Restraint and Seclusion

POLICY: Children's seeks to create an environment that minimizes the use of restraint and seclusion and maximizes the patient's health and safety when restraint and seclusion are used.

The use of restraints and seclusion requires clear indications, safe application, monitoring and reassessment guidelines, and consideration of alternative methods. Restraint and seclusion are used in behavioral emergencies, when there is an imminent risk of an individual physically harming self or others (including staff), and for medical/surgical necessity to avoid the risk of injury or re-injury.

PURPOSE: To address the care of any patient who requires the use of restrictive devices or seclusion and to:

- Protect the patient's rights, dignity and well-being.
- Guide staff in decision-making about the least restrictive methods for restraint.
- Provide guidelines for assessing and reassessing the patient’s need for the use of restraint.
- Provide guidelines for the appropriate ordering of restraints.
- Provide guidelines for monitoring the patient during the use of restraints and for meeting their personal needs.
- Ensure the safe application and removal of restraints by competent staff.
- Outline the documentation requirements during the use of restraints.

Exceptions:
This policy and procedure does not apply to:
1. Physical restraint, positioning or securing devices used to maintain position, limit mobility or temporarily immobilize during procedures – medical, dental, diagnostic or surgical (e.g., IV arm boards, radiotherapy procedures, transportation to the OR or radiology, protection of surgical sites).
2. Mechanical support used to achieve proper body position, balance or alignment so as to allow greater freedom of mobility than would be possible without the use of such support (e.g., postural support, orthopedic appliances, helmets).
3. Forensic and correction restrictions used for security purpose (See Clinical P&P, Admitting Patients from a Juvenile Detention Center).
5. Enclosed bed systems (e.g. Posey Beds) are considered a form of restraint for medical purposes.
6. Time-out for 30 minutes or less in unlocked room consistent with patient’s treatment plan.

Definitions:
Protocol refers to a guideline of care that authorizes the use of restraints, based on the patient’s condition. The protocol contains specific criteria for assessing the patient, applying a restraint, monitoring the patient, and reassessing the need for
and terminating the restraint. The protocol must be approved by the medical staff, Nursing Leadership, and others as appropriate.

The term restraint includes either a physical restraint or a drug used as a restraint. **Physical restraint** is any manual method or mechanical device attached or adjacent to the patient’s body that s/he cannot easily remove and that restricts freedom of movement, physical activity, or normal access to his/her body. A drug used as a restraint is a medication used to control behavior or to restrict the patient’s freedom of movement that is not a standard treatment for the patient’s medical or psychiatric condition.

Search refers to the assessment and emptying of pockets, removal of shoes, socks, belt, jewelry and possible pat down of patient if history of suicide and/or fire setting is present.

**Seclusion** refers to the involuntary confinement of a person in a locked room/area.

**PROCEDURE:**

I. **Restraint Use:**
   A. Each patient has rights to respectful care that maintains one’s dignity and well-being. As restraint or seclusion has the potential to restrict these rights, each episode of use considers that the:
      1. Application or initiation respects the patient as an individual.
      2. Environment is safe and clean.
      3. Patient is able to continue care and participate in care processes.
      4. Patient's modesty, visibility to staff and comfortable body temperature are maintained.
   
   B. The least restrictive and effective method that maintains the patient’s safety and safety of others is utilized. It is determined by the patient’s needs and the effectiveness of methods previously used for the patient. Examples include:
      1. Revising the clinical plan for treatment.
      2. Changing the dose or type of prescribed medication.
      4. Obtaining additional consultation.
      5. Using a sitter or family member.

   C. Whenever appropriate and/or possible, the family will be:
      1. Involved in the initial assessment of the patient, including identification of successful behavioral techniques, methods or alternative strategies.
      2. Involved in the decision to utilize restraints.
      3. Notified in the event of a restraint/seclusion episode.

   D. The use of restraint is:
      1. Based on assessed patient needs as identified in the initial assessment process (considers any mental health Advance Directive) or by qualified staff in emergent situations that pose the risk of injury to self or others.
2. Based on the patient’s needs in the immediate care environment and the interaction of the patient and staff with other patients in that environment.
3. Not based solely on prior history or use of history of dangerous behavior. Clinical justification must exist.
4. Prohibited for punishment, coercion, retaliation or staff convenience.

