

PARKLAND HEALTH & HOSPITAL SYSTEM
Nursing Service

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BEHAVIORAL RESTRAINTS/SECLUSION

I. PURPOSE

To protect a patient from injury to self or to others.

To ensure protection of the rights and physical well being of patients during restraint and/or seclusion.

II. PHILOSOPHY

Leaders of Parkland Health & Hospital System are committed to prevent, reduce and strive to eliminate restraint and seclusion.. Restraint or seclusion should only be used as an intervention of last resort after less restrictive measures have been found to be ineffective or are judged unlikely to protect the individual or others from harm. Patient rights, dignity, and physical and psychological well being will be protected throughout restraint usage. Restraint or seclusion will be used for the shortest period of time necessary for the patient to regain control and cope effectively with his/her environment.

III. DEFINITIONS

- A. Mechanical Restraint: The application of a mechanical device restricting the free movement of the whole or a portion of an individual's body in order to control physical activity.
- B. Chemical Restraint: A medication or chemical used to control behavior or restrict freedom of movement and which is not a standard treatment for the patient's medical or psychiatric condition.
- C. Seclusion: The involuntary confinement of a person in a hazard-free room or an area in which direct observation can be maintained and from which egress is prevented .

IV. PRACTICE STATEMENT

- Restraint and seclusion shall only be used in emergency situations when less restrictive interventions have been determined to be ineffective. Nonphysical interventions are attempted first as the preferred method of intervening.
- The patient may be restrained by qualified staff after exhibiting behavior(s) that may result in imminent probable death or substantial bodily harm to self and/or imminent physical or emotional harm to others.

- Restraint or seclusion must be initiated in a way that avoids undue physical discomfort, harm, or pain to the individual. A restraint shall not be used that secures an individual to a stationary object while the individual is in a standing position, that causes pain to restrict an individual's movement, that restricts circulation, that obstructs an individual's airway or puts pressure on the torso, that impairs an individual's breathing or that interferes with an individual's ability to communicate. Only the minimal amount of physical force that is reasonable and necessary may be used to implement restraint or seclusion, and only Client Management, PMAB or other departmentally approved interventions may be utilized.
- A prone or supine hold shall not be used except to transition an individual into another position and shall not exceed one minute in duration.
- Clinical time-out and quiet time shall not be used in a behavioral emergency or without the individual's consent
- Supportive or protective devices shall not be used in a behavioral emergency or without the individual's consent
- Use of chemical restraint is prohibited.
- Use of restraint or seclusion solely as a behavior therapy program or as part of a behavior therapy program is prohibited.
- Restraint or seclusion shall not be used:
 - ⇒ As punishment, discipline, retaliation or coercion
 - ⇒ For the purpose of convenience of staff or other individuals
 - ⇒ As a substitute for effective treatment or rehabilitation
- The use of a restraint or seclusion shall be in accordance with a written modification to the patient's plan of care and for the shortest period of time necessary for the patient to cope effectively with his/her environment.
- Patient rights shall be preserved at all times during the use of restraint/seclusion.
- Each individual and/or family is informed of the organization's philosophy on the use of restraint and seclusion, to the extent that such information is not clinically contraindicated.

V. ALTERNATIVES TO RESTRAINT/SECLUSION

Before ordering restraint or seclusion, the physician must take into consideration information that could contraindicate or otherwise affect the use of restraint or seclusion, including information obtained during the initial assessment of each individual at the time of admission or intake. This information includes, but is not limited to:

- ◆ Techniques, methods, or tools that would help the individual effectively cope with his or her environment;
- ◆ Pre-existing medical conditions or any physical disabilities and limitations, including substance use disorders, that would place the individual at greater risk during restraint or seclusion;
- ◆ Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint or seclusion;
- ◆ Any history that would contraindicate seclusion, the type of restraint or a particular type of restraint device;
- ◆ An advance directive for mental health treatment, if there is one.

The following and other preventive, de-escalative, and verbal intervention techniques, in addition to those in the Client Management or PMAB curriculum may be utilized whenever possible to diminish the necessity for resorting to restraint/seclusion: Diversion, Exercise, Reality Orientation, Snacks, Time-out, 1:1 verbal intervention, Medication, Decrease stimulation.

