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SECLUSION AND RESTRAINT

PURPOSE:

To establish guidelines for the use of seclusion or restraint which shall:

- Outline requirements established by the regulatory agencies of Joint Commission, Centers for Medicare and Medicaid Services (CMS), Federal law, as well as Nebraska State Law;
- Limit the use of seclusion or restraint to emergency situations when less restrictive measures have been found ineffective;
- Protect individual dignity and rights while using the least restrictive means possible;
- Ensure the safe and appropriate use of and care for the patient requiring seclusion or restraints; and
- Reinforce the utilization of patient specific preferences and choices (as possible) to diminish the traumatic perceptions of seclusion or restraints.
- Assure all patients exiting a building or the hospital for outside appointments are screened to determine use of transport restraint policy #PC-03 or this policy.

POLICY:

The Lincoln Regional Center (LRC) recognizes seclusion and/or restraint as an inherently potentially dangerous intervention. As such, it is the policy of LRC to use verbal calming techniques, behavioral alternatives, patient personal safety plans (initiated during the admission process with input from the patient and her/his family and/or significant others), PRN's etc., prior to resorting to the use of seclusion and/or restraint.

All direct care employees of LRC are trained in the use of Mandt techniques through the Mandt System. Mandt stresses the use of verbal and other non-physical de-escalation techniques. The specific techniques are delineated in the Mandt System manual and its related training materials.

Seclusion/restraint shall be used only for emergencies when the patient is posing imminent danger and treatment approaches are insufficient to prevent the patient from injuring him/herself or others. When these procedures are necessary, they are to be used for the shortest time possible. All interventions implemented shall be documented and reviewed by the Treatment Team during the Special Treatment Plan Review process.

The use and duration of seclusion and restraint shall be in compliance with the Nebraska Statutes and standards of accrediting and certifying agencies.

DEFINITIONS

1:1 OBSERVATION: Continuously monitored (by seeing and hearing) the patient in seclusion and/or restraint. During restraint episodes, the patient and staff should be positioned so that the 1:1 staff member can monitor the patient's breathing, color, level of alertness, physical and psychological comfort, and signs/symptoms of distress. (**NOTE:** Only Nursing Service staff is permitted to sit 1:1 with a patient in seclusion/restraints). Staff assigned to monitor patients on a 1:1 status will document on the Seclusion/Restraint Document.

PERSONAL SAFETY PLAN: A Personal Safety Plan which identifies treatment and interventions decided upon with the patient and/or family/guardian to address trigger(s) leading to inappropriate behaviors. This plan also includes any psychiatric conditions / medical issues that would place the patient at a greater risk during a seclusion/restraint episode.

EVENT BEGIN/END TIME: An occurrence of seclusion or restraint is an event that begins when a patient goes into seclusion or restraint and ends when the patient is released. To further clarify, if an order is rewritten and the patient never exits seclusion/restraint between the original order and the second order, only one event has occurred. If a patient is removed from seclusion or restraint for any purpose other than hygiene or range of motion exercise breaks and then is returned to seclusion or restraint, the initial event should be considered to have ended and a new event started.

FACE TO FACE EVALUATIONS: A method of assessment in which a LIP or trained R.N. (beyond the LIP normal business hours) is in the physical presence of, views, and verbally communicates with the patient in order to complete a physical and psychological assessment. The patient's physical and psychological status is reviewed with staff. A determination is made whether seclusion or restraint should be continued and guidance is provided for staff in identifying ways to help the patient regain control so that the procedure can be discontinued. The face to face evaluation is completed within one (1) hour of implementation of any seclusion or restraint procedure.

FAMILY/SIGNIFICANT OTHER(S): The person(s) who has a significant role in the individual's life, which may include a guardian or person(s) not legally related to the individual receiving care. (**NOTE:** This will be addressed in the procedure section as "family".)

IMMINENT DANGER: Immediate substantial risk of bodily injury to the patient or others (e.g., it is believed that death or serious physical harm could occur within a short time).

RESTRAINT:

- a. **MECHANICAL** – Any mechanical device, material, or equipment attached or adjacent to the patient's body that restricts freedom of movement or normal access to one's body.
- b. **MANDT HOLDS** – Direct application of non-mechanical, physical hold to a patient, from which the patient is unable to free himself/herself, with the intention and/or result of restricting the patient's physical movement.

Any contact between staff and patient that restrict a patient's movements or is for the purpose of relocating a patient from one area to another is considered a restraint. (**NOTE:** In emergency situations, trained staff present at the time of crisis, may apply approved Mandt holds until an R.N. arrives on the scene prior to receiving a Physicians Order. A Physicians Order must be obtained either during the emergency or immediately after the procedure. Manual holds are procedures to be used as protective measures for patients whose behavior poses a threat to self or others.)