II. Application of Restraints and Seclusion:
A. RNs or specially trained staff may initiate emergency restraint or seclusion use in response to a patient who poses an immediate danger to self, staff or others.
B. In the absence of adequate, trained staff, the Code CHAMP Team can be activated (ext. 7-6188) to obtain emergency assistance for implementing behavioral restraint during behavioral emergencies.
C. Staff will follow the guidelines in the Restraint Training Resources Manual, Children’s Hospital Aggression Management Plan (CHAMP®).
D. The RN must obtain an order for use.

III. Ordering Restraint, Seclusion, or Protocol:
A. Orders for behavioral restraint or seclusion must be obtained within one hour of initiation.
   1. Restraint orders for behavioral emergencies will be obtained from a physician.
   2. Restraint orders for medical necessity purposes may be obtained from either a physician or ARNP. The order may specify the initiation of restraint or the initiation of a protocol for restraint use.
   3. PRN orders are prohibited.
   4. Orders are to include both the rationale for the use of restraint/seclusion and time limits.
B. The resident writing seclusion/restraint orders had successfully completed the first year of post-graduate medical education.
C. Time Limits:
   1. For restraint/seclusion used in behavioral emergencies:
      i. 4 hours for 18+ year olds
      ii. 2 hours for 9-17 year olds
      iii. 1 hour for < 9 years old
   2. For restraints used for medical necessity to prevent injury: 24 hours or less.
   3. For protocol for restraint use: one time order; no time limit as long as the patient meets defined criteria for use.
D. In circumstances involving the use of seclusion and restraint for behavioral emergencies, the physician or licensed independent practitioner (LIP) must conduct a face-to-face assessment of the patient within one hour to determine the ongoing need for restraint/seclusion.
   1. The facts of this examination and any resulting decision to continue/discontinue restraint use will be documented in the patient’s medical record.
2. If restraint or seclusion is to be continued after the initial order, a new order (with the appropriate time limits) will be written.
3. Patients < 18 years who are restrained or secluded for a period in excess of 2 hours will be evaluated by a mental health specialist (e.g., RN with psychiatric experience, MSW, psychiatrist, psychologist).

E. The patient’s treating physician and/or attending is consulted if the restraint or seclusion is not ordered by him/her.

IV. Assessment and Monitoring:
A. Patients requiring restraint/seclusion for behavioral emergencies and those who require 4- or 5-point restraint for medical necessity are assessed at least every 15 minutes, using the Restraint and Seclusion Flow Sheet (#F22-116, Attached).
B. Patients requiring less restrictive restraint for medical necessity will be assessed at least every 2 hours, documenting on the nursing flow sheets.
C. Monitoring will be by observation and direct, face-to-face interaction with the patient. This will include observation of level of consciousness, behavior and safety.
D. Constant eyesight (CE) is to be used if significant motor agitation or restlessness occurs, or if the patient struggles against restraints.
E. Check vital signs within 2 hours of restraint initiation, unless medical condition warrants earlier assessment. Repeat vital sign assessments every 4 hours until stable.
F. Consider early release with each assessment. RNs or specially trained staff may discontinue restraint/seclusion.
G. Apply and adjust devices properly to maintain body alignment and patient comfort. Post the safety precautions for the restrictive product (from Code CHAMP Bag or Central Services restraint pack) above the patient's bed or in some other visible location near patient.
H. Keep restraints and skin clean and dry.
I. For the Suicidal Patient:
   1. While in seclusion, the suicidal patient is checked continuously through the window or other means of constant eyesight (e.g., mirror or video camera).
   2. If the secluded patient becomes self-abusive or threatens to harm self, restraint or medication may need to be considered (see Clinical P&P, Managing the Suicidal Child and Adolescent).

V. Physical and Emotional Needs:
A. Offer food, fluids, and toileting opportunities every 2 hours while awake. Restraints may be loosened to allow patient to sit upright for meals.
B. Remove restraints at least every 2 hours for a minimum of 5 minutes, and more if necessary, and allow for ROM and activities of daily living.
   1. Restraint cuffs may be removed sequentially one at a time, or two opposing sites at one time (i.e., one arm, one leg).
   2. Severely agitated or decompensated patients may have limb restraints removed sequentially. The unrestricted limb may be given passive ROM.

VI. Removal of Restraints:
A. Patients are routinely assessed for release (See IV. Assessment and Monitoring above).
B. For agitated patients, attempt trial release by progressively decreasing points of restraint, e.g., from 5- to 4- or 3-point restraint.
C. Allow 15 minutes between each step-down.
D. Make contract with the patient if s/he appears to be calming and eligible for release.
E. If patient remains calm and does not attempt injurious behavior, decrease to 2-point restraint under direct observation, then proceed to final release.
F. Team members will stand by during this release process in the event that release is premature and patient behavior re-escalates.
G. Continue close observation for the first hour after release.

