
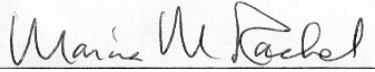


The University Hospitals and Clinics The University of Mississippi Medical Center Jackson, Mississippi	HOSPITAL ADMINISTRATIVE POLICY AND PROCEDURE MANUAL	MANUAL CODE: HADM/R-8
SUBJECT: RESTRAINT AND SECLUSION, USE OF		
Effective Date: 9/88	Review/Revision Date: 10/02, 01/03, 10/04, 03/05, 06/06	PAGE <u>1</u> OF <u>10</u>
PREPARED BY: Restraint Committee	APPROVED BY: David G. Putt, FACHE Interim Chief Executive Officer The University Hospitals and Clinics The University of Mississippi Medical Center  Marcia Rachel, RN, PhD Chief Nursing Officer 	

I. Purpose:

- A. To establish guidelines for the use of restraints and seclusion for the safety of patients and others.
- B. To provide for the safety of patients when it is determined that there is a potential for self-harm or injury to others.
- C. To comply with Centers for Medicare and Medicaid Services (CMS) regulatory statutes and Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards regarding the therapeutic utilization of restraints.

II. Intent:

It shall be the policy of the University Hospitals and Clinics to:

- A. Commit to the reduction of restraint or seclusion use through the implementation of nonphysical interventions (refer to Attachments A and B, **Alternatives to Restraints, Hierarchy of Behaviors-Change Interventions**).
- B. Limit the use of restraint or seclusion to clinically appropriate and adequately justified situations.
- C. Use restraints or seclusion as a last resort.
- D. Use the least restrictive restraint or seclusion for the least amount of time.
- E. Identify any pre-existing Medical condition, physical disabilities or history of sexual or psychological abuse that would place a patient at greater risk during restraint and seclusion.

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III. Policy:

- A. Restraints may be used for the patient in an acute care setting and for managing behavior in an emergency crisis. It excludes handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons.

A voluntary mechanical support used to achieve proper position, balance or alignment is not considered a restraint. A positioning or security device used to maintain position, limit mobility or temporarily immobilize during medical, dental, diagnostic or surgical procedure is not considered a restraint.

- B. The patient's rights, dignity and well-being shall be protected and preserved during the use of restraints or seclusion, e.g. protect modesty with sheets, blankets, or clothing, close curtains to prevent others from viewing patient.

C. Definitions:

1. Appropriately trained personnel – Registered Nurses (RNs), Licensed Practical Nurses (LPNs), mental health technicians (MHTs), psychiatric technicians (PTs), emergency department technicians, escort and nursing assistants (NAs) whose competency to apply and care for patients in restraints or seclusion has been assessed as satisfactory.
2. Behavior management emergency – an unanticipated out burst of violent, severely aggressive or destructive behavior that poses an imminent danger to the patient and/or others.
3. Behavioral Health Services – the Medical Psychiatry Unit and the Behavioral Health Units.
4. Competency in restraints and seclusion – appropriately trained personnel are able to: apply restraints, place patients in seclusion, assess patients in restraints or seclusion and use alternatives to restraints or seclusion.
5. Monitoring – observation, interaction with the patient or related examination of the patient by qualified staff to evaluate the physical and emotional well being of a patient and the continued protection of his or her rights, dignity and safety.

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III. Policy: (cont'd)

6. Reassessment – for purpose of this policy, indicates an assessment of the patient’s physical and emotional needs, review of findings from others assigned to patient’s care; assessment of need for continued restraints or seclusion; patient’s rights, dignity and safety; changes in patient behavior or clinical condition to discontinue use of restraints or seclusion; evaluates the behavior(s) that precipitated the use of restraint or seclusion to determine whether the behavior(s) is/are still present.
7. Restraint, physical – any manual or physical or mechanical device that restricts freedom of movement or normal access to one’s body, materials, or equipment attached or adjacent to the patient’s body that he or she cannot easily remove.
8. Seclusion – the involuntary confinement of a person in a room or an area where a person is physically prevented from leaving for the purpose of regaining self-control.
9. Treating physician – physician who is responsible for the management and care of the patient.