- c. **FLOOR RESTRAINT** – a protective procedure used to maintain a patient on the floor if/when a Mandt hold was not effective in maintaining a situation.

SECLUSION:

- a. The involuntary confinement or patient perception of being in a room or area where the patient's freedom to leave is restricted.
- b. Staff-directed patient confinement to a room is also considered seclusion, e.g., if patient is directed to go to a room and is not allowed to come out when the patient desires (the door may be open or closed).

TREATMENT TEAM: An interdisciplinary group of staff responsible for and directing the patients treatment planning and treatment plan revisions used to guide the patients plan of care throughout his/her hospitalization.

PROCEDURE:

- A. When a patient's behavior begins to escalate utilize appropriate intervention strategies, including a Personal Safety Plan. Be aware of any psychological conditions or medical issues that would place the patient at a greater risk upon placement in seclusion/restraint.
- B. If a patient's behavior continues to escalate and is likely to reach the level of immediate substantial risk of bodily injury to self or others (imminent danger), prepare to initiate steps to secure patient for his/her safety and the safety of others.
- C. R.N. may initiate seclusion or restraint. A physician's order for the use of the procedure must be obtained as soon as possible after initiation but within an hour. The R.N. provides the following information to the physician when obtaining the order:
 - 1. Specific behaviors and less restrictive interventions attempted; and
 - 2. A review of the patient's physical and psychological status.
 - 3. Determine whether seclusion or restraint should be continued and obtain the patient's criteria for release if continued.
 - 4. Each order for seclusion or restraint shall be time-limited based on the individual assessment of the patient and in no case shall the order be written to exceed four (4) hours. **Orders for seclusion/restraint are never written as a standing order or on an as-needed (PRN) basis.** If seclusion or restraint is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating. When the original order is about to expire, the physician can be notified of recent assessment by R.N. to request a renewal not to exceed four (4) hour limit for up to a total of 24 hours. Documentation must accompany order renewals.
- D. Prior to placing the patient in seclusion or restraint, the patient may be searched; belts and shoes will be removed. The patient may remain in personal clothing unless risk of suicide is an issue in which case the patient will be provided appropriate clothing. All patients' privacy will be respected; when feasible, same-gender staff will be present.
- E. Using only approved LRC techniques place the patient in seclusion and/or restraints to prevent immediate harm to self or others. Nursing staff will explain to the patient the specific behavior warranting the seclusion/restraint, and the specific behaviors necessary to discontinue the seclusion or restraint.

- F. An LIP or trained R.N. shall perform a face-to-face physiological and psychological assessment within one (1) hour of implementation of any restraint or seclusion procedure. A face-to-face assessment shall be conducted at least every eight (8) hours thereafter. (**NOTE:** A face-to-face assessment is completed every (12) hours for patients on Highly Restrictive Status.)
- G. Within 15 minutes of the placement in seclusion or initial application of restraint, the R.N. must personally assess the patient to:
1. Confirm that restraint or seclusion does not pose an undue risk to the individual.
 2. Identify any injury sustained during restraint or seclusion process; and
 3. Ensure application of restraint is correct and circulation is adequate.
- (**NOTE:** Documentation will be placed in the first hourly assessment note, or if patient was released within one (1) hour, this will be included in the discontinuation note.)
- H. The R.N. assigns Nursing Service Staff who has completed Nursing Service Orientation to continuously monitor the patient on a 1:1 basis. (**NOTE:** Only Nursing Service Staff are allowed to assume this duty.) Assigned trained/competent staff monitors the patient continuously and documents every fifteen (15) minutes (& as appropriate) on the Seclusion/Restraint Precautions form #70-5-35 for continued safety of the patient and to meet the patient's personal needs. Documentation may include describing behaviors observed, mental/physical status and comments made by the patient.

I. SECLUSION: Items to be monitored while a patient is in seclusion include:

- a. Any signs of injury associated with the seclusion.
 - b. Nutrition/hydration – Assess hunger and thirst by verbalization. Offer fluids every two (2) hours at a minimum, unless excess activity or perspiration indicates greater frequency, and food at regularly scheduled intervals.
 - c. Vital signs – are assessed continuously while the patient is in seclusion by observing skin color, respirations or any signs of distress. A nurse accompanied by staff will take blood pressure, pulse and respirations every 15 minutes while the patient is secluded. Documentation will validate why Vital Signs would not be done at any of the 15 minute intervals.
- (**NOTE:** Vital signs will be recorded on the Seclusion/Restraint Precautions form #7-05-35.)
- d. Hygiene and elimination – Assess need for elimination based on patient's request, behavior, and offer toileting every two (2) hours at a minimum. If unsafe to take to restroom, offer bedpan or urinal;
 - e. Physical and psychological status and comfort; and
 - f. Readiness for discontinuation of seclusion (staff continue to assist patient in meeting this criteria).

