UNIVERSITY of VIRGINIA HEALTH SYSTEM

Clinical Staff Executive Committee

MEDICAL CENTER POLICY NO. 0159

A. SUBJECT: Restraint and Seclusion of Patients

B. EFFECTIVE DATE: February 1, 2014 (R)

C. POLICY:

All patients 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. The University of Virginia Medical Center is committed to minimizing the use of restraint or seclusion; therefore the hospital will limit its use of restraint to only clinically appropriate and adequately justified situations. Restraint or seclusion will only be imposed to ensure the immediate physical safety of the patient, a staff member, or others. Staff will assess and monitor the patient's condition on an ongoing basis to ensure that the restraint is discontinued at the earliest possible time, regardless of the length of time identified in the order. An individualized patient assessment and re-evaluation shall be used to determine that the need for restraint or seclusion is no longer present, or that the patient's needs can be addressed using less restrictive methods. This policy provides a standard of practice in the use of restraint and seclusion to preserve patient's safety, rights, dignity and well-being, regardless of the patient's location within the Medical Center.

D. DEFINITIONS[1]

1. Restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. (See **Attachment A** for exceptions from and examples of restraints.)

2. Seclusion is the involuntary confinement of a patient **alone** in a room or an area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior. The use of seclusion at the University of Virginia Medical Center is limited to designated rooms on the 5 East Psychiatric Unit. The combined use of restraint and seclusion at the same time is not permitted. (See **Attachment A** for exceptions from and examples of seclusion.)

3. Medication used as a restraint is a medication or drug when it is used to manage the patient's behavior or restrict the patient's freedom of movement and **is not** a standard treatment or dosage for the patient's condition.[2]

[1] Centers for Medicare and Medicaid Services (CMS), Hospital Conditions of Participation. §482.13.
[2] Criteria used to determine whether the use of a medication is standard treatment or dosage for the patient's condition includes any of the following: a) The medication is used within the pharmaceutical parameters approved

4. Law Enforcement Devices such as handcuffs, manacles, shackles and other chain-type restraint devices applied and monitored by law enforcement are NOT healthcare restraint-related interventions. Law enforcement officers are responsible for monitoring and maintaining custody of the patient (their prisoner) in these devices. These devices should not prevent the provision of care, treatment and services required to meet the patient's needs. (See Medical Center Policy No. 0192 "Medical Treatment of Prisoners".)

5. Physical Holding, including holding in a manner that restricts the patient's movement against the patient's will, **is** considered a restraint. This includes holds commonly referred to as "therapeutic holds". Physically holding a patient during a forced psychotropic medication administration **or for other types of forced procedures** is considered a restraint.

6. Mechanical Support that is used to achieve proper body position, balance, or alignment in order to allow greater freedom of mobility than would be possible without the use of such a mechanical support **is not** considered a restraint. (See **Attachment A**.)

7. Restraint for Management of Non-Violent or Non Self-Destructive Behavior is the physical restraint used when a patient's behavior interferes with ordered treatment. The primary reason for use directly supports medical healing, (i.e., patient is pulling/removing dressings and/or tubes and lines thus disrupting medical treatment).

8. Restraint for Management of Violent or Self-Destructive Behavior is the restriction of patient movement for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.[3]

E. PROCEDURE:

1. Patient Rights

a. Patient rights, dignity and well-being are protected when restrained. Four specific items to be considered in regard to patients who are restrained include:

i. Respect for the patient as an individual;

ii. Protection of the patient's modesty, privacy, and comfort;

iii. Ensuring that the patient is still able to receive and participate in care;

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by the Food and Drug Administration and the manufacturer for the indications it is manufactured and labeled to address, including listed dosage parameters; b) The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization; c) 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 LIP's knowledge of that patient's excepted and actual response to a medication; d) The expectation that the standard use of medications 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.

