standard (e), use of restraint in medical and post-surgical care; and standard (f), **emergency** use of restraints/seclusion in behavior management. For both situations, it is important to note that these requirements **<u>are not specific to any treatment setting</u>**, but to the situation the restraint is being used to address. **<u>Emergency:</u>** a situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious dangers to the safety of the patient, other patients, staff, or others. **<u>NOTE:</u>** The behavior management standard does not apply to situations where the patient is restrained to address the risk of a fall or to control wandering.	**<u>Application:</u>** The behavioral health care standards for restraint/seclusion apply to any use of restraint and seclusion for behavioral health care reasons. Standards TX.7.1 through TX.7.1.16 apply to ***all behavioral health care settings*** in which restraint or seclusion is used. Selected standards TX.7.1.4.1, TX.7.1.5, TX.7.1.6 through TX.7.1.8 and Standards TX.7.1.10 and TX.7.1.11 apply to ***non-behavioral health care settings*** in which restraint or seclusion is used for behavioral health reasons: • acute care hospital that does not have a psychiatric unit; • acute care hospital to receive medical or surgical services; • emergency department for assessment, stabilization, treatment or awaiting transfer to a psychiatric hospital/unit; • awaiting transfer from a non-psychiatric bed to a psychiatric bed/unit after receiving medical/surgical care	
<u>Definition of Restraint:</u> placement of a patient in a posey vest and/or soft wrist/ankle restraints. **<u>Definition of Seclusion:</u>** placement of a patient in a locked security room.	**<u>Restraint:</u>** any manual method or physical or mechanical device that restricts freedom of movement or normal access to one's body, material, or equipment, attached or adjacent to the patient's body that he or **she cannot easily remove**. (Any object may be a restraint by functional definition: e.g., tucking sheets, side rails, geri chair, etc.). **<u>Drug Used as a Restraint:</u>** a medication used to restrict the patient's freedom of movement in medical-post surgical situations or for the emergency control of behavior, and is not a standard treatment for the patient's medical or psychiatric condition. **<u>Seclusion:</u>** involuntarily confining an individual alone to a room or an area where he/she is physically prevented from leaving. **<u>Time Out:</u>** restriction of a patient for any period of time to a designated area from which the patient is not physically prevented from leaving and for the purpose of providing the patient an opportunity to regain self-control.	**<u>Restraint:</u>** the direct application of physical force to an individual, without the individual's permission, to restrict his/her freedom of movement. **<u>Seclusion:</u>** the involuntary confinement of a person in a locked room. **<u>Time-out:</u>** a procedure used to assist the individual to regain emotional control by removing the individual from his/her immediate environment and restricting the individual to a quiet area or unlocked quiet room.	

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<u>When is restraint/seclusion used:</u> • When the patient poses an immediate danger to self an/or others; • When the patient threatens serious disruption to the therapeutic environment; • When less restrictive measures/approaches are/have been unsuccessful.	Seclusion or restraint can only be used in emergency situations if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective. Emergency is defined as a situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff or others.	Restraint and seclusion are used only in an **<u>emergency</u>**, when there is an imminent risk of an individual physically harming himself or herself or others, including staff. Non-physical interventions are the **preferred** intervention, unless safety issues demand an immediate physical response. **<u>Definition of Emergency:</u>** when there is **imminent risk** of an individual physically harming himself or herself, staff or others; when non-physical interventions are not viable; and safety issues require an immediate physical response.	
	<u>Initial Assessment:</u> Comprehensive assessment is critical in coming to an effective intervention decision of what would be the greater benefit to a patient. Evaluation of whether devices could be used as restraints must include: • how they benefit the patient; • whether a less restrictive device/intervention could offer the same benefit at less risk. If the effect of using an object fits the definition of restraint for that patient at that time, then for that patient at that time, the device is a restraint.	**<u>Initial Assessment:</u>** The initial assessment of each individual at the time of admission or intake assists in obtaining information about the individual that could help minimize the use of restraint/seclusion. This initial assessment identifies: • techniques, methods, or tools that would help the individual control his/her behavior; • pre-existing medical conditions/physical disabilities and limitations that would place the patient at greater physical risk; and • any history of sexual/physical abuse that would place the patient at greater psychological risk.	

<u>Orders:</u>
• An attending physician must give the order to restrain/secure the patient.
• The RN may assume this responsibility in an emergency; but a physician's order must be obtained within one hour of placing the patient in restraints or seclusion.
