SCOPE
Maple Grove Hospital (MGH)
North Memorial Health (NMH)

PURPOSE
To guide appropriate and safe management of patients who are restrained and/or in seclusion.

DEFINITIONS
Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of the patient to move his/her arms, legs, body or head freely. An object may be a restraint by functional definition—a functional definition does not name each device and situation that can be used to inhibit an individual's movement. Examples:

- Devices which are considered restraint include, but are not limited to: padded mitts, vest, soft extremity, 4 side rails, and Twice-As-Tough cuffs.
- A drug or medication 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.

Seclusion: Involuntary confinement of a person 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 is physically intervening to prevent the patient from leaving the room or areas is considered seclusion. Seclusion can 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. It is used in the Emergency Departments and Psychiatric & Integrative Care Unit (NMH).

Non-Violent or Non-Self-Destructive Restraint Use: Restraint used to manage behaviors which interfere with medical/surgical healing. For example, the patient may be trying to pull out lines or tubes and less-restrictive methods or alternative measures have not worked.

Violent or Self-Destructive Restraint Use: Restraint used to manage behaviors which are unanticipated, severely aggressive or destructive behavior placing the patient or others in
imminent risk of harming themselves or others, and non-physical intervention has not been effective.

**Alternative Measures:** Interventions taken to modify the environment, enhance interpersonal interactions, or provide treatment in efforts to minimize or eliminate the behaviors/problems which place the patient at risk.

**Episode:** The time when the restraint is initially applied until the time all restraints are discontinued. It is the period from **START** to **DISCONTINUED** in Epic documentation. There may be multiple orders within an episode.

**Time Out:** An intervention in which the patient consents to be alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Time Outs are not used at MGH. Time Outs are used on the Psychiatric & Integrative Care Unit (NMH).

**Therapeutic Hold/Physically holding:** Holding a patient in a manner that restricts the patient’s movement against his/her will is considered a restraint, including therapeutic holds. Physically holding a patient for the purpose of conducting routine physical examinations or tests is not considered restraint.

In certain circumstances, a patient may consent to an injection or procedure, but may not be able to hold still for an injection, or cooperate with a procedure. In such circumstances, and at the patient’s request, staff may “hold” the patient in order to safely administer an injection (or obtain a blood sample, or insert an intravenous line, if applicable) or to conduct a procedure. This is not considered restraint.

**Prolonged Restraint:** If restraints are used on a patient for more than a certain time:
Forty eight (48) hours is considered a prolonged restraint for non-violent restraint. Twenty four (24) hours is considered a prolonged restraint for violent restraint. A patient being in prolonged restraint triggers the interdisciplinary care team to analyze safe use and alternatives, problem solving for better options to minimize restraint use.

**POLICY**
All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients also have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

A comprehensive assessment of the patient must determine that the risks of using the restraint or seclusion are outweighed by the risk of not using the restraint or seclusion. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
A. Non-physical techniques are the preferred intervention in the management of behaviors and restraint are employed only when non-physical interactions are ineffective or not viable.

B. A request from a patient or family member for the application of a restraint which they would consider to be beneficial is not a sufficient basis for the use of a restraint intervention. Whether restraint or seclusion is used involuntarily or voluntarily, the standard applies.

C. Alternatives to restraint are always considered before restraints are used. Because of the risks and consequences of use, staff will use the least restrictive, safest and most effective method(s) to protect the patient, staff member, or others from harm. At all times staff will protect the patient and preserve their rights, dignity and well-being. Staff will address the unique needs/risks of vulnerable patients such as the pediatric and cognitively or physically impaired (patient population).

D. The behavior of the patient triggers the restraint type not the location of use (i.e., non-violent or non-self-destructive versus violent or self-destructive), and the use of restraint must be in accordance with a written modification to the patient’s plan of care.

E. All restraint or seclusion use is documented in Epic. Documentation includes:
   1. Face-to-face medical and behavioral evaluation (violent restraint use)
   2. Order
   3. Description of patient’s behavior and interventions used
   4. Alternatives or other less restrictive interventions
   5. Patients’ condition or symptom(s) that warranted the use of restraint or seclusion
   6. Patients’ response to intervention(s) used, including rationale for continued use of the intervention.
   7. Modification of plan of care

F. Physician orders are required with every restraint use and must be obtained within 60 minutes of the initial application of restraint. Standing Orders or PRN orders are not acceptable.

