CMH REGIONAL HEALTH SYSTEM
Policy and Procedure

Title: Use of Restraints and Seclusion	**Policy No: CSPP 2.192**
Department: CSPP	**Page**: 1 of 11 Pages
Approved By: Lesley Wininger, MHA, BSN, RN, CPPS, Chief Nursing Officer	**Origination Date:** 1/21/2013 **Reviewed Date:** 04/05/2021 **Revised Date:** 02/16/2015
Reviewed By: Denise Kimmich, RN, BSN, MSM-HC, Director, Acute Care Services, Mindy Roades, RN, Clinical Coordinator, Med/ Tele unit, Samantha Adkins, RN, Clinical Coordinator, ICU	
Collaborators: Matt Gunderman RN, MSN, EMT-P, Senior Director Emergency, Cardiac, IR, and Radiology Services	

Scope
This policy applies to all staff and providers with direct patient care contact**.**

Purpose
To establish a hospital-wide policy regarding the appropriate use of restraints or seclusion.

Definitions

A. 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. A chemical restraint is defined as a drug or a medication when it is used as a restriction to manage the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

1. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm, (this does not include a physical escort).

B. Seclusion is the involuntary confinement of a patient alone in a room/area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior. CMH Emergency Department is the only unit that has the ability to seclude a patient.

C. LIP (Licensed Independent Practitioner)

1. Any individual permitted by State law to order restraints and/for patients independently, within the scope of the individual's license and consistent with the individually granted clinical privileges.
2. This includes the authority of a physician to delegate this task to physician assistants (PA) and advanced practice nurses (APN), to the extent recognized under State law or regulatory mechanism and when the PA or APN has been granted privileges pursuant to the Hospital's standardized procedures.

D. Qualified Registered Nurse

A registered nurse who has received training and demonstrates knowledge in the specific needs of a patient population as it applies to the following:

1. Identifying staff and patient behaviors as well as environmental factors that may trigger circumstances that require the use of restraints

2. Identifying the risk of restraint use in vulnerable patient populations such as emergency, pediatric, cognitively or physically limited patients.
3. The use of non-physical intervention skills.
4. Choosing the least restrictive interventions based on an assessment of the patient's behavioral and medical status.
5. Identifying specific behavioral changes that indicate restraint or seclusion is no longer necessary.
6. Monitoring the physical and psychological well-being of the patient in restraints.
7. Safe application of restraints.

Based on this training, the RN is authorized to initiate restraint or seclusion, and/or perform evaluations or re-evaluations of patients in restraint or seclusion and to assess their readiness for discontinuation or establish the need to secure a new order.

Policy

Restraints will only be implemented when least restrictive methods have been employed and are determined ineffective for preventing patients from harming themselves, other patients or staff members (self-destructive/violent), or interfering with medical regimens (non-self-destructive/non-violent).

General Provisions

A. **Limitations and Criteria for Use of Restraint or Seclusion**

The use of restraint or seclusion is limited to those situations for which there is adequate and appropriate clinical justification.

1. The use of restraint or seclusion is based on the assessed needs of the patient.
2. Seclusion or restraint use may occur only after less restrictive alternatives have been considered and/or attempted as appropriate. Less restrictive alternatives may include, but are not necessarily limited to:
    a. Re-orientation
    b. De-escalation
    c. Limit setting
    d. Increased observation and monitoring
    e. Use of a sitter
    f. Change in the patient's physical environment
    g. Review and modifications of medication regimens
3. The least restrictive, safe and effective method of restraint is to be used. The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
4. Restraint use must be in accordance with a written modification to the patient's plan of care; and implemented in accordance with safe and appropriate restraint techniques as outlined in this policy and in accordance with state and federal law, and Joint Commission's accreditation standards.
5. If used, restraints or seclusion shall be discontinued at the earliest possible time when there is no longer adequate and appropriate justification for continued use, the reason for the restraint is no longer present. The following shall not be used under any circumstances on mental health patients:
    a. Face down restraint with back pressure
    b. Any technique that obstructs the airway or impairs breathing
    c. Any technique that restricts the recipient's ability to communicate
    d. Weapons and law enforcement restraint devices used by hospital staff, security or law enforcement while patient is in restraints/seclusion
    e. Chemical restraint

B. **General Requirements for Ordering of Restraint or Seclusion**

1. The use of restraint or seclusion must be in accordance with the order of a physician or other LIP who is responsible for the care of the patient.

