AdventHealth

POLICY

Policy #	Policy Name
HVL.ORG.420	Use of Restraints
Policy Location AH Hendersonville	**Responsible Department** Clinical Improvement
Policy Owner or Executive Owner Jody Webb (PR-Quality Manager)	**Original Creation Date** 02/16/1995
Policy Effective Date 12/20/2023	**Policy Review Date** 12/20/2023

I. **SCOPE:** This policy applies to all areas where clinical services are provided by AdventHealth Hendersonville. This policy serves as an addendum to the AHS Corporate policy, Restraint Management AHS CW OCE 0007.

II. **PURPOSE:** To ensure patients will be safe from physical and psychological harm, loss of dignity, and violation of individual rights during hospitalization.

III. **POLICY:** All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint of any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. Restraint is only imposed to ensure the immediate and physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

- **A.** Restraint is only used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
- **B.** 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.
- **C.** When a patient with non-violent or violent restraint is moved from one unit to another, the receiving unit completes an assessment and determines the need to continue restraint.

IV. **PROCEDURE/GUIDELINES:**

A. Non Violent Restraint

1. **Application:** A Registered Nurse (RN) initiates restraints as a last resort upon physician or LIP order, or in emergency situations, prior to obtaining an order from a physician or LIP. The patient's attending physician or LIP is consulted by the nurse as soon as possible if the MD or LIP did not order the restraint prior due to an emergent need.
   - a. Application of the restraint on the patient will follow the restraint manufacturer's instructions.
   - b. Positioning that may cause harm, when restraints are applied to patient, is avoided. (The Joint Commission, 2022)
   - c. Personnel applying restraints are able to recognize and respond to physical signs of distress (via training).

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d. Personnel applying restraints are able to recognize and respond to psychological signs of distress.

2. **Order and Continuance of Order :**
The use of non-violent restraint must be in accordance with the order of a physician or licensed independent practitioner (LIP) responsible for the care of the patient. An order for non-violent restraints will be obtained before application, or when placed in emergency situations, as soon as possible but no later than one hour after application.
   a. The order for non-violent restraint is obtained via computerized physician order entry (CPOE), telephone, written or verbal and includes the type and reason for the restraint. The order includes all devices (including physical holds) that may be utilized during the restraint episode with the goal of utilizing the least restrictive method.
   b. A protocol cannot substitute for obtaining an order.
   c. Orders for the use of non-violent restraint are never written as standing orders or on an "as needed" basis (PRN).
   d. An order for use of non-violent restraints is valid for 24 hours. If restraint usage is needed beyond 24 hours, a new order for restraints must be obtained by the provider.

3. **Monitoring and Interventions:**
   a. On inpatient units, RN assesses the continued need for non-violent restraint every 12 hours and updates the Plan of Care (POC) at least every shift.
   b. RN monitors for circulation, skin integrity, neurological status, mental status, distress and agitation at least every 2 hours or more often based on the needs of the patient, the patient condition and type of restraint used.
   c. Interventions (e.g., hydration, nutrition, hygiene, elimination and range of motion (ROM)) are offered every 2 hours and prn.
   d. Vital signs to be done per unit policy.

4. **Discontinuation**
   a. Non-violent restraint must be discontinued at the earliest possible time, regardless of the length of time identified in the order; only to be used while the unsafe situation continues.
   b. The RN contacts the provider to discontinue the non-violent restraint when the patient is no longer an imminent threat to self or others.
   c. The episode of restraint is considered discontinued when all methods of restraint are removed. A temporary directly supervised release that occurs for the purpose of caring for patient needs (e.g., toileting, feeding or ROM) is not considered a discontinuation of the restraint intervention.
   d. The physician or LIP provides the order to discontinue the restraint episode.
   e. Restraint discontinuation (time, date, name of physician and time of physician notification) is documented in the EMR.

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B. **Violent Restraints:** This includes procedures for **physical holds, mechanical device, chemical or seclusion**. These are all defined below in the Definitions section.

