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SCOPE
Maple Grove Hospital (MGH)
North Memorial Health Hospital (NMHH)

PURPOSE
To guide appropriate and safe management of customers who are restrained and/or in seclusion.

DEFINITIONS
Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of the customer to move his/her arms, legs, body or head freely. An object may be a restraint by functional definition-a functional definition does not name each device and situation that can be used to inhibit an individual's movement.
Examples:

- Devices which are considered restraint include, but are not limited to: padded mitts, vest, soft extremity, 4 side rails, and Twice-As-Tough cuffs.
    - If a customer has an order for seizure precautions, 4 side rails with pads are a part of seizure precautions and not considered a restraint. A specialty bed with a low air loss mattress requires 4 side rails for safety, therefore, not considered a restraint.
- A drug or medication when it is used as a restriction to manage the customer's behavior or restrict the customer's freedom of movement and is not a standard treatment or dosage for the customer's condition.

Seclusion: Involuntary confinement of a person alone in a room or area from which the customer is physically prevented from leaving. A situation where a customer is restricted to a room or area alone and staff is physically intervening to prevent the customer from leaving the room or areas is considered seclusion. Seclusion can only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the customer, a staff member, or others. It is used in the Emergency Departments and Psychiatric & Integrative Care Unit (NMHH).

Non-Violent or Non-Self-Destructive Restraint Use: Restraint used to manage behaviors which interfere with medical/surgical healing. For example, the customer may be trying to pull out lines or tubes and less-restrictive methods or alternative measures have not worked.

Violent or Self-Destructive Restraint Use: Restraint used to manage behaviors which are unanticipated, severely aggressive or destructive behavior placing the customer or others in

imminent risk of harming themselves or others, and non-physical intervention has not been effective.

Alternative Measures: Interventions taken to modify the environment, enhance interpersonal interactions, or provide treatment in efforts to minimize or eliminate the behaviors/problems which place the customer at risk.

Episode: The time when the restraint is initially applied until the time all restraints are discontinued. It is the period from START to DISCONTINUED in Epic documentation. There may be multiple orders within an episode.

Time Out: An intervention in which the customer consents to be alone in a designated area for an agreed upon timeframe from which the customer is not physically prevented from leaving. Time Outs are not used at MGH. Time Outs are used on the Psychiatric & Integrative Care Unit (NMHH).

Therapeutic Hold/Physically Holding: Holding a customer in a manner that restricts the customer's movement against his/her will is considered a restraint, including therapeutic holds. Physically holding a customer for the purpose of conducting routine physical examinations or tests is not considered restraint.
In certain circumstances, a customer may consent to an injection or procedure, but may not be able to hold still for an injection, or cooperate with a procedure. In such circumstances, and at the customer's request, staff may "hold" the customer in order to safely administer an injection (or obtain a blood sample, or insert an intravenous line, if applicable) or to conduct a procedure. This is **not** considered restraint.

Prolonged Restraint: If restraints are used on a customer for more than a certain time:
Forty eight (48) hours is considered a prolonged restraint for non-violent restraint. Twenty four (24) hours is considered a prolonged restraint for violent restraint.

POLICY
All customers have the right to be free from physical or mental abuse, and corporal punishment. All customers also 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. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the customer, a staff member, or others and must be discontinued at the earliest possible time.

A comprehensive assessment of the customer must determine that the risks of using the restraint or seclusion are outweighed by the risk of not using the restraint or seclusion. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the customer, a staff member, or others from harm.

A. Non-physical techniques are the preferred intervention in the management of behaviors and restraint are employed only when non-physical interactions are ineffective or not viable.
B. A request from a customer or family member for the application of a restraint which they

would consider to be beneficial is not a sufficient basis for the use of a restraint intervention. Whether restraint or seclusion is used involuntarily or voluntarily, the standard applies.

C. Alternatives to restraint are always considered before restraints are used. Because of the risks and consequences of use, staff will use the least restrictive, safest and most effective method(s) to protect the customer, staff member, or others from harm. At all times staff will protect the customer and preserve their rights, dignity and well-being. Staff will address the unique needs/risks of vulnerable customers such as the pediatric and cognitively or physically impaired (customer population).

D. The behavior of the customer triggers the restraint type not the location of use (i.e., non-violent or non-self-destructive versus violent or self-destructive), and the use of restraint must be in accordance with a written modification to the customer's plan of care.