[3]Use of restraints for patients receiving care and treatment on the inpatient psychiatry units is governed by the "Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Dept. of Behavioral Health and Development Services".

iv. Safety and cleanliness of the environment.

b. The registered nurse shall explain the reason(s) for restraint use to the patient and care partner, family, or legally authorized representative[4] of the patient.

i. This shall include an explanation that the restraint will be discontinued as soon as the behavior necessitating the restraint has been resolved and no other behavior(s) is evident that indicates the need for continuation of the restraint.

ii. Education of care partner, family or legally authorized representative may facilitate their assistance in working with the patient to reduce the need for restraint.

c. The patient has a right to be free of restraint and refuse medications unless a court has ordered medication treatment (see Medical Center Policy No. 0140 "Judicial Treatment Orders") or under other circumstances as described in Medical Center Policy No. 0024 "Informed Decision Making".

d. 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.

e. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

f. The Psychiatric Service shall comply with rules and regulations to assure the rights of individuals receiving services from providers licensed, funded, or operated by the Department of Behavioral Health and Developmental Services, both of which have been promulgated by the Virginia Department of Behavioral Health and Developmental Services and with all other applicable federal and state laws. Policies developed by the Psychiatric Service address the use of restraint and seclusion in a manner that complies with all such requirements.

2. Alternatives

One or more alternatives (less restrictive interventions) will be used or considered to prevent the use of restraint. Restraints or seclusion may only be used when alternatives have been determined to be ineffective. (See **Attachment B** for a list of frequently used alternatives.)

3. Indications

a. The decision to use a restraint is always based on a comprehensive individualized assessment of the patient's current condition and specific situation.

b. Restraint of the **Non-Violent or Non-Self Destructive Patient** is indicated by:

- Confusion
- Disorientation
- Delirium

[4] "Legally authorized representative" has the same meaning as such terms as "legal representative", "patient's authorized agent", "healthcare agent", and "surrogate decision maker" appearing in other Medical Center policies.

- Cognitive impairment
- Inability to follow commands
- Lack of awareness of potential harm to self

AND at least one of the following:

- Severe agitation that would pose an imminent threat that the patient will extubate him/herself, or remove other invasive device(s) necessary for medical management;
- Previous successful self-extubation or attempt;
- Previous successful removal of medical device or attempt.

c. Restraint of the **Violent and/or Self Destructive Patient** is indicated when:

- Violent or self-destructive behavior jeopardizes the immediate physical safety of the patient, a staff member or others.

4. Initiation

a. Restraints or seclusion will be initiated upon the order of the licensed independent practitioner (LIP)[5] who is responsible for the ongoing care of the patient, **OR**

b. In an emergency, by a registered nurse who has received focused education (See **Attachment C**). In these emergency application situations, the registered nurse shall immediately notify the LIP who is responsible for the patient and obtain an order, either during the emergency application or immediately (within a few minutes) after the restraint is initiated.

c. Each type of restraint initiated shall be selected by determining the least restrictive method needed to protect the patient, staff or others from harm.

d. The following devices, listed in order of least to most restrictive, are available at the Medical Center. An asterisk (*) denotes a device that is not always considered a restraint. (See **Attachment A** for exceptions)

i. Mitts*
   a) Adult peekaboo
   b) Hand control child
ii. Four side rails*
iii. Elbow Splint* (Adult and Pediatric)
iv. Cloth roll belt
v. Enclosure beds
vi. Soft cloth restraint limb holder quick release
vii. Cuffs wrist and ankle connect lock bed
viii. Cuffs wrist and ankle connect lock stretcher
ix. Cuffs wrist and ankle non-locking (Twice as Tough, “TAT”)

[5] For the purpose of this policy (LIP) Licensed Independent Practitioner includes physicians, nurse practitioners and physicians’ assistants.

x. Cuffs wrist and ankle locking
xi. Physical holds
xii. A combination of restraints may be used, if necessary.