VII. Documentation:
A. Staff will document in the patient’s medical record:
   1. Clinical justification for use of each episode.
   2. Measures taken to protect the patient’s rights, dignity, and well-being, including monitoring, re-assessment, and attention to patient needs (e.g., food, toileting, hygiene, ROM).
   4. Deaths and injuries related to restraint or seclusion.
B. Children’s will report to CMS (Centers for Medicare and Medicaid Services) deaths that occur while a patient is in behavioral restraint or in seclusion or that reasonably may have resulted from behavioral restraint or seclusion.
C. Children’s uses data to monitor and improve processes.

Restraint and Seclusion Overview:

<table>
<thead>
<tr>
<th></th>
<th>Medical-Surgical</th>
<th>Behavioral Management</th>
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<tbody>
<tr>
<td><strong>Examples</strong></td>
<td>To maintain placement of IV or feeding tube</td>
<td>Unanticipated outburst or severely aggressive or destructive behavior posing imminent danger to patient or others</td>
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<tr>
<td></td>
<td>To prevent patient attempt to get out of bed and walk with a broken hip</td>
<td></td>
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<tr>
<td><strong>Who May Order</strong></td>
<td>Physician (Housestaff with the exception of R1/intern)</td>
<td>Physician only (Housestaff with the exception of R1/intern)</td>
</tr>
<tr>
<td>(and document)</td>
<td>ARNP</td>
<td>No standing order or protocol</td>
</tr>
<tr>
<td><strong>Order/Time-Limits</strong></td>
<td>No PRN</td>
<td>No PRN</td>
</tr>
<tr>
<td>(and document)</td>
<td>24 hours</td>
<td>4 hours for 18+ years old</td>
</tr>
<tr>
<td></td>
<td>Protocol: order needed to initiate; no time limit</td>
<td>2 hours for 9-17 years old</td>
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<td>1 hour for &lt; 9 years old</td>
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<tr>
<td><strong>Order Justification</strong></td>
<td>Medically necessary AND</td>
<td>EMERGENCY situation to ensure physical safety of patient or others AND</td>
</tr>
<tr>
<td>(and document)</td>
<td>Not used for coercion, discipline, convenience, or retaliation AND</td>
<td>Not used for coercion, discipline, convenience, or retaliation AND</td>
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<tr>
<td></td>
<td>Needed to improve patient’s well-being AND</td>
<td>Less restrictive interventions are or considered to be ineffective</td>
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<tr>
<td><strong>Face-to-face</strong></td>
<td>No</td>
<td>Yes (CMS)</td>
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<tr>
<td>evaluation within 1 hour of intervention (and document)</td>
<td></td>
<td>Physician or LIP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Even if patient recovers and is released within that 1 hour</td>
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</table>
**Medical-Surgical** | **Behavioral Management**
---|---
**Assessment** | - Every 2 hours  
- Every 15 minutes on Restraint and Seclusion flowsheet (#F22-116) if 4- or 5-pt restraints are utilized  
- Assessment includes vital signs, circulation, hydration, elimination, distress and agitation, mental status, cognitive functioning, skin integrity, nutrition, range of motion, elimination  
- Every 15 minutes on Restraint and Seclusion flowsheet (#F22-116)

**Seclusion** (involuntary confinement in room or area when physically prevented from leaving) | - Yes  
- Simultaneous use of restraint and seclusion only if continually monitored by staff face to face  
- Staff in close proximity to patient

**Education for Staff with Direct Patient Contact** | - Initial orientation and ongoing education and training in proper and safe use of restraints  
- Ongoing education and training in proper and safe use of restraints and seclusion  
- Also on techniques and alternative methods of handling behavior, symptoms, and situations traditionally treated through use of restraints or seclusion

**Debriefing Session** | - Within 24 hours after episode

See also Clinical P&P, Managing the Suicidal Child and Adolescent.

**REFERENCES:**


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**ORIGINATED:** 3/93
BARRIER TECHNIQUES:

CLASS II GLOVES a EYE a MASK a GOWN a

Additional Key Words: Care Treatment and Services; CASPER; Environment of Care; FDA; Prevention; Safe Medical Devices Act; Sentinel Event; Sitters; State Notification Event; Mental Health Advance Directive; CMS; Centers for Medicare and Medicaid Services, Restraint