E. All restraint or seclusion use is documented in Epic. Documentation includes:
    1. Face-to-face medical and behavioral evaluation (violent restraint use only)
    2. Order
    3. Specific limb and type of restraint
    4. Description of customer's behavior and interventions used
    5. Alternatives or other less restrictive interventions
    6. Customers' condition or symptom(s) that warranted the use of restraint or seclusion
    7. Customers' response to intervention(s) used, including rationale for continued use of the intervention
    8. Modification of plan of care

F. Physician orders are required with every restraint use. Standing orders or PRN orders are not acceptable. A new order is required when an additional restraint type (i.e. limb) is added. A Physician co-sign is required for restraint orders written by an Advanced Practice Provider.
    1. Physician order must include:
        a. Restraint Type
        b. Reason for Restraint
        c. Criteria for Restraint Release

G. The attending physician must be consulted as soon as possible if restraint is not ordered by the customer's attending physician. The consultation can occur via phone.

H. If restraint or seclusion is discontinued before the original order expires, the order is no longer valid. If behavior re-escalates, a new order is needed and new application is started.

I. Restraint use is to be ended at the earliest possible time. Customers may be released before the order expires based on RN or Physician assessment.

J. Physician orders for *non-violent, non-self-destructive* restraint use:
    1) An order for restraint or seclusion must be obtained prior to the application of restraints, except in emergency situations when the need for intervention may occur quickly.
    2) In these emergency application situations, the order must be obtained either during the emergency application of the restraint or seclusion, or immediately (within a few minutes) after the restraint or seclusion has been applied.

3) Individual physician orders for non-violent restraint are required every calendar day.

K. Physician orders for *violent, self-destructive restraint* use is as follows:
   1. An order for restraint or seclusion must be obtained prior to the application of restraints, except in emergency situations when the need for intervention may occur quickly.
      a. In these emergency application situations, the order must be obtained either during the emergency application of the restraint or seclusion, or immediately (within a few minutes) after the restraint or seclusion has been applied.
   2. Orders are time-limited. Maximum length of original order is age-dependent:
      a) 18 years and older -- 4 Hours
      b) Age 9 – 17 years -- 2 Hours
      c) Age 0 - 8 years -- 1 Hour
   3. Each order may be renewed with the following limits up to a total of 24 hours:
      a) 18 years and older -- 4 Hours
      b) Age 9 – 17 years -- 2 Hours
      c) Age 0 - 8 years -- 1 Hour
   4. The original order for violent restraint may be renewed within the above time limits up to a total of 24 hours. See Prolonged Restraint definition.

L. *Violent, self-destructive* restraint: Physicians conduct face-face assessment when restraint is used to manage violent behavior. These findings are documented in customer record.
   1. Within one (1) hour of initial restraint application. Physician responsibility includes: an evaluation of the customer's immediate situation; customer's reaction to the intervention, customer's medical and behavioral condition; need to continue or terminate the restraint.
   2. The face-to-face evaluation includes both a physical and behavioral assessment of the customer. An evaluation of the customer's medical condition would include systems assessment, behavioral assessment, as well as review of the customer's history, drugs and medication, most recent lab results, etc. The purpose is to complete a comprehensive review of the customer's condition to determine if other factors, such as drugs or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc. are contributing to the customer's violent or self-destructive behavior.
   3. If a customer's violent or self-destructive behavior is resolved and the restraint is discontinued before the Physician arrives to perform the one hour face-to-face evaluation, the Physician is still required to see the customer one hour after the initiation of the intervention. Ending the intervention prior to the 1-hour point does not mean that the mandated assessment and consultation are no longer necessary.
   4. After 24 hours, and before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior a physician must see and assess the patient. See Prolonged Restraint definition.

M. The RN is responsible for customer assessment, implementing alternatives, monitoring

customer safety and modifying the plan of care. Assessment content includes:

1. Vital Signs
2. Circulation
3. Hydration & nutrition needs
4. Elimination needs
5. Level of distress and agitation
6. Mental Status
7. Cognitive functioning
8. Skin integrity
9. Range of motion
10. Restraint type and status

N. The RN may delegate components of restraint monitoring and documentation to the trained, non-licensed staff including vital signs, hydration and circulation, skin integrity, customer's level of distress and general care needs such as eating, hydration, toileting and ROM. Monitoring is accomplished by observation, interaction with the customer, or direct examination of the customer.

O. *Non-violent* restraint assessment is by the RN and is completed every two hours. Assessment is completed to determine the following:

1. customer's physical and emotional safety
2. changes in customer behavior or clinical condition needed to initiate removal of restraint
3. whether less restrictive methods are possible and whether the restraint is appropriately applied or to be removed
4. direct observation by direct care staff to ensure safety and dignity, including restraint correction application

The frequency of assessment may be more frequent based on customer condition or need as per RN assessment or PHYSICIAN directive.