1. **Application:**
   A Registered Nurse (RN) initiates violent restraints as a last resort upon physician or LIP order, or in emergency situations, prior to obtaining an order from a physician or LIP. The patient's attending physician or LIP is consulted by the nurse as soon as possible if the MD or LIP did not order the restraint prior due to an emergent need.
   a. Application of the violent restraint on the patient will follow the restraint manufacturer's instructions.
   b. Positioning that may cause harm, when restraints are applied to patient, is avoided. (The Joint Commission, 2018).
   c. Personnel applying violent restraints are able to recognize and respond to physical signs of distress (via training).
   d. Personnel applying violent restraints are able to recognize and respond to psychological signs of distress.

2. **Order Management and Continuance:**
   e. The use of violent restraint must be in accordance with the order of a physician or licensed independent practitioner (LIP) responsible for the care of the patient. An order for violent restraints will be obtained before application, or when placed in emergency situations, as soon as possible but no later than one hour after application.
   f. The order for violent restraint is obtained via computerized physician order entry (CPOE), telephone, written or verbal and includes the type and reason for the restraint. The order includes all devices (including physical holds) that may be utilized during the violent restraint episode with the goal of utilizing the least restrictive method.
   g. A protocol cannot substitute for obtaining an order.
   h. Orders for the use of violent restraint are never written as standing orders or on an "as needed" basis (PRN).
   i. Orders for the use of violent restraints for violent or self-destructive behavior are only continued in accordance with the following limits for up to a total of 24 hours:
      i. Four hours for adults 18 years of age or older.
      ii. Two hours for children and adolescents 9 to 17 years of age.
      iii. One hour for children under 9 years of age.
   j. A physician or other LIP or Behavioral Health RN who has been trained evaluates the patient face-to-face within one hour of the original order. If a trained RN completes the evaluation, s(he) consults with the physician or LIP within one after the evaluation.

k. The time limits represent the maximum amount of time of each order for restraint based on age. The physician or LIP has the discretion to write the order for a shorter length of time.
l. The original violent restraint order is renewable within the required time limits for up to a total of 24 hours. After the original order expires, a physician must see the patient and conduct a face-to-face re-evaluation before writing a new order for the continued use of violent restraint.

3. **Monitoring and Interventions for Violent Restraints**
   a. RN assesses patient in-person within 15 minutes of initiation and documents assessment in the EMR.
   b. The Behavioral Health nursing and provider team will be consulted to apply, assess, and manage violent restraints ordered for inpatient areas.
   c. The patient is evaluated in-person for physical and behavioral health assessment within 1 hour after the initiation of violent restraint by a physician or other LIP or Behavioral Health RN who has been trained. The face-to-face assessment evaluates the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition and the need to continue or terminate the violent restraint.
   d. When a trained Behavioral Health RN conducts the 1-hour face-to-face evaluation, he/she must consult the attending physician, LIP or physician responsible for the care of the patient within one hour. The trained Behavioral Health RN discusses the findings of the 1-hour face-to-face evaluation, need for other interventions/treatments, and need to continue or discontinue the use of violent restraint.
   e. The patient has continuous observation by trained staff. The condition of the patient is continually assessed, monitored, and reevaluated. When possible, a behavioral health team member will serve as the continuous observer.
   f. Patient's safety, circulation, skin integrity, behavior, affect, mood, and the need for continuing violent restraints are assessed as well as interventions (e.g., hydration, nutrition, hygiene, elimination, and ROM) are offered every 1 hour and prn by nursing staff.
   g. Vital signs to be done per unit policy.
   h. On inpatient units, RN assesses the continued need for violent restraints and updates the Plan of Care (POC) at least every shift.

4. **Discontinuation:**
   a. Violent restraints must be discontinued at the earliest possible time, regardless of the length of time identified in the order, and are only to be used while the unsafe situation continues. The RN contacts the provider to discontinue the violent restraint when the patient is no longer an imminent threat to self or others.
   b. The episode of violent restraint is considered discontinued when all methods of restraint are removed. A temporary and directly supervised release that

occurs for the purpose of caring for patient needs (e.g., toileting, feeding or ROM) is not considered a discontinuation of the restraint intervention.

c. The physician or LIP provides the order to discontinue the violent restraint episode.

d. Violent restraint discontinuation (time, date, name of physician and time of physician notification) is documented in the EMR.