5. Restraint Orders

a. As needed (PRN), standing, or protocol orders for restraint shall **NOT** be used.

b. Restraint or seclusion that is discontinued and then re-started under the same order constitutes a PRN use of a restraint and is therefore prohibited. A temporary, directly-supervised release that occurs for the purpose of providing patient care is not considered a discontinuation or "trial release" of the restraint as long as the patient remains under direct staff supervision/presence.

c. If the restraint is ordered by an LIP other than the attending physician, that LIP shall consult the attending physician as soon as possible and the consultation shall be documented within 24 hours of the restraint order.

d. Restraint orders for **Non-Violent and Non-Self Destructive** patients shall remain in effect until the patient's behavior is determined to no longer warrant the use of restraints, and a new order must be entered **each calendar day.**

i. The order for restraint(s) shall include:
   a) The clinical justification for restraint
   b) The specific time period during which the ord**e**r is valid
   c) The type(s) of restraint(s) to be used.

ii. Continuation of the need of restraint beyond **one calendar day** requires a **new** order.

iii. The LIP shall see and assess the patient each day and determine whether the need for restraint continues. If the patient's condition and behavior(s) continues to warrant the restraint, an order is required for each calendar day.

e. Restraint orders for **Violent and/or Self-Destructive** patients shall require a **face-to-face** evaluation of the patient by the LIP responsible for the care of the patient. The LIP shall perform and document a face-to-face evaluation of the patient's physical and psychological status within **one hour** of the initiation of the restraint.

i. If physical holding for forced medication is necessary with a violent patient, the one hour face-to-face evaluation also applies.

ii. If a patient's violent or self-destructive behavior resolves and the restraint or seclusion is discontinued before the LIP arrives to perform the one hour face-to-face evaluation, the LIP is still required to see the patient face-to-face and conduct the evaluation within one hour after the initiation of the restraint/seclusion.

iii. LIPs will receive education for performance and documentation of the one-hour face-to-face evaluation as specified in **Attachment C**.

iv. The in-person (face-to-face) evaluation, conducted within **one hour** of the initiation of restraint for the management of violent or self-destructive behavior shall include the following:
   a) An evaluation of the patient's immediate situation;
   b) The patient's reaction to the intervention;
   c) The patient's medical and behavioral condition;
   d) The need to continue or terminate the restraint.

v. The order for restraint(s) shall include:
   a) The clinical justification for restraint;
   b) The specific time period during which the order is valid;
   c) The type(s) of restraint(s) to be used.

vi. The order shall remain in effect until the patient's behavior or situation is determined to no longer require the use of the restraint, but no longer than:
   a) 4 hours for adults (18 years of age or older);
   b) 2 hours for children and adolescents (9 to 17 years of age);
   c) 1 hour for children (8 years of age or younger).

vii. The order may be renewed for a maximum of 24 consecutive hours, in the durations specified in Section E.5.e.vi above, if indication for restraint is assessed to be present.

When the original order is about to expire, a registered nurse will, if indicated, contact the LIP, report the results of his or her most recent assessment and request that the original order be renewed (not to exceed the time limits stated above).

viii. Continuation of the restraint for longer than 24 consecutive hours shall be based on an in-person assessment by the LIP responsible for the patient's care, and if the determination that the need for the restraint continues, then a **NEW** order shall be written.

6. Application

a. Oversight of the application of restraints shall be the responsibility of the registered nurse with the assistance of additional trained personnel as needed. Restraint(s) shall be applied maintaining proper body alignment and without causing undue physical discomfort to the patient.

b. In addition to regular assessment, the registered nurse will consider the age and any physical or cognitive impairments of the patient and trauma history before applying the restraint(s).

c. The least restrictive restraint shall be utilized. There shall be an adequate number of staff to safely restrain the patient.

d. The use of 4 side rails shall be considered a restraint, EXCEPT when using a therapeutic bed or stretcher. (See UVA Specialty Beds Resource for Side Rail Requirements for Function/Patient Safety per Manufacturer Recommendations.)

e. Patient Positioning

i. A patient shall be placed in a position that allows airway access and does not compromise respiration.

ii. A patient placed with one arm overhead may only have one arm at a time placed over the head. The patient must be repositioned at least every 2 hours and the same arm may not be overhead more than 2 consecutive hours at a time.

