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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*

Restraint Use for Non-Violent 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.

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:

A. A restraint is 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.

B. 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.

PERTINENT INFORMATION:

A. Restraints are never used as a punishment to the patient or for the convenience of staff, but are used to assist in the care of the patient, as a means of controlling physical activities, to protect the patient or other's health, safety and still preserve patient dignity, rights, and well-being.

B. Restrictive intervention should only be used when alternatives to care have been considered or attempted and such as physiological care, psychosocial care, activities, environmental manipulation, administrative support and staff education. Patient's rights, dignity and safety shall be maintained.

C. Vulnerable patient populations, such as emergency, pediatric and cognitively or physically limited patients, shall be closely monitored and evaluated according to standards due to increased risks associated with restraint use.

D. The patient's medical record shall show documentation of the less restrictive intervention attempts and reflect the patient's current condition.

E. When restraints are used for behavioral health reasons, refer to the policy on Restraint Use for Behavioral reasons for requirements.

F. Use of a restraint must be discontinued at earliest possible time. Restraint use for violent/aggressive behavior: refer to policy on restraint use for behavioral reasons.

G. All instances of restraint use will be monitored for performance improvement. Data will be reviewed monthly by the unit manager or designee. Any areas falling below the benchmark will have action plans for improvement documented. All of the collected data will be reported quarterly to the Patient Care Committee.

H. Exclusions:

1. Restraint use that is associated with medical, dental, diagnostic or surgical procedure and is based on standard practices for the procedure. Such standard practices are described in protocols and procedures. For example, the policy does not apply to medical immobilization in the form of surgical positioning, Intravenous (IV) arm boards, radiotherapy procedures and so on.
2. Use of a restraint device to meet the assessed needs of a patient who requires adaptive support (for example, postural support, orthopedic appliances) or medical protective devices (for example, helmets, table top chairs, bedrails). Such use is based on the assessed needs of the individual. Periodic reassessments determine that the intervention continues to meet an individual need.
3. Comforting of children.
4. Forensic and correctional restrictions used for security purposes.
5. Use of four side rails in the **"** up" position for a patient who is physically unable to move.
6. Padded side rails utilized for seizure precautions.
7. Use of rails on narrow cart or gurney.

WORK FLOW:

A. **Implementation of Medical Restraints.**

1. Prior to implementing the use of restrictive interventions, the following shall occur:
   a. An assessment of the patient and current conditions that protect the patient's safety and documentation of any alternatives that have failed.
   b. Consultation with other disciplines as appropriate.
   c. Educate patients/families 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, whenever possible.
   d. In an emergency situation where severe harm to patient or staff is imminent, restrictive devices may be applied without the use of alternative devices.
2. All instances requiring the use of restraints must have an order issued by the physician.
   a. Each physician order must be written for a specific episode and include a time frame.
   b. In an emergency situation, a trained RN may implement restraints/seclusion and obtain an order either during the emergency application or immediately after the application has occurred (within 10 minutes).
   c. Each physician order must be renewed every calendar day. It is the responsibility of the

attending physician or physician managing the aspect of care that requires restraint use to renew the orders.

d. Restrictive intervention may not be applied prior to receiving a physician order unless there is an emergency situation, in that instance a physician order must be obtained and on the medical record immediately.

e. **PRN (**as needed) **orders for restraints are not permitted** .

3. The use of less restrictive devices shall be tried periodically and results documented. If patient is released early from restraints, a new order must be obtained prior to re-application.
4. Reasonable attempts shall be made to obtain consent from patient/family if not previously obtained.
5. Ancillary departments shall not initiate or terminate restraints unless instructed by the nursing team leader; therefore all documentation shall be in the nurses notes.
6. Appropriate efforts are made to protect the individual's health, safety, dignity, rights and well-being.