VI. PROCEDURE

1. The physician or clinically competent registered nurse shall conduct a face-to-face assessment of the patient to determine whether or not the behavior requires restraint or seclusion.
2. No PRN orders shall be accepted.
3. Only a physician member of the facility's medical staff shall order restraint/seclusion.
4. Only a clinically competent Registered Nurse may initiate restraints if a physician is not immediately available. The Registered Nurse shall obtain and document a physician's verbal order by telephone no later than one (1) hour following initiation of the restraints.
5. The physician shall perform a face-to-face assessment of the patient and evaluate the need for restraint or seclusion within one hour after the initiation of this intervention.

6. The physician may delegate the face-to-face evaluation of the patient to a staff person who is under the clinical supervision of a physician appointed to the medical staff and who is privileged to practice in the facility; and who is a physician assistant or an advanced practice nurse who is appointed to medical staff and has privileges to practice. The delegating physician must ensure that the follow-up face-to-face evaluation be performed not later than 24 hours following the initiation of seclusion or restraint.
7. The physician must personally sign, time, and date the telephone order within 24 hours of the time the order was issued.
8. If the physician who ordered the intervention is not the treating physician, the physician ordering the intervention must consult with the treating physician as soon as possible. The physician who ordered the intervention must document the consultation in the individual's medical record.
9. Each written order for restraint or seclusion is limited to
 - Adults: 4 hours
 - Children/adolescents ages 9-17 years: 2 hours
 - Children under 9 years: 1 hour
 - Personal restraint: 15 minutes

The order must stipulate if the physician's order may be continued based on a face-to-face evaluation by a clinically competent registered nurse. If that clinically competent registered nurse has determined the continuing existence of an emergency, the nurse must contact the physician. The physician may then renew the original order.

10. The original order shall be renewed in accordance with the above limits for up to a total of 15 minutes for personal restraint, 8 hours for individuals older than 17 years, 4 hours for individuals ages 9- 17 years and 2 hours total for individuals under age 9.
11. After the original order expires, the physician shall perform a face-to-face evaluation of the patient prior to issuing a new order.
12. Orders for restraint/seclusion automatically expire when the patient is released for any reason.
- 13 The **physician's order** for the use of restraint/seclusion shall:

- ◆ Specify the date, time of day, and maximum length of time the intervention and procedures may be used
- ◆ Be signed, timed, and dated by the physician or the RN who accepted the prescribing physician's telephone order.
- Be in accordance with a written modification to the patient's plan of care
- Designate the specific intervention and procedures authorized, including any specific measures for ensuring the individual's safety, health, and well-being
- Describe the specific behaviors that resulted in the need for restraints/seclusion.
- Describe the specific behaviors necessary for the patient to be removed from restraint/seclusion.
- Indicate whether or not patient has a medical history of seizures, heart disease, Asthma, COPD, Diabetes, and/or Substance Abuse, physical/sexual abuse, and/or physical disabilities
- Indicate whether or not the patient has consented to notification of family regarding the use of restraint or seclusion.

14. Family Notification: The patient's legally authorized representative or family member must be notified of each episode of restraint or seclusion as follows:

- ◆ A staff member must notify as soon as possible the legally authorized representative of a minor under age 18 who has not been married
- ◆ In cases in which the adult patient has consented to have family members informed regarding his/her care, the staff member will inform the family member of the restraint or seclusion episode.
- ◆ The date and time of notification and the name of the staff member providing the notification will be documented in the record
- ◆ As permitted by the Texas Health and Safety Code, the psychiatric unit may deny an individual's legally authorized representative access of any portion of the patient's record if determined that disclosure of the information would be harmful to the patient's physical, mental or emotional health.

15. Personal Possessions: The individual's right to retain personal possessions and personal articles of clothing may be suspended during restraint or seclusion episodes when necessary to ensure the safety of the individual or others. An

inventory of the belongings removed from the patient will be listed on the unit-specific, appropriate paperwork for patient belongings.

16. The Role of the Clinically Competent Registered Nurse:

- Change of Shift: The status of any patient in restraint/seclusion shall be reviewed and documented. The review must include the time the intervention was initiated, the current physical, emotional and behavioral condition of the patient, medication administered and type of care needed.
- Assessment & Documentation: The Registered Nurse shall assess and document:
 - Patient's behavior/action
 - Non-restrictive intervention prior to restraint application
 - Time of application
 - Inspection of seclusion area
 - Safety and appropriate application of restraints
- The Registered Nurse shall re-evaluate the patient at least hourly and at an interval determined by assessment of the individual patient's needs with documentation on the Psychiatry Restraint/Seclusion flow sheet.