iii. A face-down position **shall not be used** for the purpose of restraint unless:
   a) There is a specified preference and no psychological or medical contraindications to its use; or
   b) There is an overriding psychological or medical justification for its use, which shall be documented.

f. Application of Four-Point Restraint:

i. There shall be a minimum of three, and preferably five, staff members present when placing a patient in four-point restraints (one staff member for each limb and one to give directions and/or hold the patient's head).

ii. The patient shall be positioned close to the foot of the bed to prevent him/her from tipping the bed over or being able to hit the back of his/her head on the headboard.

iii. Each restraint strap with cuffs or anklets shall be positioned on the bed in alignment with the patient's extremities.

iv. The restraint straps shall be secured to a section of the furniture/bed frame that moves vertically when the patient's bed position is adjusted (e.g. hooks under bed's mattress platform).

v. When applying 4-point restraints to a female patient, a female staff member shall be present.

7. Notification of Unit Manager

The Unit Manager or Nursing Supervisor (during off hours) will be notified of any patient requiring 4-point restraints, and of all patients restrained or secluded for violent and/or self-destructive behavior, as soon as possible and daily thereafter.

8. Monitoring Frequency and Parameters

a. The condition of the patient who is restrained or secluded will be assessed and monitored, and care will be provided by educated staff members who have completed the training specified in **Attachment C**.

b. Monitoring is accomplished by observation, interaction with the patient, or direct examination of the patient by qualified staff.

c. The registered nurse is responsible for reassessing and monitoring the patient in restraints.

i. The registered nurse may delegate components of monitoring to other competent staff members within the scope of their practice or licensure.

ii. The registered nurse is responsible for supervising all delegated monitoring components.

iii. When the Patient Care Assistant (PCA) or Patient Care Technician (PCT) notices a change from the previous monitoring, the registered nurse shall be notified immediately.

d. Immediately after the application of the restraint/seclusion, the patient shall be assessed to ensure that the intervention was safely and correctly applied without undue harm or pain to the patient.

e. The frequency of assessment, monitoring, and care shall be individualized, within the framework of established minimums, taking into consideration the patient's condition, cognitive status, and risks associated with the type of restraint chosen.

f. Staff performing, monitoring and caring for patient in restraints shall be trained to immediately notify the registered nurse of any of the following observations. The registered nurse will determine if immediate removal and/or other intervention is indicated.

i. Cyanosis of the limb(s) or any body part
ii. Improper body alignment
iii. Skin chafing at restraint site
iv. Signs of deteriorating physical condition and/or mental status, (e.g. confusion, disorientation, memory problems or respiratory distress)

g. A restrained patient who travels off the nursing unit (e.g., for diagnostic procedures) shall be accompanied by staff trained in the management of restraints.

h. The following frequencies for assessment, monitoring and care are based on minimum requirements for all restrained and secluded patients.

Monitoring Frequency and Responsibility for Non-violent and Non Self-Destructive Patients				
Type of Restraint	**Assessment** 1. Need for continued restraint 2. Physical status 3. Level of distress, agitation, mental status, emotional status & cognitive functioning	**Monitoring** 1. Mental status 2. Type, location & appropriate application of restraint 3. Skin circulation & appearance 4. Mobility & sensation 5. Signs of injury from restraint	**Care Needs** 1. Fluid and food 2. Repositioning & range of motion 3. Toileting 4. Personal hygiene 5. Safety & comfort measures	**Vital Signs** 1. Pulse & Respiration 2. T/P/R/BP

(SUBJECT: Restraint and Seclusion of Patients)

Monitoring Frequency and Responsibility for Non-violent and Non Self-Destructive Patients				
1 to 3-point soft restraints	RN Q2H at a minimum, and as needed	RN/PCA/PCT Hourly	RN/PCA/PCT Q2H **while patient awake**	RN/PCA/PCT Pulse & respiration **immediately after application**, then T/P/R/BP Q4H or more often based on patient assessment
4-point soft restraints	RN Q2H at a minimum, and as needed	RN/PCA/PCT Q 15 minutes	RN/PCA/PCT Q2H **while patient awake**	RN/PCA/PCT Pulse & respiration **immediately after application**, then T/P/R/BP Q4H or more often based on patient assessment

