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Restraints, Seclusion, & the One Hour Face-To-Face Evaluation

Study Guide

Restraints, Seclusion, and the 1 Hour Face-to-Face Evaluation of the Violent/Self-Destructive Patient

ACKNOWLEDGEMENTS

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Table of Contents

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Objectives

After completing this program, the participant will be able to:

- Discuss The Joint Commission (TJC) standards and Centers for Medicare and Medicaid Services (CMS) regulations as they apply to the 1 Hour Face-to-Face Evaluation of the Violent or Self-Destructive patient
- Define seclusion and the different types of restraints
- Identify best practice approaches to the selection of interventions
- Recognize the importance of appropriate evaluation and care of the restrained or secluded patient
- Determine readiness to discontinue restraints or seclusion
- Fulfill proper documentation and reporting requirements for CMS regulations and Joint Commission standards

I. Introduction

Restraints and Seclusion are difficult concepts in today's healthcare environment. On the one hand, restraints and seclusion can prevent a patient from causing possible injury to themselves and others. On the other hand, these interventions have the potential to cause great physical and psychological harm, impede patient recovery, and damage therapeutic relationships.

Restraints and seclusion have historically been used to control the behavior of patients. These practices have come under scrutiny in the last decade, resulting in the current environment discouraging their use.

It is imperative that if restraints and seclusion are to be used, they be utilized safely and with regard to the rights and dignity of the individual. This often requires that facilities blend federal and state regulations as well as standards by The Joint Commission and other accreditation agencies, and the most stringent rules must always be followed.

II. Restraint and Seclusion: Regulations, Standards and Laws

It is always easier to prevent a violent episode than it is to react to one. The physical act of applying restraints or secluding a patient can not only be physically dangerous to the patient and staff, it can also elicit undesirable outcomes including a more aggressive response, and physical and psychological trauma. This is why the use of restraint and seclusion must be avoided except in emergent situations, and only when all other less restrictive alternative interventions have failed.

NOTE: De-escalation is no longer required by hospitals that use The Joint Commission for deemed status, nor it is required by the CMS Conditions of Participation. However, many of the state departments of mental health require it for patients on behavior health units. It has also been considered to be a standard of practice for behavioral health patients who are violent and/or self-destructive. Teaching staff de-escalation techniques has long been recognized as a way of improving care and communication throughout the treatment process. In addition, many hospitals provide training in safe management of disruptive and assaultive behavior, such as training offered by The Crisis Prevention Institute or CPI, mentioned by CMS in the federal register when the restraint standards were first published. CPI teaches non-invasive methods to defuse escalating behavior and safely manage physically aggressive behavior that can avoid the use of restraints.

Restraints, Seclusion, and the 1 Hour Face-to-Face Evaluation of the Violent/Self-Destructive Patient

When choosing to restrain a patient, the least restrictive yet appropriate method must be considered, and then must be discontinued at the earliest possible time. The intervention should not be seen as an attempt to control the patient, but rather as a therapeutic intervention that will ensure the safety of the patient and staff.

Any hospital that accepts Medicare or Medicaid patients must follow CMS regulations, and they must be followed for all patients regardless of Medicare or Medicaid status. Therefore, any participating hospital – acute care or behavioral - with a patient who becomes violent and/or self-destructive is subject to the CMS Conditions of Participation (CoP) regulations. **CMS does not look at the treatment setting or department the patient is in, but rather the behavior of the patient. This is why all nurses and staff in the hospital who may encounter a violent or self-destructive patient need to be familiar with the CMS regulations as they relate to the use of restraints and seclusion.**

In addition, hospitals that are accredited by one of the three accreditation agencies that have been awarded deemed status by CMS must also be in compliance with CMS CoP Restraint and Seclusion Interpretive Guidelines. The three accreditation agencies that have deemed status are The Joint Commission (TJC), America Osteopathic Association (AOA) Healthcare Facilities Accreditation Program, and DNV Healthcare. For purposes of clarification, all statements regarding CMS in this program also reflect those requirements by hospitals with deemed status.

Critical Access Hospitals have a separate Conditions of Participation (CoPs), and there is not a section on restraint and seclusion. However, any Critical Access Hospital that has a separate rehab or behavioral health unit must follow the CMS Prospective Payment System (PPS) hospital restraint standards. For safety reasons, Critical Access Hospitals still need to have a policy and procedure to ensure safe care regarding restraint and seclusion. However, Critical Access Hospitals do not have to adopt all of the provisions required by PPS hospitals.