(**NOTE:** If activities require a staff to enter the seclusion room, a minimum of two(2) staff should enter.)

II. RESTRAINT: Items to be monitored while a patient is in restraints include:

- a. Any signs of injury associated with the application of restraint.
- b. Nutrition/hydration – Assess hunger and thirst by verbalization. Offer fluids every two (2) hours at a minimum, unless excess activity or perspiration indicates greater frequency, and food at regularly scheduled intervals.
- c. Vital signs – are assessed continuously. During the 1:1 observation, blood pressure, pulse and respirations will be done every 15 minutes. Documentation will validate why Vital Signs would not be done at any of the 15 minute intervals.

(NOTE: Vital signs will be recorded on the Seclusion/Restraint Precautions Form #70-5-35.)

- d. Hygiene and elimination – Assess need for elimination based on patient's request, behavior, and offer toileting every two (2) hours at a minimum. If unsafe to take to restroom, offer bedpan or urinal;
- e. Circulation in and range of motion to the extremities while in restraint – Range of Motion exercises shall be provided every two (2) hours at a minimum. This is to be accomplished with a minimum of two (2) staff, one extremity released at a time. Circulation checks are to be completed upon application/reapplication of restraint every two (2) hours at a minimum. Checks include skin color, temperature, and presence of capillary refill.
- f. Physical and psychological status and comfort; and
- g. Readiness for discontinuation of restraint (staff continue to assist patient in meeting this criteria).

(NOTE: If activities require a staff to enter the seclusion room, a minimum of two(2) staff should enter.)

- h. After order is obtained from LIP: Nursing Service staff shall describe the specific behavior(s) leading up to the seclusion and/or restraint incident on Form #70-5-35. This documentation should include what de-escalation techniques or Personal Safety Plan responses were attempted to assist the patient in calming, and any information that may be useful in the management of the next crisis. **(NOTE:** The R.N. may write the assessment on the Nursing Seclusion and Restraint Documentation Form #70-5-35.) If the patient incurred a physical injury requiring the attention of Medical Staff, the R.N. must also document the injury and any follow-up treatment.
- i. If a PRN or STAT medication is administered, the R.N. assesses patient's response to medication within one (1) hour and documents response on the Nursing Seclusion and Restraint Documentation Form #70-5-35.
- j. R.N. assesses patient and writes an hourly assessment note on Form #70-5-35, comparing current behavior to the specific conditions for release, documents education provided to patient to help patient meet the release criteria, and documents patient's responses to any PRN/STAT medications administered. If restraint is utilized, reviews documentation of circulation checks and vital signs and includes status in the hourly assessment.

- k. R.N. ensures family/significant other/guardian notification in all cases for which the patient has given approval to provide this notification on the permission to release information found in the database section of the medical record. (**NOTE:** Family/significant other/guardian are provided a copy of this policy upon admission.)
- 1. If attempt to contact family is unsuccessful, document on Form #70-5-35 the attempt that was made (all attempts to make family/guardian contact will be documented), including the date, time, and reason contact was not successful (i.e., no answer, left message, phone disconnected, etc.). The Social Worker will be notified for follow-up if contact unsuccessful.
- 2. If family contact is made, documents on the Nursing Seclusion and Restraint Documentation Form #70-5-35 that notification took place, the date and time of notification, who was spoken to, and any pertinent information.
- l. The R.N. releases patient immediately from seclusion and/or restraint when the patient meets the pre-established behavioral criteria set by LIP for release. The R.N. documents time of release and assesses patient's response to the discontinuation on Form #70-5-35. (**NOTE:** The time-limited order does not mean that seclusion and/or restraint must be applied for the entire length of time for which the order is written.)
- m. The R.N. will initiate a debriefing with the patient as soon as possible after patient release from hold/seclusion/restraint. The R.N. will document the debriefing on the Nursing Seclusion and Restraint Documentation Form #70-5-35.
- n. Staff will initiate a Post-Intervention Conference with the staff involved in the event within the shift of occurrence to allow for expression of experiences concerning the incident and to review what was done and if anything could have been done differently. (A Compliance Specialist can be notified to facilitate the Post-Intervention Conference.) The Team Leader of the Post-Intervention Conference will document the Conference on the Post-Intervention Conference Form #70-5-35.
- o. All seclusion and restraint situations will be reported to the designated Manager-On-Call within the shift that the incident occurred.
- p. All incidents of seclusion and restraint are reviewed weekly by the LRC Leadership Team. Data is collected in the following areas to identify opportunities to reduce risk associated with the use of seclusion and restraint:
 - shift of occurrence
 - location of episode
 - staff who initiated
 - length of episode
 - date & time of each episode
 - day of the week
 - restraint type
 - any injuries sustained
 - patient age / gender
 - use of medication associated with each episode
 - patient identifier
- q. The Treatment Team shall review the patient's treatment plan on the first working day after the event (Special Treatment Plan Review Form #70-5-149) with each seclusion or