• The MD order must include clinical justification for the use of restraint/seclusion, including specific behavior(s) which requires the need for such intervention.
• Written orders must be time-limited and may not exceed 4 hours for adults and 2 hours for adolescents.
• The MD may continue the original order, in 4-hour increments (2 hour for adolescents) for a maximum of 24 hours without a face-to-face contact.
• The use of PRN orders for restraint/seclusion is
	<u>Orders for the use of Restraint/Seclusion:</u>
	• Must be written by a physician or other licensed independent practitioner (LIP) permitted by the State and hospital to order a restraint/seclusion
	• May never be written as a standing order or on an as needed basis (i.e., PRN)
	• Must be time limited to 4 hours for adults; 2 hours for children and adolescents ages 10 to 17; or 1 hour for patients under 9 years of age
	• May only be renewed in accordance with these time limits for up to a total of 24 hours
	• Must be in accordance with a **written modification** to the patient's plan of care
	• Must be implemented in the least restrictive manner possible (i.e., less intrusive measures were tried/documented)
	• Must be in accordance with safe and appropriate
		<u>Orders for the use of Restraint/Seclusion:</u>
		• All restraint/seclusion is used and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his/her LIP designee
		• Written or verbal orders for initial and continuing use of restraint/seclusion are time limited to:
		  • **4 hours** for individuals **18 and older**
		  • **2 hours** for children and adolescents **9 to 17**
		  • **1 hour** for children **under age 9**
		• Orders for restraint/seclusion are not written as a standing order or on an as needed basis (i.e., PRN)
		• The organization may authorize qualified registered nurses or other qualified, trained staff members who are not LIPs to *initiate* the use of restraint/seclusion
		• The qualified RN or other qualified staff notifies the LIP and an order is obtained **no longer than one hour** after the	

strictly prohibited. • When restraints/seclusion are discontinued early and the same behavior is still evident, the original order can be reapplied if alternatives remain ineffective. The time limit for the original order is cumulative. Release of the patient from restraints/seclusion for a period longer than 60 minutes requires obtaining a new MD order to include additional clinical justification.	restraining techniques • Must be ended at the earliest possible time • If restraints/seclusion are discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating seclusion or reapplying the restraints and the requirements restart. • After the original order expires, a physician or LIP (if allowed under State law) must see and assess the patient before issuing a new order	initiation of restraint/seclusion • The LIP reviews with the staff the physical and psychological status of the patient, determines whether restraint/seclusion should be continued, gives staff guidance in identifying ways to help the individual regain control in order to discontinue restraint/seclusion, and gives an order • If restraint/seclusion needs to continue beyond the expiration of the time-limited order, **a new order (written or verbal) for restraint/seclusion is obtained** from the LIP, or his/her LIP designee limited to the time frames outlined above	

<u>Ongoing Assessment of the Need for Continuation:</u>
• The attending MD or his/her designee (i.e., RN) must reassess the patient's status every 4 hours to determine the need for continuation. Designation of this responsibility by the MD to the RN must be included in the written order.
	<u>Ongoing Assessment of the Need for Continuation:</u>
	• An MD or other LIP must see and evaluate the need for restraint/seclusion **within 1 hour** after the initiation of this intervention (***a telephone call is not adequate***)
	• The MD is not required to perform another face-to-face assessment of the patient after 4 hours (or 2 hours or 1 hour for younger patients). When the original order is about to expire, a nurse can telephone the MD or LIP, report the results of his/her most recent assessment, and request that the original order be renewed for another period of time (not to exceed the time limits established in the regulation).
		<u>Ongoing Assessment of the Need for Continuation:</u>
		• Individuals who are in restraint/seclusion are regularly reevaluated every
		  • **4 hours** for individuals **18 and older**
		  • **2 hours** for children and adolescents **9 to 17**
		  • **1 hour** for children **under age 9**
		• The LIP who is primarily responsible for the individual's ongoing care, or his/her LIP designee, conducts an in-person evaluation of the individual **within 4 hours** of the initiation of restraint/seclusion for individuals **ages 18 or over**; **within 2 hours** of initiation for children and adolescents **age 17 and under**
		• This in-person reevaluation may be delegated to:
		• his/her LIP designee
		• a **qualified RN** or other **qualified, trained staff** who is authorized by the organization to perform this function (see training requirements in intent)
		• **Minimum** time frames for an in-person reevaluation by the LIP are at least every
		  • **8 hours** for individuals **18 years and older**, and
		  • **4 hours** for individuals **ages 17 and younger**
		• If the individual is **no longer in restraint/seclusion** when an original *verbal* order expires, the LIP conducts an in-person evaluation of the individual **within 24 hours** of the initiation of restraint/seclusion	

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<tr><th>Current Policy</th><th>HCFA Rules</th><th>JCAHO Standards</th><th>Action Plan</th></tr>
<tr><td><u>Notification Requirements:</u>
• All uses of restraint/seclusion are to be recorded on the Critical Incident Log for each new restraint/seclusion event
• All uses of restraint/seclusion are reported daily to the Medical Director or a designee (Nurse Coordinator) for review.
