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Owner:	*Darren Morr: Manager, RN*
Policy Area:	*PCS: Nursing - ICC*
Committee Approvals:	*9/2/2020 Patient Care, 9/29/2020 CNO/VP PCS*

Behavioral Restraint Use for Violent/Self Destructive Behaviors

PURPOSE:

It is the goal of McLaren St. Luke's (MSL) to have an ongoing organization wide initiative to reduce use of restraining devices and methods, and to identify and implement less restrictive or non-restrictive alternatives whenever feasible. The patient has the right to be free from any restraint. Restraints may be imposed only to ensure immediate physical safety of the patient, staff or others from:

1. Those patients who unexpectedly become violent / self-destructive (V/SD) thus presenting a danger to self or others.
2. For the agitated, psychotic, self-destructive, suicidal or homicidal patient whose behavior or condition may necessitate a more restrictive environment.

SCOPE & RESPONSIBILITY :

This procedure provides direction for appropriate usage and implementation of restraint. It is the responsibility of all those involved with patient care to maintain the safety of the patient during restraint use.

PROCEDURE:

DEFINITION:

- Behavioral restraints are defined as any type of restraint used to manage violent/aggressive behavior and can be any 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.
- Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. A situation where a patient is restricted to a room or area alone and staff are physically intervening to prevent the patient from leaving the room or area is also considered seclusion. Seclusion may only be used for the management of violent or self- destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.
- A drug or medication is a restraint when it is 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.
- A restraint episode is defined as the period of time the patient is in restraints. Each 24 hour period is considered one episode. Patients requiring prolonged use of restraints (greater than 3 episodes) will be

undergo evaluation by the unit manager or designee to ensure appropriate alternatives have been tried and documented and that there is a continued need for restraint..

I. **PERTINENT INFORMATION**

A. Restraints/seclusion are to be used if needed to ensure physical safety of patients, visitors, and/or staff in emergency situations where there is an imminent risk of harm.

B. Behavioral restraint use shall be used based on assessment by an R.N./Licensed Independent Practitioner (LIP). These restraints shall be used to set limits for the individual when he/she demonstrates the inability to control his/her behavior and/or has demonstrated an actual/observed threat to self/others.

C. Use of a restraints/seclusion must be discontinued at the earliest possible time.

D. Restraints/seclusion are never used as a means of coercion, discipline **,** convenience or retaliation by staff but are used to assist in the care of the patient, as a means of controlling physical activities, to protect the patient's or other's health and safety and still preserve patient dignity, privacy, rights and well being.

E. All staff shall provide a safe environment for those patients in behavioral restraints/seclusion by the following means:

1. Remove all unneeded equipment from the patient room, including tubings, etc.
2. Place patient in a hospital gown
3. Remove all personal belongings (i.e. clothes, shoes, belts, etc.) from the patient.
    a. Personal belongings of value will be kept in Safety and Security per hospital policy
    b. All other belongings will be bagged and shall be kept at the nurses station

II. **TYPES OF BEHAVIORAL (V/SD) RESTRAINTS:**

The type of restraint is not determined by WHAT you are restraining the patient with, but rather WHY they are being restrained. The list may include, but is not limited to:

A. Leather/humane restraints (ankle, wrist & securing straps).

B. Soft restraints x 4

C. Seclusion - V/SD patient held under continuous observation

D. Chemical/Medications

a. If the use of the medication for the patient meets the definition of a drug used as a restraint, the assessment,
monitoring and documentation requirements apply.
    i. The use of as needed (PRN) orders is prohibited for drugs or medications that are being used as restraints.

b. The policy is not intended to interfere with the clinical treatment of patients who need medication in appropriate doses that are standard medical or psychiatric treatment for the patient’s condition. Medications such as the following are not considered restraints when based on the assessed needs of the particular patient with careful monitoring to minimize adverse effects:
    i. Therapeutic doses of psychotropic medication for patients who are suffering from serious mental illness to improve their level of functioning so that they can more actively participate in their treatment.

ii. Therapeutic doses of anti-anxiety medications to calm the patient who is anxious.

iii. Appropriate doses of sleeping medication prescribed to treat insomnia.

iv. Appropriate doses of analgesic medication ordered for pain management.

c. Therefore, a notation that certain medications are a standard treatment for a patient's medical or psychiatric conditions and are NOT subject to the requirements of the restraint policy is acceptable in the following circumstances:

i. The medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications it is manufactured and labeled to address, including listed dosage parameters.