G. The attending physician must be consulted as soon as possible if restraint is not ordered by the patient’s attending physician. The consultation can occur via phone.

H. If restraint or seclusion is discontinued before the original order expires, the order is no longer valid. If behavior re-escalates, a new order is needed and new application is started.

I. Restraint use is to be ended at the earliest possible time. Patients may be released before the order expires based on RN or MD assessment.

J. MD orders for non-violent, non-self-destructive restraint use:
   1. If an RN implements emergency initiation of restraint, a physician order is required.
   2. Individual physician orders for non-violent restraint are required every calendar day.

K. MD orders for violent, self-destructive restraint use is as follows:
   1. A MD initial order is obtained within 60 minutes
2. Orders are time-limited. Maximum length of original order is age-dependent
   a) 18 years and older -- 4 Hours
   b) Age 9 – 17 years -- 2 Hours
   c) Age 0 - 8 years -- 1 Hour
3. Each order may be renewed with the following limits up to a total of 24 hours:
   a) 18 years and older -- 4 Hours
   b) Age 9 – 17 years -- 2 Hours
   c) Age 0 - 8 years -- 1 Hour
4. The original order for violent restraint maybe renewed within the above time limits
   up to a total of 24 hours. After the original order expires, a physician must see
   and assess the patient before issuing a new order.
L. Physicians conduct face-face assessment when restraint is used to manage violent
   behavior. These findings are documented in patient record.
   1. Non-Violent use
      a) Within 24 hours of initiation
   2. Violent, self-destructive restraint use
      a) Within one (1) hour of initial restraint application. MD responsibility
         includes: an evaluation of the patient's immediate situation; patient's
         reaction to the intervention, patient's medical and behavioral
         condition; need to continue or terminate the restraint.
      b) The face-to-face evaluation includes both a physical and behavioral
         assessment of the patient. An evaluation of the patient’s medical
         condition would include systems assessment, behavioral assessment,
         as well as review of the patient’s history, drugs and medication, most
         recent lab results, etc. The purpose is to complete a comprehensive
         review of the patient’s condition to determine if other factors, such as
         drugs or medication interactions, electrolyte imbalances, hypoxia,
         sepsis, etc. are contributing to the patient’s violent or self-destructive
         behavior.
      c) If a patient's violent or self-destructive behavior is resolved and the
         restraint is discontinued before the MD arrives to perform the one
         hour face-to-face evaluation, the MD is still required to see the patient
         one hour after the initiation of the intervention. Ending the intervention
         prior to the 1-hour point does not mean that the mandated
         assessment and consultation are no longer necessary.
      d) A face to face re-assessment by the MD is required for continuous
         use of violent restraint when the original order expires (e.g. Use
         longer than 24 hours). That is, the original order may only be renewed
         within the time limits up to a total of 24 hours. The MD must physically
         re-assess the patient before issuing the new order.
M. The RN is responsible for patient assessment, implementing alternatives, monitoring
   patient safety and modifying the plan of care. Assessment content includes:
   1. Vital Signs
2. Circulation
3. Hydration & nutrition needs
4. Elimination needs
5. Level of distress and agitation
6. Mental Status
7. Cognitive functioning
8. Skin integrity
9. Range of motion.

N. The RN may delegate components of restraint monitoring to the trained, non-licensed staff including vital signs, hydration and circulation, skin integrity, patient’s level of distress and general care needs such as eating, hydration, toileting and ROM. Monitoring is accomplished by observation, interaction with the patient, or direct examination of the patient.

O. Non-violent restraint assessment is by the RN and is completed every two hours. Assessment is completed to determine the patient’s physical and emotional safety; changes in patient behavior or clinical condition needed to initiate removal of restraint; whether less restrictive methods are possible and whether the restraint is appropriately applied or to be removed; direct observation by direct care staff to ensure safety and dignity, including restraint correction application. The frequency of assessment may be more frequent based on patient condition or need as per RN assessment or MD directive.