IV. Procedure:

A. PATIENTS WITH BEHAVIOR MANAGEMENT EMERGENCY

1. Assessment:
 - a. At the time of admission or intake, information about the patient will be used to aid in minimizing the use of restraint or seclusion.
 - b. RN performs assessment of patient and believes that situation/patient behavior may escalate into an emergency.
 - c. RN shall use clinical judgment to de-escalate the situation and employ alternatives to restraints or seclusion (Refer to Attachment A, **Alternatives to Restraints** and Attachment B, **Hierarchy of Behavior Change Interventions**).
 - d. If alternatives/interventions are not effective, the RN shall explain the procedure to the patient/family and obtain assistance, if needed, and apply the least restrictive method of restraints or seclusion. (Seclusion is used only in Behavioral Health or Medical Psychiatric settings).
 - 1) Restraints shall be applied in accordance with safe and appropriate restraining techniques

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IV. Procedure: (cont'd)

- and per manufacturer's instructions.
 - 2) Restraints may not be applied as punishment or for staff convenience.
 - e. RN or LPN shall immediately contact the physician to inform him/her that patient has been restrained for a behavior management emergency.
 - f. The physician shall see and evaluate the patient **within one hour after initiation** of restraint or seclusion. Note: He/she must sign verbal order and document face-to-face evaluation. If the physician ordering restraints/seclusion is not the treating physician, he/she shall consult with the treating physician as soon as possible.
 - g. The RN/LPN shall consult with the physician regarding the appropriateness of continued placement of the patient in the acute care setting. If it is determined that transfer to the Medical Psychiatric Unit or the Behavioral Health Unit is in the patient's best interest, notify the appropriate Nurse Manager or the Assistant Director of Nursing after hours and weekends, and then contact the receiving unit.
- 2. Plan/Order
 - a. Obtain physician's verbal or written order within 1 hour of initiation of restraints or seclusion. Order shall specify reason, time limit, type of restraint and placement for restraint or seclusion:
 - 1) up to 4 hours for adults 18 years old or older
 - 2) up to 2 hours for children and adolescents age 9-17 years
 - 3) up to 1 hour for children under age 9 years.
 - b. "PRN" orders are not allowed.
 - c. RN: modify the patient's plan of care to reflect patient behavior and goals.
RN: Document the patient's behavior, interventions, initiation and discontinuance of restraints or seclusion on the:
 - 1) Daily Restraints/Seclusion Flowsheet (See Attachment C)
 - 2) Frequent Observation Record (See Attachment D)
 - d. RN must document in the nurse's notes every 4 hours while patient is restrained or secluded.
 - e. The individual's family (when appropriate) must be notified (as soon as possible) and notification must be documented.

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IV. Procedure: (cont'd)

3. Application

The staff must follow the manufacturer's instructions when applying restraints.

4. Interventions/Monitoring.

- a. Appropriately trained personnel shall monitor and document the following:
 - 1) Continuous in-person observation (Note: after first hour a patient in seclusion may be continuously monitored using both video and audio equipment)
 - a) restraint application – at time of initiation and every 15 minutes
 - b) appearance of skin – every 15 minutes
 - c) circulation, mobility and sensation – every 15 minutes while awake
 - d) range of motion – every 2 hours
repositioning and restraints released – every 2 hours
fluids, nutrition, toilet – every 2 hours while awake, as appropriate for patient
 - e) vital signs – as ordered or minimum of every 8 hours
- b. Aspects of monitoring may be assigned to a mental health technician, nursing assistant or psychiatric technician. He/she shall report abnormal feelings immediately to the RN/LPN. The RN shall assess the patient at least every 2 hours to include the patient's physical and emotional needs, review findings from others assigned to the patient's care and assess the need for continued restraints or seclusion.
- c. Patients held in a physical hold for behavioral health emergencies require a staff person assigned to observe/monitor. (Exception: children held for 30 minutes or less).
- d. The RN will reassess the patient at the end of the time and, if there is need for continued restraint, will contact the physician to obtain a verbal order in the same time increment as the original order.
- e. The physician must conduct an in-person reevaluation and document, for continued restraint or seclusion use, at least every:

8 hours for individuals ages 18 years and older and at least every 4 hours for individuals ages 17 years and younger

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IV. Procedure: (cont'd)

He/she must sign verbal order and document face-to-face evaluation

- f. Nurse Managers and Medical Directors/designees for Medical/Psychiatric Unit and the Adult and Child Behavioral Health Units shall be informed of any instance in which an individual
 - 1) remains in restraints or seclusion for more than 12 hours or
 - 2) experiences 2 or more separate episodes of restraint and/or seclusion of any duration within 12 hours. **Nurse Managers and Medical Director/designee shall be notified every 24 hours if either of the above conditions continue.**

5. Evaluation/Discontinuing restraints or seclusion
 - a. The RN may assess the patient's readiness for early release/discontinuation of restraints or seclusion and is authorized to discontinue restraints or seclusion when appropriate.
 - b. The individual shall participate in a debriefing session with staff following release when appropriate.
 - c. A physician's order is not required for the re-application of a restraint or re-initiation of seclusion provided that:
 - 1) alternative methods were ineffective,
 - 2) restraints or seclusion is applied for the same behavior which generated the order, and
 - 3) the time limit for the order has not been reached.
 - d. The RN will continue to assess the patient after restraint discontinuation for behavior requiring the reapplication of restraints. In the event the order has expired, a new order must be obtained.
 - e. Restraint/seclusion shall be discontinued when ordered by the physician.

6. Documentation:
 - a. RN: initial clinical reason for restraint, alternatives attempted, type of restraint applied, time MD notified and implementation of procedure for behavior management in an emergency, assessment/attendance to patient's physical and emotional needs, patient's response, and continued need for restraints. (Refer to Attachments C and D, **Daily Restraints/Seclusion Flowsheet, Frequent Observation Record**).
Nurse initials indicate that care/actions have been provided

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IV. Procedure: (cont'd)

according to guidelines for specified period of time. RN is to document every 4 hours for continued restraint use.

- b. Documentation must include notification of individual's family (when appropriate), education on behavioral criteria for discontinuation, and assistance with meeting criteria, and an account of debriefing session. Debriefing is used to do the following:
- Identify what led to the incident and what could have been handled differently
 - Ascertain that the patient's physical well-being, psychological comfort, and right to privacy were addressed.
 - Counsel the patient for any trauma that may have resulted from the incident.
 - When indicated, modify the patient's plan for care, treatment, and services.
- c. MD: Time visited patient, restraint order, consultation with treating MD (if ordered MD is not the treating MD), re-assessment/new order (refer to Attachment 5, **Behavioral Management Restraint/Seclusion Order** form).

7. Death:

RN/LPN shall notify the Director of Nursing/Assistant Director of Nursing if a patient dies while he/she is restrained or where it is reasonable to assume that patient's death is a result of restraint or seclusion. The Administrator On Call and the Director of Social Work/designee shall be notified of the death by the Director of Nursing/Assistant Director of Nursing. The Director of Social Work/designee shall report the patient's death to the State Department of Health (CMS's Regional Office) by the next business day.

**B. ACUTE MEDICAL AND SURGICAL CARE
Delirium tremens is considered behavior that may warrant use of Acute Medical Surgical restraints.**

1. Assessment
- a. RN performs assessment of patient and believes that restraint is necessary to:
- 1) temporarily limit patient's mobility until it is medically appropriate (e.g. patient with broken hip who should not attempt to walk).