ii. The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization.

iii. The use of the medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's or other Qualified Licensed Practitioner's knowledge of that patients expected and actual response to the medication.

d. An additional component of ''standard treatment'' for a medication is the expectation that the standard use of a
medication to treat the patient's condition enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of the medication.

e. If the overall effect of a medication is to reduce the patient's ability to effectively or appropriately interact with the world around the patient, then the medication is not being used as a standard treatment for the patient's condition and meets the definition of a medication used as a restraint.

f. The policy supports existing State laws that provide more vigorous promotion of the patient's choice and rights. Therefore, when a State's law prohibits the administration of drugs against the wishes of the patient without a court order, the State law applies.

E. **EXCEPTIONS** :

1. **Forensic Restraints** - Handcuffs or other restrictive devices applied by police or law enforcement officials for custody, detention and public safety reasons (when used by law enforcement officials who are not employees of the hospital).

a. The use of restrictive devices applied and monitored by law enforcement officers and who maintain custody and direct supervision of their prisoners, is an exception to the rule and are not considered to be restraints and are not covered by these regulations.

b. Hospital staff shall closely monitor and observe the patient's safety.

2. **Postural Support** - A voluntary mechanical support used to achieve proper body position, balance or alignment that would not be possible without the use of such a mechanical support (i.e. surgical procedures, radiology exams, etc).

III. **PROCEDURE:**

A. Determine/confirm the need for behavioral restraint.

1. Include assessment data in the decision process.

2. Attempt alternatives prior to use of behavioral restraints.

a. In an emergency situation where severe harm to patient or staff is imminent, restrictive devices may be applied without the use of less restrictive alternatives.

3. The least restrictive restraint shall be utilized based on the behavior and condition of the patient.

B. Educate patients/families whenever possible about the reasons why restraint is necessary, alternatives to restraints as appropriate, potential consequences of using alternative and/or restraint, willingness to incorporate patient/family preferences.

C. A consent for restraint use should be obtained and placed with the patient's chart if the situation allows.

D. Obtain order

1. A physician/LIP order must be obtained immediately for placement of the patient in behavioral restraints and shall include:
    a. Date and time initiated
    b. Physician signature
    c. Type of restraint utilized
    d. Length of time restraint is to be utilized
    e. Reason/clinical justification for restraint (patient's immediate situation)
    f. Reaction to intervention
    g. Patient's medical and behavioral condition
    h. Status of restraint usage
    i. Less restrictive alternatives attempted (may include but is not limited to the following)
        - Frequent observation/move patient closer to nurses' station
        - Involve family in care/have family stay with patient
        - Decrease environmental stimuli
        - Diversional activities (i.e. television, books, etc.)
        - Review medications for side effects
        - Place in room with camera observation if available
        - Use simple directions/explain procedures
        - Reality orientation
        - Maintain oxygen therapy
        - Do not awaken unnecessarily
        - Approach in a slow, non-threatening manner
        - Offer walking, range of motion, or other activity
        - Pain management
        - Smile
2. Orders for restraints/seclusion are never to be written as a standing order or as needed (=prn).
3. Physician/LIP orders for behavioral restraints/seclusion must be renewed according to the patient's age as follows :

a. ≥18 years = every 4 hours
b. 9 -17 years = every 2 hours
c. <9 years = every 1 hour

4. In an emergency situation, a competent RN may implement restraints/seclusion and obtain an order either during the emergency application or immediately after the application has occurred (within 10 minutes).
5. If the patient's LIP or his/her LIP designee, is not the LIP who gives the order the patient's LIP is notified of the patient's status and order renewal.
6. It is the responsibility of the attending physician to renew the orders.
7. If the restraints are discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying the restraints and the requirements restarts.

E. Face-to-Face Evaluation by physician/LIP

1. A face-to-face evaluation of the patient must be done by a physician/LIP within 1 hour of onset of behavioral restraint use.
2. Face to face evaluation includes:
   a. The patient's immediate situation.
   b. The patient's reaction to the situation.
   c. The patient's medical and behavioral situation.
   d. The need to continue or terminate the restraint or seclusion
3. Physician/LIP must collaborate with staff to identify ways to assist patient in regaining control to ensure behavioral restraints/seclusion can be discontinued at the earliest possible time.
4. After 24 hours, and before writing an new order for the use of restraint or seclusion for the management of V/SD behavior a physician/LIP must see and assess the patient.
5. Original restraint initiation criteria shall be reviewed at the time of re-evaluation.