Monitoring Frequency and Responsibility for Violent and/or Self-Destructive Patients				
Type of Restraint	**Assessment** 1. Need for continued restraint 2. Physical status 3. Level of distress, agitation, mental status, emotional status & cognitive functioning	**Monitoring** 1. Mental status 2. Type, location & appropriate application of restraint 3. Skin appearance & circulation checks 4. Mobility & sensation 5. Signs of injury from restraint	**Care Needs** 1. Fluid and food 2. Repositioning & range of motion 3. Toileting 4. Personal hygiene 5. Safety & comfort measures	**Vital Signs** 1. Pulse & Respiration 2. T/P/R/BP
1 to 3-point soft restraint	RN Q2H at a minimum, and as needed	RN/PCA/PCT Q15 minutes	RN/PCA/PCT Q2H	RN/PCA/PCT Pulse & respiration **immediately after application**, then T/P/R/BP Q4H or more often based on patient assessment
4-point soft restraints	RN Q2H at a minimum, and as needed	RN/PCA/PCT Q15 minutes	RN/PCA/PCT Q2H	RN/PCA/PCT Pulse & respiration **immediately after application**, then T/P/R/BP Q4H or more often based on patient assessment

Monitoring Frequency and Responsibility for Violent and/or Self-Destructive Patients				
Seclusion	RN Q2H at a minimum, and as needed	RN/PCA/PCT Continuous face-to-face monitoring	RN/PCA/PCT Q2H	RN/PCA/PCT Pulse & respiration **immediately after application**, then T/P/R/BP Q4H or more often based on patient assessment
Medication	RN Q15 minutes X 4 (times 1 hour)	RN/PCA/PCT Q15 minutes X 4 (times 1 hour)	RN/PCA/PCT Q1H (times 1 hour)	RN/PCA/PCT Q15 minutes X 4 (times 1 hour)

9. Discontinuation

a. Restraint and seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

b. Restraint and seclusion shall be discontinued by a registered nurse once the behavior(s) or situation(s) that prompted the determined need for restraint/seclusion are assessed to no longer be harmful to the physical safety of the patient, staff members, or others and medical treatment may be accomplished through less restrictive means. The RN will document the date and time the restraint was discontinued.

c. If the restraint or seclusion is discontinued prior to the expiration of the original order, a **new order** must be obtained prior to reinitiating the use of restraint or seclusion.

d. If the restraint or seclusion is discontinued and the same behavior or situation occurs, a **new order** must be obtained by the LIP even if there is time remaining on the previous order.

e. The restraint will be removed when it is assessed that the patient no longer meets the indication for use and presents two or more of the following behaviors:

i. Calm, quiet, normal sleep pattern for patient;
ii. Able to follow instructions;
iii. Absence of impulsive behaviors;
iv. Not attempting to remove tubes/lines/drains/dressings;
v. Not attempting to harm self/others.

f. The removal of the restraint shall be the responsibility of the registered nurse with the assistance of additional trained personnel as needed.

g. Restraints shall be removed gradually (i.e., one extremity at a time) until all extremities are released. A minimum of two staff person under the directions of the registered nurse s is required at the time of the removal of 4-point restraints.

10. Documentation

a. A Licensed Independent Practitioner shall document the following in the restraint order:

i. A description of the patent's behavior;

ii. The patient's condition or symptoms(s) that warranted the use of restraint/seclusion;

iii. The reassessment of the patient regarding the continued need for restraint/seclusion.

b. A Registered Nurse shall document upon initiation of the restraint/seclusion:

i. A description of the patent's behavior;

ii. Any alternatives (less restrictive interventions) used to avoid use of restraint and effectiveness of those methods;

iii. The rationale for use of restraint as assessed by the registered nurse;

iv. Discussion with the patient and/or care partner, family, or legally authorized representative concerning the use of restraints/seclusion;

v. Pulse and respirations immediately following restraint application;

vi. The patient's Plan of Care shall be modified to address patient safety interventions and the monitoring intervals to be implemented.