• If restraint/seclusion continues beyond 48 hours or if the patient requires restraint/seclusion more than 4 times in one week, the RN will request a case conference with the MD and other team members to discuss alternatives.</td><td><u>Notification Requirements:</u>
• The RN who initiates restraint/seclusion must consult with the patient's treating MD, as soon as possible, if the restraint/seclusion is not ordered by the patient's treating MD</td><td><u>Notification Requirements:</u>
• The individual's family is notified promptly of the initiation of restraint or seclusion, in cases where the individual has consented to have the family kept informed regarding his/her care and the family has agreed to be notified.
• Clinical leadership is informed of instances in which individuals experience extended, or multiple episodes of, restraint/seclusion (e.g., remains in restraint/seclusion for more than 12 hours; experiences 2 or more separate episodes of restraint/seclusion of any duration within 12 hours). The leadership is notified every 24 hours if either of the above conditions continue.</td><td></td></tr>
<tr><td><u>Monitoring/Care Requirements:</u>
• Each restrained/secured patient will be placed on the appropriate PICR (10/15 minute flow sheet)
• Nursing staff will check the patient every 15 minutes (or less) depending upon patient need. (Children 14 years of age or younger must be checked every 10 minutes or less).
• Each reassessment for monitoring purposes is used to determine the patient's well being and must be documented.
• If the patient's condition warrants, restraints are removed every 2 hours and the patient exercised (while awake). If the patient is assessed to be at risk for violence, the restraints will not be removed unless repositioning, circulation and mobility is impaired. (Under these circumstances, the restraint is removed from one extremity at a time with range of motion provided to the free extremity.)
• The personal needs of the patient (e.g., nourishment, fluids, hygiene, and use of the toilet) must be attended to every 2 hours while awake during each 8-hour shift. Other comfort measures are provided as appropriate and desired by the patient.
• If a patient is restrained in a security room, the door to the room may not be locked. Any patient in 4-point restraints will be monitored 1:1 by staff.</td><td><u>Monitoring/Care Requirements:</u>
The frequency of monitoring will vary according to the type and design of the device/intervention as well as the emotional, psychological and physical condition, needs, and symptoms of the patient.
• A restraint and seclusion may not be used simultaneously unless the patient is --
➢ Continually monitored face-to-face by an assigned staff member; or
➢ Continually monitored by staff using both video and audio equipment. (This monitoring must be done in close proximity to the patient.)
• The condition of the patient who is in a restraint or in seclusion must be continually be assessed, monitored, and reevaluated.
• The frequency of monitoring will vary according to the type and design of the device or intervention as well as the emotional, psychological and physical condition, needs, and symptoms of the patient.
• Hospital policy should describe:
➢ which staff are responsible for assessing and monitoring the patient;
➢ time frames for monitoring vital signs, respiratory and cardiac status, skin integrity, intake/output, weight, hygiene, injury, etc.;
➢ opportunities for offering fluids and nourishment,</td><td><u>Monitoring/Care Requirements:</u>
• A trained and competent staff member assesses the individual at the initiation of restraint/seclusion and every 15 minutes thereafter, to include:
➢ signs of injury;
➢ nutrition/hydration;
➢ circulation and range of motion in extremities;
➢ vital signs;
➢ hygiene and elimination;
➢ physical and psychological status and comfort; and
➢ readiness for discontinuation of restraint/seclusion.
• Monitoring is accomplished through continuous in-person observation by an assigned staff member
• After the first hour, an individual in seclusion only, may be continuously monitored using simultaneous video and audio equipment, if this is consistent with the individual's condition or wishes.
• If the individual is in a physical hold, a second staff person is assigned to observe the individual.