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IV. Procedure: (cont'd)

- 2) maintain a medical device to prevent its accidental removal.
 - b. RN or LPN shall employ alternatives to restraints (Refer to Attachment A **Alternatives to Restraints**).
 - c. If alternatives are not effective, the RN shall explain the procedure to the patient/family and obtain assistance, if needed, and apply the least restrictive method of restraint available.
 - d. RN or LPN shall contact the physician to obtain an order for restraints.
 - e. RN shall modify the patient's plan of care to reflect the use of restraints and required monitoring. The plan of care shall be updated after restraints are discontinued.
2. Plan/Order
 - a. The physician's verbal order or written order for restraints in acute care setting shall include the reason and time limit up to 24 hours from initiation of restraints.
 - b. The physician shall conduct a face to face evaluation of the patient each calendar day to re-assess the need for restraints, and write a new order, if indicated. He/she must sign verbal order and document face-to-face evaluation
3. Application:

The staff must follow the manufacturer's instructions when applying restraints.
4. Interventions/Monitoring:
 - a. Appropriately trained personnel shall monitor and document the following at least every two hours:
 - 1) Appropriate application of restraint or seclusion
 - 2) Nutrition and hydration
 - 3) Circulation, mobility and sensation in the extremities
 - 4) Range of motion
 - 5) Repositioning and restraint/release
 - 6) Hygiene and elimination status
 - 7) Vital signs as ordered or minimum of every 8 hours
 - 8) Physical and psychological status and comfort, and
 - 9) Readiness for discontinuation of restraint and seclusion

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IV. Procedure: (cont'd)

- b. Aspects of monitoring may be assigned to nursing assistants, psychiatric technicians or mental health technicians. He/she shall report abnormal findings immediately to the RN or LPN. The RN shall assess the patient at least every 2 hours. He/she shall re-assess the patient's physical and emotional needs, review findings from others assigned to the patient's care and assess the need for continued restraints.

5. Evaluation/Discontinuing restraints
 - a. The RN may assess the patient's readiness for early release/discontinuation of restraints and is authorized to discontinue restraints when appropriate.
 - b. A physician's order is not required for the re-application of a restraint provided that:
 - 1) alternative methods were ineffective,
 - 2) restraint is applied for the same behavior which generated the order, and
 - 3) the time limit for the restraint order has not been reached
 - 4) restraint order is obtained for the same increments as the original order up to a total of 24 hours.
 - c. A physician's order is required if the behavior is different or if the order has expired.
 - 1) New order is required when patient is transferred from one unit to another as per Transfer Procedure Policy (Nursing Clinical Policy CL/T-7).
 - d. Restraints shall be discontinued when ordered by the physician.

6. Documentation:
 - a. RN/LPN: Initial clinical reason for restraint, alternatives, type of restraint applied, time MD notified, assessment/attendance to patient's physical and emotional needs, patient's response and continued need for restraints (Refer to Attachment C **Daily Restraint Flowsheet**).
 - b. MD: Restraint Order, re-assessment/new order no less than once each calendar day based on examination of the patient (Refer to Attachment F, **Acute Medical Surgical Restraint Order**)

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IV. Procedure: (cont'd)

D. Death:

RN/LPN shall notify the Director of Nursing/Assistant Director of Nursing if a patient dies while he/she is restrained or where it is reasonable to assume that patient's death is a result of restraint or seclusion. The Administrator On Call and Director of Social Work/designee shall be notified of the death by the Director of Nursing/Assistant Director of Nursing. The Director of Social Work/designee shall report the Patient's death to the State Department of Health (CMS's Regional Office) by the next business day.

- E. Every restraint and seclusion episode is reviewed and data submitted to the PI department for analysis and inclusion into performance improvement outcomes.

V: Attachments:

- A. [Alternatives to Restraints](#)
- B. [Hierarchy of Behavior-Change Interventions](#)
- C. [Daily Restraint Flowsheet – \(Page 1 - 4\)](#)
- D. [Frequent Observation Record](#)
- E. [Behavioral management Restrain/Seclusion Order](#)
- F. [Acute Medical Surgical Restraint Order](#)
- G. [Restraint – Summary Fact Sheet](#)
- H. [Behavioral Restraint/Seclusion Log](#)
- I. [Acute Medical Surgical Restraint Log](#)