17. Care and Monitoring

- Assigned staff members shall document observations and behaviors on the Psychiatry Restraint/Seclusion flow sheet.
- ◆ A staff member of the same gender as the individual must maintain continuous face-to-face observation of an individual in restraint, unless the individual's history or other factors indicate this would be contraindicated.
- ◆ A staff member who is not physically applying personal restraint must maintain continuous face-to-face observation of an individual in personal restraint.
- Observation, circulation, respiration, position checks and skin integrity checks shall be provided every 15 minutes.
- ◆ Cardiac status must be monitored and documented hourly.
- Every two hours and prn, offer hydration, feeding and bathroom privileges.
- Patient is bathed at least once daily.

- Patient's personal possessions/articles are handled according to unit-specific patient belonging procedures.
- Opportunity for range of motion and exercise shall be provided for a period of not less than 5 minutes during each hour in which a patient is in restraints.
- Patients placed in a restraint shall be placed on 1:1 observation. A patient in seclusion must have continuous face-to-face observation for the first hour. After the first hour, the staff members may monitor the patient continuously using video and audio equipment.
- A staff member of the same gender shall provide face-to-face observation unless contraindicated.
- During meal times and when the secluded patient is medicated, he/she will be observed continuously.
- Frequency of monitoring may increase based on patient assessment.

18. Release

If the individual appears to fall asleep while in restraint or seclusion, the clinically competent RN will assess the individual and determine if the individual is asleep. If the patient is asleep, the RN will instruct authorized staff to release the patient from restraint or unlock the seclusion room door. Face-to-face observation will continue until the patient is awake. The RN will assess the patient upon awakening for evidence of behaviors requiring restraint or seclusion. If the behaviors are present, the RN must obtain a new physician's order.

When the individual has exhibited the release behaviors described in the physician's order, the staff member must contact the physician or the RN, who will evaluate the individual for release. If it is determined that the patient meets the release criteria, staff must immediately release the individual.

Following the release of an individual from seclusion or restraint, staff must take appropriate action to facilitate the patient's re-entry into the milieu, and must observe the patient for at least 15 minutes. Staff members must document the individual's behavior during the 15 minute transition period.

19. Emergency Situations

If an emergency health situation (e.g., seizure) occurs, the patient must be released from restraint or seclusion as soon as possible as dictated by the emergency. The individual's emergency medical condition will be promptly addressed and treated in accordance with procedures for appropriate management of emergency medical conditions. If the specific conditions that required the initiation of restraint or seclusion still exist after the emergency health situation is resolved, a physician must conduct a face-to-face examination of the patient to determine if restraint or seclusion may be initiated without adverse effects. The physician's examination must be documented in the patient's record, and the physician must write a new order before the procedure may be initiated.

During evacuation of the facility due to a drill or actual disaster, the patient shall be released from restraint or seclusion.

20.. Debriefing

A debriefing meeting shall occur as soon as is possible and appropriate, but no longer than 24 hours after the seclusion/restraint episode. The individual and/or family members shall be included as appropriate in the debriefing meeting. The debriefing is used to identify what led to the incident and what could have been handled differently, ascertain that the individual's physical well-being, psychological comfort and right to privacy were addressed, counsel the individual involved for any trauma that may have resulted from the incident, and modify the treatment plan as needed. The occurrence of the debriefing is documented on the Seclusion/Restraint Debriefing Record and the Unit Manager or designee is notified, within 24 hours, of any problematic issues that arise from that debriefing.

21. Staffing

Staffing needs shall be considered at the time restraint or seclusion is initiated; i.e., adjustment of assignments, relocation of patient within unit, or the need for additional staffing.

22. Education

- Staff

All Psychiatry staff shall be provided education regarding seclusion/restraint in orientation with an annual update. Education will be in accordance with the Seclusion/Restraint Staff Training and Competence Guidelines (appendix A).

- Patients

- ⇒ As soon as is feasible after restraint or seclusion has been implemented, staff must discuss with the individual the specific behaviors that necessitated restraint or seclusion, how the individual's behavior continues to meet the criteria, and the behaviors that must be demonstrated to be released from restraint or seclusion or have a reduction of physical restraint. Communication with the individual must be conducted in a language or method that is understandable to the individual.
- ⇒ If the individual does not appear to understand the information, staff must attempt to re-explain it every 15 minutes until understanding is reached or the order for restraint or seclusion has expired.
- ⇒ Staff must document all attempts to communicate the information.