B. Documentation

1. Documentation of each restraint episode must contain a written physician time limited order.
2. Any patient with restrictive interventions shall be reassessed for the need at least every 2 hours by a RN to include specific behavior, type of restraint, and alternatives attempted.
    a. Patient's behavior and the restraint type used.
    b. The indication for the use of the restraint.
    c. Patient response to restraint.
    d. Need to continue or terminate restraints.
    e. Vital signs, including a minimum respiratory rate.
    f. Any patient with restrictive intervention utilized shall have nursing rounds completed every 2 hours to include the following observations as appropriate:
        i. Circulation and condition of limbs as appropriate.
        ii. Assessment of other needs which include attention to hydration, feeding, toileting and range of motion.
        iii. Patient's response to the restraint.
        iv. Evidence of injury.
    g. Modification to the plan of care will reflect restraint use and will be updated as needed.
3. Upon removal, documentation shall include reason for removal and safety measures substituted for restraint use.
    a. Verification of required rounds shall be documented every shift.

C. Alternatives/Less Restrictive Interventions

1. Keep call light in reach
2. Offer toileting every two hours
3. Keep articles within reach such as urinals, tissues, etc.
4. Frequent observation/move closer to nurses' station

5. Involve family in care
6. Have family stay with patient as much as possible
7. Provide quiet music/environment
8. Diversional activities such as television or books
9. Review medication for side effects
10. Place in room for camera observation
11. Offer snacks
12. Keep equipment out of sight at head of bed
13. Use simple directions/explain procedures
14. Reality orientation
15. Maintain oxygen therapy
16. Night light
17. Don't awaken unnecessarily
18. Use abdominal binders to cover G-tubes, etc.
19. Use Cover-all tape to secure tubes
20. Put pajama bottoms on over urinary catheters
21. Approach in slow non-threatening manner
22. Offer walking, range of motion (ROM), or other activity
23. Utilize positioning aids
24. Smile
25. Pain management
26. Bed/Chair/door Alarms
27. Sitter/attendant

NOTE: Any patient, who in the judgment of the nurse and/or physician, who requires restrictive intervention and refuses it, must have a Refusal of Care form signed by patient/family.

D. All Use of restraints will be reported to the unit manager or designee via a restraint log kept on each unit.

E. Implementation of limb restraint

1. Explain purpose of restraints to patient/family/significant other.
2. Have patient in a comfortable, natural position. Do not place in prone position.
3. Apply in accordance with manufacturer's instructions by staff that have completed annual competency under the direction of a RN after alternative methods have failed.
4. Apply restraint securely enough only to restrain patient and not constrict or impair circulation.
5. Tie to bed frame, chair frame and out of patient's reach.

F. In an emergency situation, any registered nurse who has received required training may implement restraints and obtain an order either during the emergency application of immediately after the application has occurred. MSL preprinted orders will be utilized in emergency situations.

1. Documentation and evaluation in an emergency situation shall include:
    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.

EDUCATION:

A. All staff shall complete training for restraint use dependent upon their position. Staff must be able to demonstrate competency in the application of restraints, assessment and providing care for a patient in a restraint. Physician privileging will include restraint review.

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 use.
    2. Use of non-physical 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.
    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. As needed education for implementation of new restraints/restraint alternatives.
    8. Certification in Cardiopulmonary Resuscitation (CPR) and associated first aid shall be completed, including recertification every other year.

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

C. NOTIFICATION PROCEDURE
Each death must be reported to 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 and/or Critical Access Hospital (CAH) Medicare-certified distinct part psychiatric units (DPUs)

will be able to insert the Universal 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.

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

D. INFORMATION TO BE FURNISHED

1. Section A: Hospital Information
    - Document the complete name of hospital, Centers for Medicare and Medicaid Services (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 I)
    a. 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/CAH 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/CAH 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/CAH 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), affect 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/CAH (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.

The above information to be completed on the *Hospital Restraint/Seclusion Death Report Worksheet*
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.

E. RESPONSIBILITY
Clinical Quality staff has been assigned the responsibility for checking the deaths every Monday through Friday (except Holidays).

F. GENERAL
Every morning the death list is emailed.
If the patient had restraints that fits the guidelines, then pull up the chart in electronic medical record (EMR) to find the date of birth, admitting diagnoses, date of admission, date, time and cause of death.

G. Staff must document in the patient's medical record the date and time that death was reported to CMS on the appropriate form in the EMR.

H. Screen all deaths for any quality issues, if found, notify the Clinical Quality 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