P. Violent restraint assessment and monitoring is on-going by the RN or trained, non-licensed staff. At the earliest appropriate time, staff inform patient of rationale for restraint or seclusion and behavioral criteria for discontinuation (as per order). Frequency of monitoring is as listed below and maybe more frequent based on patient condition or need as per RN or MD directive:
   1. Upon initiation and every 15 minutes, patient’s assessed for:
      a) Meeting behavioral discontinuation criteria
   2. Every two hours:
      a) Nutrition/hydration needs
      b) Circulation
      c) CMS
      d) Toileting
      e) Physical and psychological status; comfort

Q. If restraints and seclusion are used simultaneously, one-to-one observation is required with an assigned, trained staff member in constant attendance or continual monitoring (NMH only).

R. Restraint are applied, monitored and removed by qualified staff.
   1. Training documentation
      a) Staff records reflect training and demonstration of competency were successfully completed.
   2. Trainer requirements
      a) Individuals providing staff training are qualified as evidenced by
education, training and experience in techniques used to address patients behavior,

3. Staff training requirements
   a) Education is required for staff with direct care responsibility prior to the application of any restraint or seclusion, as part of orientation and subsequently on a yearly basis.
   b) Staff is trained and demonstrate competency in the application of restraint, monitoring, assessment and providing care for a patient in restraint or seclusion.
   c) Appropriate staff providing direct patient care have education, training and demonstrated knowledge based on the specific needs of the patient population in at least the following:
      i. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion
      ii. The use of nonphysical intervention skills
      iii. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition
      iv. The safe application and use of all types of restraint or seclusions or used in the applicable area, including training in how to recognize and respond to signs of physical and psychological distress (e.g. positional asphyxia)
      v. Clinical identification of specific behavioral changes that indicate restraint or seclusion or seclusion is no longer necessary
      vi. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, and vital signs.
      vii. Emergency response system (e.g. Rapid Response Team)
   d) MD ordering restraint or seclusion has a working knowledge of restraint policy. MD/provider frequency of training is upon initial privileging and at the time of re-credentialing.

S. Patient and family involvement and education is critical to prevention of restraint use.
   Discussions regarding restraint prevention and use are held with patient, and/or family, as appropriate. Family is notified of restraint use as patient permits.

T. When conflict develops with staff and/or family in the management of patient behavior and restraint, any staff member should consult with their area leader(s) or refer to Chain of Command.

U. Deaths associated with use of restraint or seclusion are reported to Clinical Effectiveness (MGH) or Risk Management (NMH) immediately so required reports can be made to regulatory agencies (i.e. CMS). Date and time the death is reported to CMS
will be documented in EPIC.

V. MGH collects, analyzes and evaluates aggregate restraint or seclusion data on all episodes and reports to the Quality Assurance and Performance Improvement (QAPI) Committee.

POLICY EXCLUSIONS
This policy does not apply to:
A. Devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for:
   1. purpose of conducting routine physical examination or tests, or
   2. protect the patient from falling out of bed, or
   3. Permit the patient to participate in activities without the risk of physical harm.

B. Age or developmentally appropriate protective safety intervention (e.g. raised crib rails, crib covers).
C. 4-siderails when used to prevent the patient from falling off of a stretcher, when recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds.
D. Picking up, redirecting or holding an infant, toddler or pre-school aged child to comfort them.
E. Forensic restrictions imposed by correction authorities for security purposes.

TABLE OF REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of Change(s)</th>
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<tbody>
<tr>
<td>March 2015</td>
<td>Policy became a system policy. Used MGH policy as it was updated with current CMS requirements. Added definition for “episode” and “prolonged restraint”. Clarified length of time that an order must be obtained by and who can order a restraint along with expectation to actually discontinue order when restraints discontinued. Added reporting actions should a death be associated with use of restraint. Removed attachment - algorithm from MGH version.</td>
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<tr>
<td>July 2015</td>
<td>Updated policy to reflect standards by changing the hourly rounding observation to every 2 hour assessment and removing every 2 hour vital signs and 4 hour face to face for violent restraints which is not required based on the standards.</td>
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<tr>
<td>October 2015</td>
<td>Added more clarity around the expectations for the timing of obtaining initial order and during emergent initiation of restraint. Cleaned up who can order restraint or seclusion.</td>
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<tr>
<td>February 2016</td>
<td>Under education, changed “periodic” to “yearly”.</td>
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