• The individual is made aware of the rationale for restraint/seclusion and the behavior criteria for its discontinuation (e.g., ability to contract for safety; orientation to the environment; and/or cessation of verbal threats).</td><td></td></tr>
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	toileting/elimination, range of motion, exercise of limbs and systematic release of restrained limbs; ➢ assessment of mental status; ➢ assessment and justification for continued use of restraint/seclusion; ➢ who has the authority to discontinue restraints or seclusion, and, under what circumstances.		
Documentation: The medical record for a restrained/secured patient must include: • precipitating factors and patient's behavior prior to intervention; • less restrictive alternatives used and the patient's response; • explanation given to patient addressing the reason for restraint seclusion and conditions for discontinuation; • RN assessment at the time of initiation and notification of attending MD; • initiation of PICR with visual checks every 15 minutes; • reassessment by the RN at regular intervals (at least once per shift); • attention to patient needs by nursing staff; • time of discontinuation of restraint seclusion and patient's response; • MD signature with date/time for each order received.	**Documentation:** Documentation in the patient's record should include: • the patient's behavior and the intervention used; • the rationale for the use of the physical restraint or seclusion; • the patient's response to the use of physical restraint/seclusion. Documentation in the patient's record should indicate a clear progression in how techniques are implemented with less intrusive restrictive interventions attempted (or considered) prior to the introduction of more restrictive measures.	**Documentation:** Medical records document that the use of restraint/seclusion is consistent with organization policy. The clinical record verifies: • that the individual/family was **informed of the organization's policy** on the use of restraint/seclusion; • any **pre-existing medical conditions** or any physical disabilities that would place the individual at greater risk during restraint/seclusion; and • any **history of sexual or physical abuse** that would place the individual at greater psychological risk during restraint/seclusion. **Each** episode of use is recorded to include: • the **circumstances** that led to their use; • consideration or failure of **non-physical interventions**; • the **rationale** for the type of physical intervention selected; • **notification** of the individual's family, when appropriate; • **written orders** for use; • **behavior criteria** for discontinuation of restraint/seclusion; • **informing the individual** of behavior criteria for discontinuation of restraint/seclusion; • **each verbal order** received from a LIP; • **each in-person evaluation** and reevaluation of the patient; • **15 minute assessments** of the patient's status; • **assistance provided** to the patient to help him/her meet the behavior criteria for discontinuation of restraint/seclusion; • evidence of **continuous monitoring**; • **debriefing** of the individual with staff; and • any injuries that are sustained and treatment received for these **injuries…**or any **deaths** resulting from injury. Documentation is accomplished in a manner that allows for the collection and analysis of data for performance improvement activities.	

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<u>Staff Training:</u> Staff with direct patient care responsibilities are trained in: • identification of potential risk behaviors; • the appropriate use of alternative strategies; • correct application and removal of restraints; • clinical strategies to meet emergent patient needs.	**<u>Staff Training:</u>** All staff who have direct patient contact must have ongoing education and training in: • the proper and safe use of restraint/seclusion application and techniques; • alternative methods for handling behavior symptoms, and situations that traditionally have been treated through the use of restraints/seclusion	**<u>Staff Training:</u>** **All direct care staff** are trained/competent to minimize the use of restraint and seclusion, and **demonstrate an understanding**: • of the underlying causes of threatening behaviors; • that some aggressive behavior may be related to a medical condition; • of how their own behaviors can affect the behaviors of patients; • of the use of de-escalation, medication, self-protection and other techniques, such as time-out; and • in recognizing signs of physical distress in individuals who are restrained/secluded. All staff **authorized to physically apply restraint or seclusion** receive **ongoing training** and **demonstrate competence** in the safe use of restraints, including: • physical holding techniques; • take-down procedures; and • the application and removal of mechanical restraints. Staff who are **authorized to perform 15 minute assessments** of individuals in restraint/seclusion **receive ongoing training** and **demonstrate competence** in: • taking vital signs and interpreting their relevance; • recognizing nutritional/hydration needs; • checking circulation and range of motion in extremities; • addressing hygiene and elimination needs; • addressing physical and psychological status and comfort; • assisting individuals in meeting behavior criteria for the discontinuation of restraint/seclusion; • recognizing when to contact a medically trained LIP or EMS to evaluate/treat the patient's physical condition. Staff who are **authorized to initiate restraint/seclusion**, in the absence of a LIP, and/or perform evaluations/reevaluations of individuals who are in restraint/seclusion are **educated** and **demonstrate competence** in: • recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual reacts to physical contact; and • the use of behavior criteria for the discontinuation of restraint/seclusion and how to assist individuals in meeting this criteria.	