c. Documentation shall also include:

i. Any injury related to the restraint application;

ii. Date and time of removal of restraints.

d. On-going documentation of assessment, monitoring and care:

i. Assessment, monitoring, and care provided will be based on the frequencies listed above and documented on the *Restraint Flowsheet.* Documentation includes:
   a) Assessment of the patient's physical, mental, emotional status, including identification of triggers which may escalate behavior;
   b) Assessment of the patient's response to the restraint;
   c) Continued need for restraints assessed.

ii. Documentation shall also include:
   a) Type, location and appropriate application of restraint
   b) Skin appearance and circulation checks
   c) Safety and comfort measures
   d) Mobility and sensation
   e) Fluids and nutrition offered
   f) Repositioning and range of motion
   g) Toileting and personal hygiene
   h) Safety and comfort measures

e. Non-Licensed Care Providers (PCAs and PCTs) may document the following based on the above frequencies:
   i. Patient present on unit to monitor
   ii. Mental status
   iii. Type, location and appropriate application of restraint
   iv. Skin appearance and circulation checks
   v. Safety and comfort measures
   vi. Mobility and sensation
   vii. Fluids and nutrition offered
   viii. Repositioning and range of motion
   ix. Toileting and personal hygiene
   x. Safety and comfort measures

11. Reporting Restraint-Related Deaths

a. Every business day, the Patient Safety Office staff shall review all patient deaths to determine:

   i. If the death occurred while the patient was in restraint or seclusion;

   ii. If the death occurred within 24 hours after the patient was removed from restraint or seclusion;

   iii. If death occurred within one week after restraint or seclusion, where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death.[6]

b. The Patient Safety Office shall report the following deaths to the CMS Regional Office by telephone, facsimile, or electronically no later than the close of business on the next business day following knowledge of the patient's death:

   i. Deaths occurring during or within 24 hours of discontinuation of 2-point soft, cloth-like non-rigid wrist restraints used in combination with any other restraint device;

   ii. Deaths associated with the use of other types of wrist restraint, such as 2-point rigid or leather wrist restraints;

   iii. Deaths that occurred with one week after restraint or seclusion, where it is reasonable to assume that the use of restraint/seclusion contributed directly or indirectly to the patient's death, regardless of the type(s) of restraint used on the patient during this time.
   iv. The report shall include the patient's:
      a) Name;
      b) Date of birth;
      c) Date of death;

[6] "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

d) Name of attending physician;
e) Primary diagnosis, cause of death (preliminary, in case a final, official cause of death is not yet available);
f) Type(s) of restraint or seclusion used.

v. The Patient Safety Office staff shall document in the patient's medical record the date and time the death was reported to CMS.

c. When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the Patient Safety office will record the following information in an internal log no later than seven days after the date of death:

i. Patient's name
ii. Date of birth
iii. Date of death
iv. Name of attending physician
v. Medical record number
vi. Primary diagnosis
vii. The Patient Safety Office staff shall document in the patient's medical record the date and time the death was recorded in the internal log.
viii. The log shall be made immediately available to representatives of CMS upon request.

12. Education

a. Designated hospital staff shall receive focused education as appropriate to perform assigned duties under this policy, as outlined in **Attachment C**.

b. Such education shall take place prior to staff being asked to implement the provisions of this policy. Competency will be assessed periodically as indicated in the hospital's annual education plan.

c. The restraint education plan may be revised as needed based on the results of quality assessment and performance improvement activities.

13. Performance Improvement Monitoring

a. The Medical Center shall collect, analyze and evaluate aggregate restraint/seclusion data on all episodes to identify improvement opportunities including:

i. Alternatives to restraint use
ii. Episodes and classification (types) from all care settings, units and/or location by the following:
a) Shift
b) Day of the week each episode was initiated
c) Type of restraint
d) Age of patient
e) Gender of patient
f) Average length of episodes
g) Whether injuries were sustained by patients

(SUBJECT: Restraint and Seclusion of Patients)

h) Periodic observational audits
i) Quarterly percentage of restraint used house wide
j) Other data as defined by the leaders.

b. The findings shall be reported to the Restraint Committee on a monthly basis and to the Quality Committee on a quarterly basis.