2. The patient's treating physician must be notified as soon as possible (without time delay) if the restraint or seclusion was ordered by a different physician.
3. Restraint or seclusion orders may not be written as standing orders or on an as needed basis (PRN).
4. Seclusion may only be ordered for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.
5. Restraint and Seclusion may not be used simultaneously unless the patient is continually monitored face-to-face by an assigned staff member or continuously monitored by staff using both video and audio equipment that is in close proximity to the patient.
6. Each order for restraint must contain, at a minimum, the following information:
    a. The name of the patient being restrained.
    b. The date and time the order was given.
    c. The date and time the restraints were initiated (if they were initiated prior to the order being given).
    d. The name of the MD or other LIP ordering the restraint.
    e. The type of restraint to be applied.
    f. The time limit (duration) of the restraint for violent restraints only.
7. If there is to be any variation from this policy for monitoring of the patient and/or release from restraint, then the rationale for such variation must be contained in the order.
8. In an emergency, the least restrictive, yet effective restraint or seclusion may be initiated by a qualified Registered Nurse (RN), without a prior order from the patient's doctor or other LIP, based on an appropriate assessment of the patient. In this case, the patient's doctor or another LIP must be contacted immediately (without time delay) for an order.
9. Any verbal or telephone order must be countersigned, dated, and timed by the patient's doctor or a covering physician on the next visit and no later than 24 hours after the order was given.

C. Additional Requirement for the Ordering of Nonviolent Restraints

1. The use of restraint must be clinically indicated to meet the **medical needs** of a patient who is **NOT violent or self-destructive**.
2. The order for a nonviolent restraint must be episode specific..

D. Additional Requirements for Ordering Violent Restraints

1. Each order for restraint used for the management of violent behavior that jeopardizes the immediate physical safety of the patient, a staff member or others may only be ordered/renewed in accordance with the following limits for up to a total of 24 hours:
    a. Four (4) hours for adults age 18 and older
    b. Two (2) hours for children and adolescents ages 9 to 17
    c. One (1) hour for patients under age 9.
2. After 24 hours, a physician or other LIP who is responsible for the care of the patient must see and assess the patient daily before writing a new order.
3. See section, Additional Assessment Requirements for Patients in Violent Restraints, for further reassessment requirements.

E. Application and Removal of Restraint

1. The type of restraint used shall be consistent with the type of restraint ordered.
2. Restraint devices are applied/removed in accordance with manufacturer's instructions and used in a manner consistent with their intended purpose.
3. Restraint devices are applied and removed in a manner that preserves the dignity, comfort, and well being of the patient.
4. Restraints will be secured to the bedsprings or frame if being used while the patient is in bed. Restraints are never tied to the mattress or side rails. Knots shall be tied so that they may be released quickly (with one hand) in the event of an emergency.

5. Restraint devices are to be applied/removed only by staff authorized, trained, and with the demonstrated competency to do so.
6. A "trial release" constitutes a PRN use of restraint and are therefore, not permitted.

F. Education of the Patient and/or Family

The reasons for the use of restraint or seclusion (as appropriate) are provided to the patient and/or family in understandable terms and include, but are not limited to,

1. An explanation as to the clinical justification for restraint or seclusion.
2. An explanation of the purpose and use of the restraint or seclusion.
3. The criteria by which restraint or seclusion will be terminated.
4. An explanation as to the monitoring and care that will be provided to the patient.
5. Other information necessary to assure the safety and comfort, dignity, preservation of rights, and well being of the patient.