IV. **APPLICATION OF BEHAVIORAL (V/SD) RESTRAINTS** :

A. General points

1. Physical holds for behavioral health purposes will not be utilized except while physical restraints are being applied. During that time, a staff person who is trained and competent in the use of behavioral restraints and who is not involved in the physical hold will be assigned to observe the patient.
2. No restraining devices shall be placed across the patient's chest (i.e. blanket, sheet, etc.) nor will anything obstruct the patient's airway during the restraint process.
3. If patient has potential for vomiting or a history of breathing problems, the head of the bed shall be elevated.
4. Law enforcement may be contacted/utilized as needed for assistance in restraining the patient with V/SD behaviors.

B. Leather/Humane Restraints

1. Leather/Humane restraints are applied 4 point (2 ankle/2 wrist plus straps) or 2 point (1 ankle /1 wrist plus straps, opposite application or bilateral arms).

2. Patients shall be placed in a private room if possible.
3. Obtain adequate assistance to apply restraints. Activate Code Violet if needed. Have equipment ready.
4. Position patient in supine position (back lying) and secure limbs at joints to minimized movement without excessive force.
5. Flex limbs slightly before securing to allow some movement.
6. Pad patient's wrists and ankles (with washcloths, stockinette, webril, etc.) to reduce friction and to prevent skin irritation/breakdown.
7. Apply restraint securely, but not tightly, by wrapping the device around the patient's padded extremity and inserting the metal loop through the slit in the device. Thread strap through metal loop and secure strap to non-movable portion of bed frame. One to two fingers should be able to slip between patient's skin and the restraint.

C. 1-4 Point Soft Restraints

1. Patients shall be placed in a private room if possible.
2. Obtain adequate assistance to apply restraints. Activate Code Violet if needed. Have equipment ready.
3. Position patient in supine position (back lying) and secure limbs at joints to minimized movement without excessive force.
4. Flex limbs slightly before securing to allow some movement.
5. Apply restraint to both arms (wrists), legs (ankles) securely, but not tightly and secure strap to non-movable portion of bed frame. One to two fingers should be able to slip between patient's skin and the restraint.
6. Side rails placed in up position. Seizure pads may be placed on side rails as a safety device.

D. Seclusion

1. Notify Safety & Security of patients placed in seclusion.
2. Patient should be provided with positional changes, nutrition/hydration, and hygiene/elimination as necessary **.**
3. Patient is not allowed to leave the area voluntarily. Transportation of patient from the area (i.e. to bathroom, ancillary areas for testing, etc.) shall be done with trained nursing staff and/or accompanied by Safety & Security as needed. Observation will be maintained at all times.

V. **REASSESSMENT & DOCUMENTATION GUIDELINES**

1. **Continuous, one-on-one visual observation of the patient shall be maintained and staff will remain in close proximity of the patient at all times during the restraint process** .
   The patient's physical and behavioral status and needs for care must be observed/assessed and documented at minimum according to the following guidelines:
   1. Every 30 minutes documentation by an RN.
      a. Behavioral status (i.e. agitated, delusional, hallucinating, etc.)
      b. Indications for use (i.e. danger to self, danger to others, explosive behavior, etc.)
      c. Restraint type (i.e. four point humane, seclusion, chemical, etc.)

d. Restraint tolerated (i.e. well, fair, poor, decreased agitation, etc.)
e. Restraint activity (i.e. applied, continued, reduced, discontinued, etc.)
f. Signs of injury

2. Every 2 hours must be assessed by the RN.
   a. Vital Signs
   b. Neurovascular status
   c. Nutrition/hydration
   d. Toileting
   e. Passive range of motion/Active range of motion
   f. Skin condition
   g. Alternatives attempted

2. Continuous physiological monitoring (cardiac monitoring, Non-Invasive Blood Pressure (NIBP), pulse oximeter) may be utilized when the patient is placed in restraint devices.
3. Any changes in patient condition shall be assessed by the nurse and the physician/LIP shall be notified immediately.
4. Documentation shall be completed in the medical record.
5. Modification to the plan of care shall reflect restraint/seclusion use.
6. RN will log restraint use on departmental restraint log
   1. All instances of restraint use will be monitored for performance improvement
   2. Data will be reviewed monthly by department manager
   3. Any area falling below the benchmark will have action plans for improvement documented.
   4. All of the collected data will be reported quarterly to the Patient Care Committee.