P. *Violent* restraint assessment and monitoring is on-going by the RN or trained, non-licensed staff. At the earliest appropriate time, staff inform customer of rationale for restraint or seclusion and behavioral criteria for discontinuation (as per order). Frequency of monitoring is as listed below and maybe more frequent based on customer condition or need as per RN or PHYSICIAN directive:

1. Upon initiation and every 15 minutes, customer's assessed for:
    a) Meeting behavioral discontinuation criteria
    b) Physical and psychological status; comfort
2. Every two hours:
    a) Nutrition/hydration needs
    b) Circulation
    c) CMS
    d) Toileting

Q. If restraints and seclusion are used simultaneously, one-to-one observation is required with an assigned, trained staff member in constant attendance or continual monitoring (NMHH only).

R. Restraints are applied, monitored and removed by qualified staff.

1. Training documentation

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a) Staff records reflect training and demonstration of competency were successfully completed.

2. Trainer requirements
   a) Individuals providing staff training are qualified as evidenced by education, training and experience in techniques used to address customers behavior.
3. Staff training requirements
   a) Education is required for staff with direct care responsibility prior to the application of any restraint or seclusion, as part of orientation and subsequently on a yearly basis.
   b) Staff is trained and demonstrate competency in the application of restraint, monitoring, assessment and providing care for a customer in restraint or seclusion.
   c) Appropriate staff providing direct customer care have education, training and demonstrated knowledge based on the specific needs of the customer population in at least the following:
      i. Techniques to identify staff and customer behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion
      ii. The use of nonphysical intervention skills
      iii. Choosing the least restrictive intervention based on an individualized assessment of the customer's medical, or behavioral status or condition
      iv. The safe application and use of all types of restraint or seclusions or used in the applicable area, including training in how to recognize and respond to signs of physical and psychological distress (e.g. positional asphyxia)
      v. Clinical identification of specific behavioral changes that indicate restraint or seclusion is no longer necessary
      vi. Monitoring the physical and psychological well-being of the customer who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, and vital signs
      vii. Emergency response system (e.g. Rapid Response Team)
   d) Physician ordering restraint or seclusion has a working knowledge of restraint policy. Physician/provider frequency of training is upon initial privileging and at the time of re-credentialing.

S. Customer and family involvement and education is critical to prevention of restraint use. Discussions regarding restraint prevention and use are held with customer, and/or family, as appropriate. Family is notified of restraint use as customer permits.
T. When conflict develops with staff and/or family in the management of customer behavior and restraint, any staff member should consult with their area leader(s) or refer to Chain of Command.
U. Deaths with use of restraint or seclusion within 7 days of a patient death are reported to

Clinical Effectiveness (MGH) or Risk Management (NMHH) immediately so required reports can be made to regulatory agencies (i.e. CMS). Date and time the death is reported to CMS will be documented in EPIC.

V. MGH and NMHH collects, analyzes, and evaluates aggregate restraint/seclusion data on all episodes and reports to their Quality Assurance and Performance Improvement (QAPI) Committee.

POLICY EXCLUSIONS

This policy does not apply to:

A. Devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a customer for:
   1. purpose of conducting routine physical examination or tests, or
   2. protect the customer from falling out of bed, or
   3. permit the customer to participate in activities without the risk of physical harm

B. If a customer has an order for seizure precautions, 4 side rails with pads are a part of seizure precautions and not considered a restraint. A specialty bed with a low air loss mattress requires 4 side rails for safety, therefore, not considered a restraint.

C. Age or developmentally appropriate protective safety intervention (e.g. raised crib rails, crib covers).

D. 4-siderails when used to prevent the customer from falling off of a stretcher, when recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds.

E. Picking up, redirecting or holding an infant, toddler or pre-school aged child to comfort them.

F. Forensic restrictions imposed by correction authorities for security purposes.

REFERENCES

NIAHO PR.7 RESTRAINT OR SECLUSION standards, Revision 18-2, 01-21-2019.
Restraint Utilization Quick Reference Tool

TABLE OF REVISIONS

Date	Description of Change(s)
July 2019	Added statement that a new order is required when an additional restraint type (i.e. limb) is added. Updated that an order must be obtained either during the emergency application of the restraint or seclusion, or immediately within a few minutes after the restraint or seclusion has been applied.