G. Monitoring the Patient in Restraint or Seclusion

1. **The frequency, nature, and extent of monitoring and evaluation are dependent on the needs and health status of the individual patient.**
2. **At a minimum and monitored as follows:**

    a. At least every <u>two hours</u> for all patients <u>in nonviolent restraints</u>

    b. At least <u>every 15 minutes</u> for patients in <u>violent restraints</u>

3. **Appropriately qualified staff, as defined in this policy, will monitor/evaluate the following:**

    a. The <u>physical</u> and <u>emotional</u> well being of the patient

    <u>Physical – Based upon results of monitoring and evaluation of behavior.</u>

    c. Vital signs
    d. Circulation
    e. Any hydration, hygiene, elimination, range of motion, or comfort needs the patient may have.
    f. Skin integrity
    g. Respiratory status

    <u>Emotional – Based upon results of monitoring and evaluation of behavior.</u>

    h. Level of distress and agitation
    i. Mental status
    j. Cognitive functioning
    k. That the patient's rights, dignity, and safety are maintained.
    l. Whether less restrictive measures are possible.
    m. Changes in the patient's behavior or clinical condition required for removal of restraints
    n. Whether the restraint has been appropriately applied, removed, or reapplied.

H. Additional Assessment/Monitoring Requirements Patient in Violent Restraints

1. The patient must be seen face-to-face within one (1) hour after the violent restraints
2. The one-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient. The practitioner who conducts this evaluation must be qualified and competent to complete both a

physical and behavioral assessment of the patient. The purpose of the face-to-face evaluation is to assess:

a. 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

3. If the face-to-face evaluation is conducted by an RN or PA, the RN or PA must consult the attending physician or other LIP who is responsible for the care of the patient as soon as possible (without time delay) after completing the evaluation. Such consultation should occur before the end of the RN or PA shift.
4. Prior to renewing a restraint or seclusion order for violent restraints, the patient's physical and psychological status is reassessed during a face-to-face evaluation to determine if restraint or seclusion should be continued. This evaluation may be conducted by one of the following individuals:
    a. The licensed independent practitioner primarily responsible for the patient's ongoing care, treatment or services
    b. His or her licensed independent practitioner designee
    c. Another licensed independent practitioner or
    d. A qualified RN
5. The frequency of this re-assessment depends on the patients age and must be renewed at the following time intervals:

Patient's Age	**Time**
Under 9 years	1 hour
9 to 17 years	2 hours
18 and older	4 hours

I. Termination of Restraint or Seclusion

1. Restraint or seclusion will be terminated at the earliest possible time regardless of the time length of the order.
2. Based upon RN or physician assessment, a restraint may be released early. An RN or an LIP may discontinue restraints as soon as the unsafe situation ends or less restrictive measures can be used.
3. If a restraint is discontinued for any reason, even if prior to the expiration of the original order, a new order must be obtained prior to reinitiating the use of restraint. The reasons for reapplication of the restraint must be documented in the medical record.
4. If restraints are released by a staff member and the patient remains under the continuous direct supervision of the staff member, then a new order to re-apply the restraints is not necessary. An example of this is for range of motion or toileting.
5. Trial releases of restraints are not permitted.

J. Documentation

For each episode of restraint, the patient's medical record should contain at least the following documentation:

1. The complete order for restraint or seclusion.
2. A description of the patient's condition or symptom(s) that warranted the use of the restraint or seclusion
3. Alternatives or other less restrictive interventions attempted or considered.
4. A description of the restraints that were used.
5. The one-hour face-to-face medical and behavioral evaluation for violent restraints or seclusion.
6. The patient's response to the interventions(s) used, including the rationale for continued use of the intervention.
7. Modification of the plan of care to include the use of restraint or seclusion.

8. Documentation of each assessment (at least **every two hours for nonviolent restraints** and **at least every 15 minutes for violent restraints).**
9. Documentation of the periodic re-assessment (frequency depends on the age of the patient) of the need for violent restraints.
10. Each incident of seclusion or restraint shall be clinically and/or administratively reviewed. Such review shall be documented via report to Quality Outcomes
11. Each department shall maintain a log of patients placed in restraints. The log shall include at a minimum, the following information:
    a. The patient's name and date of birth, and/or medical record number
    b. The date, time and type of restraint device utilized, i.e. seclusion, violent or nonviolent restraint.
    c. Type of restraint utilized
    d. Duration of the method or methods
    e. Death or serious disability of patients in restraint or seclusion