VI. **DISCONTINUATION OF BEHAVIORAL RESTRAINTS** :

A. Restraint and seclusion should be discontinued at the earliest possible time regardless of the length of time specified in the order.

B. When a patient no longer exhibits the behavior that lead to his/her being placed in restraints:
   1. Patient's readiness for removal shall be assessed and documented before removal.
   2. Upon removal, documentation shall include reason for removal and safety measures substituted for restraint use.
   3. The method or number of restraints may be gradually reduced based on the patient's behavior.
   4. The restraint(s) may be removed.
   5. If the restraints are discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying the restraints and the requirements restarts.

C. In the event of a disaster (i.e. fire, tornado, bomb threat, etc.), trained staff shall relocate the patient to a safe area.

VII. **STAFF EDUCATION** :

A. All staff involved in patient care shall complete training for restraint use dependent upon their

position. Staff involved in restraint application must be able to demonstrate competency in the application of restraints, assessment and providing care for a patient in a restraint.

B. Education shall be completed during initial orientation to the facility and on a yearly basis. Education shall include the following as appropriate for job description:

1. Techniques to identify staff and patient behaviors, events and environmental factors that may trigger restraint/seclusion use.
2. Use of non-physical, alternative interventions.
3. Choosing least restrictive interventions based on an individualized assessment of the patient's medical, behavioral status or conduct.
4. Safe application and use of all types of restraints used at MSL including training in how to recognize and respond to signs of physical and psychological distress and how to implement de-escalation techniques if at all possible.
5. Identification of specific behavioral changes that indicate restraint use is no longer necessary.
6. Monitoring of physical and psychological well-being of the patient.
7. Certification in cardiopulmonary resuscitation/Automated External Defibrillator (CPR/AED) and associated first aid shall be completed, and recertified every other year.
8. As needed education for implementation of new restraints/restraint alternatives.

VIII. **REPORTING REQUIREMENTS** :

A. Death reporting requirements shall occur as outlined per center for Medicare and Medicaid (CMS) through the Clinical Quality Department. Documentation of this reporting shall be kept with the medical record.

B. The following information must be reported to CMS:

1. Deaths that occurs while a patient is in restraint/seclusion
2. Deaths that occurs within 24 hours after the patient has been removed from restraint/ seclusion. Note: (For 1 and 2, omit those in soft wrist restraints*)
3. Deaths that occur within 1 week after restraint or seclusion where use of restraint/ seclusion contributed directly to patient's death.

IX. **NOTIFICATION PROCEDURE**

A. Each death must be reported to Center for Medicare and Medicaid (CMS) by completing the electronic form no later than the close of business the next business day following knowledge of a patient's death
Hospitals will be able to insert the Uniform Resource Locator (URL) below into any browser and click to access the electronic Form CMS-10455.
https://restraintdeathreport.gov1.qualtrics.com/jfe/form/SV_5pXmjIw2WAzto8J
The hospital must complete sections A-D of the electronic Form CMS-10455.

B. *For those in soft wrist restraints, maintain a log so that CMS can view if requested. Log is located in Nursing Health Information Services (HIS) Directors/CMS Restraints/2 Point Restraint Death Log.

X. **INFORMATION TO BE FURNISHED**

1. Section A: Hospital Information

- Document the complete name of hospital, Claim Control Number (CCN#), and full address. Use

the legal name of the hospital that is used on the facility's enrollment form (Form CMS- 855A).

- Document the name of the person filing the Form CMS-10455 and include their title, contact information, phone number, and email address.

2. Section B: Patient Information
    - List the patient's name and date of birth (DOB).
    - List the medical diagnosis(es) and include psychiatric diagnosis(es), if applicable.
    - List the date of the patient's admission or presentation for care.
    - List the date and time of death.
    - Condition of the patient leading to death

    In the text box, document health condition(s) leading, causing, or contributing to death such as hypoxia, hypovolemia, hemorrhage, sepsis, kidney failure, dehydration, infection, temperature elevation, hypoglycemia, electrolyte imbalance, probable drug interaction, etc. as per 42 CFR 482.13(e)10.