restraint episode, with the exception of transport restraints. For multiple episodes in a 24-hour period one review will be held.

- r. The Clinical Director shall be immediately notified by the RN of any instance in which a patient remains in seclusion or restraint for more than 12 hours, or experiences two (2) or more separate episodes of seclusion or restraint of any duration within 12 hours.
- s. If a seclusion and restraint exceeds 24 hours in duration, the Clinical Director will be contacted and will review the case. A notation will be made by the R.N. on Form #70-5-35 of the decision by the Clinical Director. If the Clinical Director is the attending physician in such a case, the President of the Medical Staff, or designee, shall review the seclusion and restraint. Thereafter, the Clinical Director is notified every 24 hours if either of the above conditions continues.

NOTE: The hospital must report the following information to CMS:

- Each death that occurs while a patient is in seclusion or restraint.
- Each death that occurs within 24 hours after the patient has been removed from seclusion or restraint.
- Each death known to the hospital that occurs within one (1) week after seclusion or restraint where it is reasonable to assume that use of seclusion or restraint contributed directly or indirectly to a patient's death.
- Each of the above incidents must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death. Staff must document in the patient's medical record the date and time the death was reported to CMS.

TRAINING:

- A. All R.N.'s are required to receive face-to-face training prior to conducting face-to-face assessments.
- B. LRC utilizes Mandt de-escalation. All employees working for/at LRC will complete Relational, Conceptual and Technical Skills Mandt upon hire during their new employee orientation.
 - Nursing Service, Therapeutic Recreation, Security Officers and Whitehall staff are required to complete the following during their new employee orientation and annually:
 1. Mandt RCT Certification
 2. Safety skills training and return demonstration in the concepts of distancing (punches, kicks, corners), separating skills (chokes and headlocks), separating patients, objects thrown/jabbed/swung, team application of skills and holding/restraining for intramuscular injections.
 3. Floor Restraint training and return demonstration per the Nursing Service Floor Restraint procedure.

- Security Officers require additional certification in Mandt Advanced skills (a pre-requisite for Advanced Mandt is current certification in Mandt (RCT), and annual Mandt Advanced recertification.
 - All physicians and A.P.R.N.s will have a working knowledge of hospital policy regarding the use of Mandt, seclusion and restraint. The remainder of LRC employees are not required to maintain any level of Mandt Certification after initial completion.
- C. All employees working for/at LRC will be trained on the LRC Seclusion and Restraint policy during their new employee orientation.

Nursing Service, Therapeutic Recreation, Security and Whitehall staff require seclusion and safe restraint application basics with return demonstration and training in monitoring, assessment, and providing care for a patient in seclusion or restraint.

Nursing Service staff are required to complete the monthly seclusion and restraint reviews/competency demonstrations held in the programs.

- D. Patients are not to be “taken down” to the floor. In the event the patient were to fall/move to the floor during a Mandt physical intervention and for safety reasons the staff are not able to separate from the patient, staff are to utilize the Nursing Service Floor Restraint procedure to safely restrain the patient on the floor.
- E. AT NO TIME IS AN ESCALATED PATIENT TO BE LIFTED OR CARRIED. The patient in restraint devices may be moved to the seclusion or restraint room utilizing a blanket wrap device to slide the patient on the floor to the seclusion or restraint room. If a patient requires lifting from the floor to the bed for full bed restraint, a sufficient number of staff should be utilized and staff should lift utilizing proper body mechanics.
- F. Documentation of training and competence is captured on the employee’s education tracking sheet.

See also: **Policy PC-01 (LRC) – *Personal Safety Plan***
Policy PC-02(a) (LRC) – *Clinical Restraint*
Policy PC-04a (LRC) – *Highly Restrictive Status*
Policy PC-04b (Whitehall) – *Youth Safety Precautions*
Nursing Service Policy – *Floor Restraint*

Procedures specific to Forensic Mental Health Services for transporting a patient are defined in separate policies: **PC-03 (FMHS/SOSR) Transport Restraint.**