5. **Debriefing:**
   a. A post violent restraint debrief is intended to provide support and decrease the likelihood of future violent restraint events.
   b. The debriefing discussion takes place within 24 hours after violent restraint release with the patient, staff involved, and supervisor, and covers:
      1. The incident within the framework of the patient's life history and mental health issues.
      2. The impact of the event on the patient and ideas to assist in identification of coping mechanisms to avoid violent restraint in the future.
      3. The circumstances leading to the event, nature of de-escalation efforts and alternatives to violent restraint attempted.
      4. Staff response to the incident and ways to effectively support the patient's constructive coping in the future.
      5. Support for patients and staff to return the unit to a therapeutic environment.
   c. Patient debriefing is documented in the medical record.

C. For Any Restraint:

1. **Death Reporting**
   a. Patient deaths that occur:
      i. while a patient is in restraint
      ii. within 24 hours after removed from restraint
      iii. within 1 week after the use of restraint, where it is reasonable to assume that restraints contributed directly or indirectly to the patient's death -- are reported to the Centers for Medicare and Medicaid Services (CMS) within 7 days by the Quality Department. The reporting to CMS is documented in the medical record.
   b. Excluded are patients in only soft wrist restraints; these deaths will be logged and provided to CMS upon request.

2. **Training**
   a. Only staff members successfully completing the AdventHealth Hendersonville restraint principles and application training participate in episodes of restraint utilization. As part of initial orientation, all direct-care staff members, security and contract staff receive education and training regarding the safe use of restraint and alternative methods for handling behavior, symptoms, and potentially violent situations.

b. Annual education regarding restraints is provided to all staff members with direct patient care responsibilities, who are responsible for the application of restraint intervention or the monitoring and/or assessment of patients in restraints.
c. Physicians and LIPs are trained to be competent in a working knowledge of hospital policy on restraints. Training requirements include general policy, types and indications, ordering, and monitoring requirements.
d. RNs authorized to perform face-to-face evaluations are required to complete restraint education that includes all the training requirements defined in Medicare Conditions of Participation.
e. A record of restraint education participation is maintained.

V. DEFINITION(S):

A. Debriefing: (Violent restraint): A post restraint process intended to provide support and decrease the likelihood of future restraint events.
B. Non-violent restraint : Implemented for non-violent, nondestructive behavior such as: confusion, agitation, inability to follow safety directions, and attempting to remove needed medical equipment, when less restrictive interventions have failed to produce the desired behavioral change.
C. Violent restraint process: Implemented for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.
D. Restraint: 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
E. Chemical Restraint: A drug or medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
F. Physical Holding: Any physical hold is considered a restraint, thus will follow all the aforementioned procedures for restraints.
G. Seclusion: The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion is only used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff members, or others. AdventHealth Hendersonville does participate in seclusion of patients.

VI. EXCEPTION(S):

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.

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VII. REFERENCE(S):

A. Centers for Medicare and Medicaid Services. (20 14). State operations manual: Appendix A: Interpretive guidelines. Rev. Rev. 151, 1 1-20-15. Medicare (cms.gov)

B. Electronic Code of Federal Regulations (eCFR™). (2014). Condition of Participation: Patient Rights. Title42: Public Health. 5482.13: Patient Rights. Retrieved on May 3, 2022, from eCFR :: 42 CFR 482.13 -- Condition of participation: Patient's rights.

C. The Joint Commission. (2022 E-Dition). PC 03.05.01 through PC 03.05.19

D. North Carolina Department of Health and Human Services (NCDHHS) 10A NCAC 27E .0104 (e) (10) (A) https://www.ncdhhs.gov/media/10426/open

VIII. RELATED DOCUMENT(S) / ATTACHMENT(S):

A. Use of Restraints – Decision Tree

B. Restraint 1 Hour Face to Face Evaluation for Violent or Self-Destructive Behavior

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