SIGNATURE:

Robert S. Gibson, M.D., President, Clinical Staff

R. Edward Howell, CEO, UVA Medical Center

DATE: 11/24/13

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Approved by Quality Committee
Approved by Clinical Staff Executive Committee

(SUBJECT: Restraint and Seclusion of Patients)

ATTACHMENT A
Examples of Restraint and Seclusion
CMS State Operation Manual Interpretive Guidelines June 2013

Device	Not a Restraint	Restraint
Adaptive Devices (Seat belts, lap belts, stretcher chairs, recliners, etc.)	When the patient can easily remove the device (or remove themselves from the device) in the same manner in which it was applied (i.e., unlocking, unlatching, unstrapping).	When the patient cannot easily remove or exit from the device.
Covered Bed	Covered bassinet for infants or covered cribs for toddlers.	When used on adults to keep them from getting out of bed (net bed, tightly tucked sheets limiting patient's movement).
Devices to protect the patient following anesthesia	When used during recovery of anesthesia while in the post anesthesia recovery unit or a critical care unit.	Devices used after the patient has recovered from anesthesia or has been transferred to a different unit.
Four Side Rails	When used for seizure precautions, when on a stretcher, when recovering from anesthesia, or when the patient is sedated or experiencing involuntary movement, when used on a therapeutic bed.	When rails completely surround the patient to prevent the patient from getting out of bed. (See UVA Specialty Beds Resource for Side Rail Requirements for Function/Patient Safety per Manufacturer Recommendations)
Law Enforcement Mechanical Restraint / Forensic Devices (handcuffs, manacles, shackles or other chain-type devices)	Used by law enforcement officials for patient in legal custody	NOT considered a healthcare restraint.
Mechanical Support	When used to achieve proper body position, balance, or alignment for greater freedom of mobility (i.e., orthopedic devices, surgical dressings or bandages, protective helmets, IV arm boards).	If the device is tied down in some fashion to prevent freedom of mobility (i.e., IV arm board tied down or attached to bed).
Mitt	When one or two mitt(s) not tied down. Patient can flex fingers and has access to his/her body.	If tied down or the entire arm is immobilized preventing the patient from having access to his/her body.
Physical Escort	With a "light" touch or grasp during escorting, which a patient can easily remove or escape.	
Physical Holding to Administer Medication or Perform Treatment or Procedure	When patient volunteers to allow the holding (i.e., for support, balance, or assistance).	When force is used to restrict a patient's movement against the patient's will.
Protective or developmentally appropriate devices	Safety devices used for infants, toddler, pre-school children or for developmentally challenged individuals (i.e., stroller with safety belts; seat belts for high chairs, raised crib rails, swing safety belts etc.).	N/A
Secure Sleeve	When used on one of the upper arms to protect tubes, lines, and/or dressings and is not tied down. Patient can flex fingers and has access to his/her body.	If tied down to prevent use of hand, or when both arms are secured in sleeves.

(SUBJECT: Restraint and Seclusion of Patients)

Device	Not a Restraint	Restraint
Sedating Medication	When standard use of a medication to treat the patient's behavior or medical condition, even if given on a PRN basis.	When not a standard use of the medication to treat the patient's medical or behavioral condition.
Standard Practice During a Procedure	Used to maintain position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures.	When not used as a standard part of a procedure.

Definition of Seclusion (42 CFR 482.13(e)(1)(ii)

Not Seclusion	Seclusion
Confinement on a locked unit or ward where the patient is with others.	Confinement in a locked room apart from other patients.
Having a patient agree to confine their movement to a room with an open door.	Physically preventing a patient from leaving an unlocked room.
A "time out" in a secluded (unlocked) location.	Preventing a patient from leaving an unlocked room through intimidation.