    - Condition(s) leading, causing, contributing to death - This should be the physician's best medical opinion to include any contributing factors leading to the death.
    - A condition may be listed as "probable" even if it has not been definitively diagnosed. (Cardiac failure or respiratory arrest is not a sufficient answer to this question).
    - Condition of a patient who is restrained must be monitored.
    - Mortality Review to be completed if applicable per your state requirements – indicate Yes or No.
    - Report Submission - The date and time that the Form CMS-10455 report was submitted to CMS must be documented in the patient's medical record. Indicate if this has been documented.
3. Section C: Restraint Information (Part 1)
    - For restraint and seclusion definitions and death reporting requirements, refer to CMS State Operations Manual (SOM), Appendix A, 42 CFR 482.13(e) Standard: Restraint and Seclusion and 42 CFR 482.13(g) Standard: Death Reporting Requirements: Hospitals must report deaths associated with the use of seclusion or restraint. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

      The hospital must select one of the following to indicate when the patient's death occurred:

        - While in restraint, seclusion, or both
        - Within 24 hours of the removal of restraint, seclusion, or both
        - Within 1 week (7 days), where the use of restraint, seclusion, or both is reasonable to assume contributed to the patient's death. If the use of restraint or seclusion was not a factor in the patient's death (i.e.: no falls, aspiration, became injured by self or others, entanglement, etc.) and the patients' death occurred 2-7 days after the removal of the restraint, the hospital would not be required to report the death. However, if the use of the restraint or seclusion was a factor (i.e. while being placed in restraint or seclusion or while in restraint, or seclusion, the patient fell, became entangled, became injured by self or others, aspirated, etc.) and the death occurred 2-7 days after the use of restraint, seclusion, or both, the hospital would be required to report the death.
4. Section D: Restraint Information (Part II)

- The hospital must document in the text box titled: Reason(s) for Restraint/Seclusion Use, the circumstances leading up to the use of restraint, seclusion, or both. Examples include: patient behavior (e.g. kicking staff, using threatening language, pulling tubes out, moving during a procedure, sliding out of chair), alternative interventions attempted (e.g. sitters in the room, removing underlying causes of agitation or confusion), etc.
  The hospital must document in the text box titled: Circumstances Surrounding Death, the circumstances or events leading up to the death of the patient and describe how restraint and/or seclusion were associated with the death. Examples include: positioning of the patient (e.g. prone, supine), effect of the patient prior to death (e.g. unresponsive, agitate, verbal, non-verbal), medications administered minutes prior (e.g. side effects, reactions), location within the hospital (e.g. in the hallway, in a private room, in a chair, in bed, on the floor), etc.
- Document the restraint and/or seclusion order details.
- Date and Time restraint and/or seclusion were applied.
- Date and Time the patient was last monitored and/or assessed.
- Total length of time restraint and/or seclusion were applied.
- For drug(s) used as a restraint:
- List the drug name, drug dose, and time drug was administered (for ALL doses). When a combination of drugs was used that resulted in drugs used as a restraint, enter this information for each drug.
- Document if the restraint and/or seclusion were used as an intervention for violent behavior.
  If NO – Form CMS-10455 documentation is complete at this point. Submit. If YES -
- Indicate if the face-to–face evaluation was completed and documented.
- Indicate the date and time the face-to-face evaluation was completed.
- Indicate if the order was renewed at required intervals (age dependent), if applicable.
- If simultaneous restraint and seclusion were ordered, describe in the text box the continuous monitoring method(s) that were used to monitor the patient. (i.e.: 1:1 continuous staff monitoring, use of 1:1 staff, as well as video monitoring, etc.).

Hospital documentation stops here. Submit. Document in patient's medical record. Form CMS-10455 will automatically send to the respective CMS Locations for review.

XI. **RESPONSIBILITY**

Clinical Quality staff has been assigned the responsibility of checking the Daily Death Report every Monday through Friday (except Holidays).

XII. **GENERAL**

Every morning the Daily Death Report is emailed.

1. If the patient had restraints that fit the guidelines, then pull up the chart in the electronic medical record (EMR) to find the date of birth, admitting diagnosis, date of admission, date, time and cause of death.
2. Staff must document the date and time that death was reported to CMS on the appropriate form in the EMR.
3. Screen all deaths for any quality issues, if found, notify the Clinical Quality Administrative Director.

Attachments

No Attachments

Approval Signatures

Approver	Date
Laura Hamid: Support Coordinator IV - PCS	09/2020
Jill Trosin: Vice President	09/2020
Diane Wollam: Administrative Director, RN	09/2020
Mynde Stoncheck: Director, RN	09/2020
Darren Morr: Nursing Supervisor, RN	09/2020