K. Training and Competency of Staff

1. Staff training and education on restraints and seclusion is provided by the education department.
    a. Trainer requirements
        i. Individuals providing staff training must be qualified as evidenced by education, training and experience in techniques used to address patients behavior.
2. Staff that are involved with applying restraints and/or providing care for patients in restraint, or with assessing and monitoring the condition of restrained patients shall be trained and able to demonstrate competency in the application of restraints, monitoring, assessment, and providing care for a patient in restraint prior to doing so.
3. Staff shall complete restraint training during orientation and at least once a year thereafter.
4. Staff shall have education, training, and demonstrated knowledge based on the specific needs of the patient population served in at least the following:
    a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint.
    b. The use of nonphysical intervention skills.
    c. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
    d. The safe application and use of all types of restraint used in the hospital, including training on how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).
    e. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary.
    f. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the one-hour face-to-face evaluation.
    g. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
5. Successful completion of training and demonstration of competency will be documented in staff personnel records.
6. Physicians and other LIPs authorized to order restraint or seclusion receive orientation to this policy through distribution of printed material.
7. Radiology, phlebotomy, physical and occupational therapy staff are trained in the untying and tying of restraints.
8. Contracted staff completes the required training during orientation.

L. Reporting of Deaths and Serious Disability of Patients in Restraint or Seclusion

1. Any deaths associated with the use of restraint or seclusion must be immediately reported to the Nursing Supervisor. The following steps shall be taken after notification of the appropriate individuals:
    a. RN completes the Hospital Restraint/Seclusion Death Report Worksheet. The Hospital Restraint/Seclusion Death Report Worksheet is not a part of the permanent medical record.
    b. Nursing Supervisor reviews the worksheet for completeness, signs, dates, and times the form.
    c. Nursing Supervisorr hand delivers the completed form to the Performance Improvement department within 12 hours of the patient's death and places in the red folder labeled "Death Reports."
    d. Staff caring for the patient shall complete an occurrence report in Quantros.
    e. The hospital will report to CMH CMS Regional Office by fax (443) 380-8952 or email **05RESTRAINTRR@CMS.HHS.gov** no later than the close of business on the next CMS business day following knowledge of the patient's death in the following instances: any death that occurs within 24 hours after removal from restraints and within one week where it is reasonable to assume that the use of restraints directly or indirectly contributed to a patient's death.

References

Joint Commission Accreditation Standards
CMS Interpretative Guidelines for Hospitals
Ohio Revised Code
Ohio Administrative Code

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 14-27-Hospital-CAH/DPU

DATE: May 9, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Hospital Restraint/Seclusion Deaths to be Reported Using the Centers for Medicare and Medicaid Services (CMS) Form CMS-10455, Report of a Hospital Death Associated with Restraint or Seclusion

Memorandum Summary

- ***Hospital Restraint/Seclusion Deaths to be Reported Using Form CMS-10455:*** Hospitals must use Form CMS-10455 to report those deaths associated with restraint and/or seclusion that are required by 42 CFR §482.13(g) to be reported directly to their Centers for Medicare & Medicaid Services (CMS) Regional Office (RO). This requirement also applies to rehabilitation or psychiatric distinct part units (DPUs) in Critical Access Hospitals (CAHs).

- ***RO to Provide Submission Instructions:*** CMS ROs must provide hospitals with instructions for submitting the form to the RO by fax and/or e-mail, based on RO preference.

Hospitals (meaning all types of hospitals, including Psychiatric Hospitals, Rehabilitation Hospitals, Long Term Care Hospitals, and not just Short Term Acute Care Hospitals) and CAHs with rehabilitation and/or psychiatric DPUs must now use Form CMS-10455, "Report of a Hospital Death Associated with Restraint or Seclusion," to report deaths associated with restraint and/or seclusion that are required by 42 CFR §482.13(g) to be reported directly to the CMS RO. The form has been approved by the Federal Office of Management and Budget (OMB) and may be downloaded from the following webpage: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10455.pdf.