(SUBJECT: Restraint and Seclusion of Patients)

ATTACHMENT B
Frequently Used Alternatives to Restraint

1. Physiologic assessment, including a review of laboratory values (e.g., hypoxia, hypoglycemia, electrolyte disturbances) and other diagnostic test results and assessment for withdrawal (including nicotine). Treat accordingly.
2. Pain assessment and intervention.
3. Medication assessment and intervention, including drug effects/interactions.
4. Increase staff observation/rounding.
5. Environmental factors including, but not limited to:
   a. Decreased stimulation
   b. Adequate lighting/night light
   c. Bed in low position
   d. Removal of obstacles
   e. Frequently used items near patient
   f. Decrease environmental noise as much as possible.
6. Up in chair, moved to hallway or moved closer to nurses' station.
7. Bed/chair alarms.
8. Personal care factors including, but not limited to:
   a. Toileting routine
   b. Beverage/food
   c. Pillow or positioning aids at least every two hours
   d. Structured rest periods
   e. Personal grooming items near patient.
9. Assistive devices
   a. Glasses
   b. Hearing aid
   c. Walker
   d. Cane
   e. Well-fitting non-skid footwear.
10. Psychosocial factors
    a. Provide 1:1 interactions
    b. Frequently reorient or redirect patient
    c. Increased family involvement.
11. Wean off ventilator.
12. Remove invasive lines as appropriate.
13. Various diversion activities (e.g., therapy dolls, activity blankets/aprons).
14. Securing lines/tubing along the extremity or over the shoulder to prevent the line/tubing from dangling. Keep IV poles and IV bags out of the patient's field of vision. These measures may reduce visibility of tubing and limit the patient's reach decreasing the tendency to pull at the catheter, tube or line.
15. Use of one secure sleeve or mitt without ties to prevent pulling at tubes and lines.
16. Use of two mitts that are not tied down. Mitts that are tied down are considered a restraint.
17. Cover torso to protect catheters, tubes or lines exiting from patient's midsection.
18. Consider Velcro belts which can be easily removed by patient.

(SUBJECT: Restraint and Seclusion of Patients)

ATTACHMENT C

Restraint and Seclusion Education Plan

LIP	Licensed Independent Practitioners who order restraint or seclusion shall be educated in the requirements of this policy, including the performance and documentation of the one-hour face-to-face evaluation required for the restraint of the Violent and/or Self-Destructive patient, and shall demonstrate a working knowledge of this policy through ongoing compliance. Training shall be documented by the Clinical Staff Office or the Office of Graduate Medical Education utilizing normal processes.
All direct care staff applying and/or monitoring restraint/seclusion (as appropriate to their role): RN/PCA/PCT/ Medical Center Security	All staff designated by the Medical Center as having direct patient care responsibilities, including contract and agency personnel, shall participate in training and demonstrate competencies prior to participating in the application of restraint, implementation of seclusion, monitoring, and assessment of restrained or secluded patients. This competency will be demonstrated during orientation. Periodic training will occur thereafter and will be based on findings from quality assessment and performance improvement data.
RN	1. Techniques to identify patient and staff behaviors, events, and environmental factors that may trigger circumstances that require the use of restraints or seclusion 2. The use of nonphysical, less restrictive, intervention (alternative) skills. 3. Selection of the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition. 4. The safe application and use of all types of restraint used by the staff member, including education in how to recognize and respond to signs of physical and psychological distress (e.g., positional asphyxia). 5. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary. 6. 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. 7. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic re-certification.
PCA/PCT/ Patient Companion	1. The components of monitoring including: mental status; type, location and appropriate application of restraint; skin circulation and appearance; mobility and sensation; hydration/nutrition; toileting; personal hygiene needs; safety and comfort measures. 2. Recognition of signs of physical and psychological distress including: a. Cyanosis of the limbs or any body part b. Improper body alignment c. Chafing or redness of any skin surface d. Incontinence e. Signs of deteriorating physical condition and /or mental status from baseline assessment, (e.g. confusion, disorientation or memory problems, respiratory distress).
External Law Enforcement Officers	Receive restraint education during the orientation process.