23. Treatment Team Review

The treatment team reviews alternative strategies for dealing with behaviors necessitating the use of restraint or seclusion more often than twice in any hospital admission or 30-day period, whichever is shorter. The treatment team must explore whether alternative treatment strategies for the future should be considered for an individual when restraint or seclusion is used:

- ◆ More than twice in any 30 day period,
- ◆ In two or more separate episodes of any duration within 12 hours; or
- ◆ For more than 12 continuous hours.

24. Restraint Reporting

- All uses of Behavioral restraint or seclusion in an emergency situation are reported to the Clinical Research/Performance Improvement Department and appropriate action is taken to correct unusual or unwarranted utilization patterns.
- The Unit Manager or designee is notified of any instances in which an individual:
 - ⇒ Remains in restraints or seclusion for more than 12 hours;
 - ⇒ Experience 2 or more separate episodes of restraint and/or seclusion of any duration within 12 hours.
 - ⇒ Receives injuries or death as a result of the intervention

Thereafter, the Unit Manager or designee is notified every 24 hours if any of the above conditions continue.

Notification will be documented on the Behavioral Restraint/Seclusion log sheet.

25. Restraint during transport

- ◆ A registered nurse shall accompany the staff members transporting a patient off facility premises when restraint is ordered prior to departure or when there is reason to believe that during the time away from the facility the individual may require medical attention, medication or restraint. Procedures and time frames for obtaining physician orders will be followed. Procedures for implementing, monitoring, documenting and reporting restraints will also be maintained.

VII DEFINITIONS — ACCEPTABLE MECHANICAL RESTRAINTS

Only PHHS available or departmentally approved devices specifically designed for the safe and comfortable restraint of humans may be used as mechanical restraints.

- Ankles — a cloth or leather band fastened around the ankle or leg and secured to a stationary object. Acceptable fasteners include Velcro and buckles.
- Belts — a cloth or leather band fastened around the waist. The belt may either be attached to a stationery object or used for securing the arms to the sides of the body.
- Vests — a sleeveless cloth jacket that covers the upper trunk and is fastened in the back or front with ties or Velcro. The vest may be secured to a stationary object.
- Wristlets — a cloth or leather band fastened around the wrist or arm to a stationary object. Acceptable fasteners include Velcro and buckles.
- Mittens — a cloth, plastic or foam rubber covering fastened around the wrist or lower arm. Acceptable fasteners include elastic, Velcro, ties or strings.
- Restraining Net — mesh fabric over the upper and lower trunk of the body, with head, arms and lower legs exposed, secured over a mattress to a bed frame.
- Helmet — A plastic, foam rubber or leather head covering, such as a sports helmet, that may include an attached face guard. The device must be the

proper size and the chinstrap should not be so tight as to interfere with breathing and circulation.

- Enclosed bed – A bed with high side rails or other type of side enclosure, and in some cases, an enclosure (e.g., mesh, rails, etc.) on the top of the bed that prevents the individual's voluntary egress from the bed.
- Transport Jacket — A heavy canvas jacket without sleeves that encases the arms and upper trunk. It is fastened with Velcro closures and roller buckles and held in place with a strap between the legs. The device is used only as a temporary measure during transport.
- Straight Jacket — A heavy canvas jacket that is open in the back with sleeves that are stitched closed. The individual's arms are crossed in front of the body; the sleeves secured with ties behind the individual's back. The device must not be secured so tightly as to interfere with vital functions, including breathing and circulation or cause muscle strain. Caution should be exercised when using this device because it may impair the individual's balance and ability to break a fall.

VIII. UNACCEPTABLE RESTRAINTS/POSITIONS

Tape of any kind

Metal wrist or ankle restraint/cuff (Except patients in custody of Law Enforcement Agencies)

Long ties, i.e., leashes

Bed sheets

Restrain patient in a standing position to a stationary object

Restrain a patient's upper extremities above head

Hands and feet tied together behind patient's back

IX. USE OF RESTRAINT OR SECLUSION DURING MEDICAL OR DENTAL CARE OR REHABILITATION

- (a) Restraint or seclusion may be used during medical and dental rehabilitation if necessary and a regular and customary part of care or rehabilitation treatment (e.g., seclusion as part of isolation procedures for an individual with a contagious disease; body restraint during surgery; arm restraint during intravenous administration; restraints to prevent an individual who is unable to ambulate independently and safely from falling out of bed or out of a wheelchair; restraint devices to carry out dental procedures, etc.).