CMS ROs must provide hospitals and affected CAHs in their regions instructions for submitting the form to the RO by fax and/or e-mail, based on RO preference. ROs are not expected to contact each hospital or affected CAH directly, but may provide their instructions to the applicable State Survey Agency (SA) and hospital association for further dissemination. ROs may not require hospitals to submit in their initial report any information beyond that contained in Form CMS-10455. However, after reviewing a report, the RO may contact the hospital for additional information it needs in order to determine whether an investigation of the hospital's use of restraint or seclusion is warranted.

ROs may also want to remind hospitals and affected CAHs that they are no longer to report deaths directly to the RO when no seclusion has been used and when the only restraints used on the patient were applied exclusively to the patient's wrist(s) and composed solely of soft, non-rigid, cloth-like materials, as provided in §482.13(g)(2). Rather, in such situations, the hospital staff must record information in an internal log or other system.

Under 42 CFR §482.13(g), the following hospital reporting of deaths associated with use of restraint or seclusion is required; since CAH DPUs are subject to the Hospital Conditions of Participation, every reference below to "hospital" also applies to a CAH DPU:

1. Hospitals must report the following deaths associated with restraint and seclusion directly to their CMS RO no later than the close of business on the next business day following knowledge of the patient's death:

   - Each death that occurs while a patient is in restraint or seclusion, ***excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion at the time of death***;

   - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion, ***excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion within 24 hours of their death***; and

   - Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time.

2. Hospitals must record in an internal hospital log or other system deaths that occur in the following circumstances listed below. The log must include the information specified at 42 CFR §482.13(g)(4)(ii) and the log entry must be made no later than seven days after the date of death of the patient. Hospitals must not send reports of these deaths directly to the RO:

   - Each death that occurs while a patient is in restraint but not seclusion and the only restraints used on the patient were applied exclusively to the patient's wrist(s) and were composed solely of soft, non-rigid, cloth-like materials; and

   - Each death that occurs within 24 hours after the patient has been removed from restraint, when no seclusion has been used and the only restraints used on the patient were applied exclusively to the patient's wrist(s) and were composed solely of soft, non-rigid, cloth-like materials.

   The information in the log must be made available in either written or electronic form to CMS immediately upon request.

3. The following must also be documented in the patient's medical record for *any* patient whose death is associated with the use of restraint or seclusion:

   - The date and time the death was reported to CMS for deaths required to be directly reported; and

   - The date and time the death was recorded in the hospital's/CAH's internal log or other system for deaths that are required to be logged and not directly reported to CMS.

Questions concerning this memorandum may be sent to hospitalscg@cms.hhs.gov.

Effective Date: ROs must issue instructions on how the required direct reports are to be submitted to them within thirty days of the date of this memorandum.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1210

REPORT OF A HOSPITAL DEATH ASSOCIATED WITH RESTRAINT OR SECLUSION

A. Hospital Information:

Hospital Name	CCN

Address

City	State	Zip Code

Person Filing the Report	Filer's Phone Number

B. Patient Information:

Name	Date of Birth

Primary Diagnosis(es)

Medical Record Number	Date of Admission	Date of Death

Cause of Death

C. Restraint Information ***(check only one)*****:**

- ☐ While in Restraint, Seclusion, or Both
- ☐ Within 24 Hours of Removal of Restraint, Seclusion, or Both
- ☐ Within 1 Week, Where Restraint, Seclusion or Both Contributed to the Patient's Death

Type *(check all that apply)*:

☐ Physical Restraint ☐ Seclusion ☐ Drug Used as a Restraint

If Physical Restraint(s), Type *(check all that apply)*:

- ☐ 01 Side Rails
- ☐ 02 Two Point, Soft Wrist
- ☐ 03 Two Point, Hard Wrist
- ☐ 04 Four Point, Soft Restraints
- ☐ 05 Four Point, Hard Restraints
- ☐ 06 Forced Medication Holds
- ☐ 07 Therapeutic Holds
- ☐ 08 Take-downs
- ☐ 09 Other Physical Holds (specify): _____
- ☐ 10 Enclosed Beds
- ☐ 11 Vest Restraints
- ☐ 12 Elbow Immobilizers
- ☐ 13 Law Enforcement Restraints

If Drug Used as Restraint:

Drug Name	Dosage