- (1) *Medical care or rehabilitation.* Restraint or seclusion may be used without a physician's written order only if its use is part of the facility's written medical or nursing procedures. The procedures used must be recorded in the individual's record.
 - (2) *Dental care or rehabilitation.* A dentist may order restraint or seclusion for dental procedures only. In order to determine potential contraindications to restraint or seclusion, the dentist must consult with the individual's treating physician before the individual's initial dental treatment (*and subsequently as necessary*) and document the consultation and recommendations. The procedures used must be recorded in the dental section of the individual's record.
- (b) The facility's medical and nursing staff must develop specific procedures for monitoring the individual's physical condition while in restraint (i.e., skin integrity checks, circulation checks, range of motion, etc.), and the procedures must be included in the facility's written policies and procedures.

X. USE OF PROTECTIVE DEVICES

(a) Protective devices may be used for the following purposes:

- (1) To prevent self injury. Protective devices may be used for individuals with physical disabilities if the individual exhibits involuntary movements that are potentially self-injurious (e.g., helmets for individuals with seizures, use of bed rails to prevent individuals with seizures from falling out of bed, seat belts to prevent individuals from falling out of wheelchairs) and other, less restrictive interventions are not appropriate.
 - (1.1) The temporary use of protective devices requires a physician's order. A separate order must be obtained if a protective device is used for emergency restraint.
 - (1.2) If the use of a protective device continues after one week, its use must be reviewed by the individual's treatment team, and a plan describing the use of protective devices documented in the treatment plan. The treatment plan must document what is being prescribed to identify and overcome the need for the protective device. It should be documented as an objective in the treatment plan with a goal to alleviate the need for the device or prevent further deterioration. The plan for use of the protective device must be approved by the staff physician and reviewed and renewed, as appropriate, at each treatment plan review.

(2) To permit the healing of wounds. Protective devices may be employed to allow wounds to heal.

(2.1) The use of protective devices to permit wounds to heal may be implemented only with a physician's written order.

(2.2) The order must be reviewed and, if appropriate, 405.127 of this title (relating to Use of Restraint or Seclusion).

(b) Protective devices may not be used:

(1) As punishment;

(2) For the purpose of convenience of staff or other individuals; or

(3) As a substitute for effective treatment or habilitation.

XI. USE OF SUPPORTIVE DEVICES

(a) Types of mechanical restraints may be used as supportive devices to posturally support an individual or assist in obtaining and maintaining normative bodily functioning (e.g., use of vests for individuals who are not able to posturally support themselves). The facility must have written policies and procedures that address the proper implementation and monitoring of supportive devices.

(b) The use of a supportive device is considered an adjunct to proper care of an individual, and may not be used as a substitute for appropriate nursing care.

(c) If an individual cannot obtain or maintain normal body functioning, the treatment team may consider the need for a supportive device and make recommendations to the physician. When considering the need for a supportive device, the treatment team must include an occupational or physical therapist or registered nurse who is familiar with the individual being discussed. The treatment plan must document what is being prescribed to identify and overcome the need for the supportive device. It should be documented as an objective in the treatment plan with a goal to alleviate the need for the device or prevent further deterioration.

(1) The use of a supportive device is a temporary solution to a situation. A separate order must be obtained if a supportive device is used for emergency restraint.

(2) In recommending a supportive device, the treatment team must document in the individual's treatment plan record the:

(2.1) Device's therapeutic purpose

(2.2) Conditions necessitating its use

(2.3) Alternative strategies that have been attempted and failed.

- (d) The use of a supportive device must be prescribed by a physician whose written order designates the:
 - (1) Specific device authorized
 - (2) Maximum length of time for its use
 - (3) Intervals for release from the device for exercise
 - (4) Monitoring of physical conditions while in the device, if needed.

- (e) The use of supportive devices must be reviewed at each treatment plan review and may be reordered, if indicated.

- (f) If the prescribed device is not specifically for assisting with sleep or safety

- (g) Supportive devices may not be used:
 - (1) As punishment
 - (2) For the purpose of convenience of staff or other individuals
 - (3) As a substitute for effective treatment or habilitation.