If a hospital is accredited by TJC, but does not use TJC for deemed status because they do not bill for Medicaid or Medicare patients (such as the Veterans Affairs and Shriner Hospitals), then TJC has different standards in the Provision of Care, Treatment and Services (PC) chapter that apply to the patients who need restraint and/or section in the hospital. (PC.03.02.01 to PC.03.02.11, PC.03.03.01 to PC. 03.03.31, and RC.02.01.01). If the hospital uses TJC for deemed status, then there are ten standards in the PC chapter that apply, and these are closely aligned with the current CMS CoP regulations (PC.03.05.01 to PC.03.05.19). Additionally, PC.01.01.01 EPT has to do with forensic restraints which are not governed by the restraint standards. These are things such as handcuffs or shackles, and hospitals need to make a decision if they can accommodate those under legal or correctional restrictions. Another standard, PC.01.03.05, states that the hospital's use of behavior management procedures must be part of the patient's plan of care, and the patient should participate in selecting behavior management and treatment interventions. Time-outs and procedures using restraining devices or aversive techniques may only be used in a manner consistent with the patient's plan of care.

In addition, like TJC standards, the CMS interpretative guidelines state that leadership is responsible for creating a culture that supports a patients' right to be free from unnecessary restraint and seclusion. Leadership must ensure that systems and processes are developed, implemented and evaluated to ensure that patients are not unnecessarily restrained. Physicians and Licensed Independent Practitioners (LIPs) must be educated on hospital policy regarding restraint and seclusion; and both TJC and CMS require staff training on restraint and seclusion in orientation, as well as an ongoing basis (which is generally interpreted to mean annually).

Every hospital should be aware of specific state mental health department law or regulations that apply to restraints or seclusion, especially in regards to behavioral health patients. State laws can be stricter, but weaker state laws are pre-empted by federal regulation. **Hospitals need to keep all standards and regulations in mind; and remember, the most stringent standard applies.**

III. Definitions

Let's consider the three very different types of emergent interventions, as defined by CMS.

A **medication** may be considered a restraint when it is used 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.

Medications are not restraints if the following criteria are met:

- The drug is used within the parameters set by the FDA and the manufacturer
- The drug follows national practice standards
- The drug is used to treat a specific condition
- The drug is used as part of standard medical or psychiatric treatment, administered in the appropriate dosage for the patient's condition, that would enable the patient to more effectively or appropriately function

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. A patient is in seclusion if the room is locked or a security guard stands at the door preventing the patient from leaving.

A patient is not considered in seclusion if:

- The patient is confined to an area where the patient is with others
- The patient is locked in a room for his/her protection but can open the door from the inside
- The patient is told to take a time-out in the lounge and there is nothing preventing the patient from getting up and leaving

Seclusion may only be used for the management of Violent or Self-Destructive (V/SD) behavior that jeopardizes the immediate physical safety of the patient, staff or others.

Seclusion may be considered when a patient is temporarily unable to control behavior that may harm themselves or others; a patient needs to be alone so that others may be protected; or a patient must be removed from a situation that has the potential to trigger escalating or harmful behaviors.

Mechanical restraints include 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. The most commonly used restraint devices are soft limb restraints such as wrist and ankle ties, and belts.

Under this definition, the following practices or devices could meet the definition of restraint:

- Tucking a patient's sheets in tightly so that the patient cannot move
- The use of an enclosed or net bed that prevents the patient from freely exiting the bed. (Exception: the placement of a toddler in an enclosed or domed crib)
- Use of freedom splints that immobilize a patient's limb
- Use of side rails to prevent a patient from voluntarily getting out of bed
- The use of Geri chairs or recliners if the patient cannot easily remove* the restraint device and get out of the chair on his or her own
- The application of force to physically hold a patient in order to administer a medication against the patient's wishes

* **"Easily remove"** *means that the manual method, device, material or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff considering the patient's physical condition and ability to accomplish the objective (i.e. get to bathroom in time). If a patient can easily remove a device, the device would not be considered a restraint.*

Interventions that are not considered restraints by CMS include:

- Side rails, if they are raised during transport or on a narrow stretcher or cart
- Devices such as camouflage sleeves, surgical dressings, orthopedically prescribed devices, protective helmets, postural support devices in response to assessed patient need
- Freedom splints, if the patient is able to remove them
- Enclosure beds, if the zipper is on the inside where the patient could unzip it
- Standard practices such as surgical positioning, IV boards, X-ray procedures, and protection of surgical sites in pediatric patients
- Use of a seat belt when transporting a patient in a wheelchair
- When the patient is on a special bed that constantly moves to improve circulation or prevent skin breakdown
- Many types of mitts are not restraints unless they are tied down or so bulky as to immobilize fingers or the patient's hand
- Limitation of mobility or temporary immobilization related to medical, dental, diagnostic or surgical procedures, including post-procedure processes
- Methods that protect the patient from falling out of bed. (Note: Side rails are considered a restraint if they prevent voluntary movement out of bed. CMS allows an exception for raising all four side rails for seizure precautions)
- Methods that permit the patient to participate in activities without the risk of physical harm (does not include a physical escort)
- Recovery from anesthesia while the patient is in critical care or post-anesthesia care unit (PACU) is considered part of the surgical procedure and therefore restraints may be medically necessary. (However if the intervention is maintained after the patient recovers from the effects of the anesthesia or is transferred to another unit, a restraint order would be required.)
- Forensic restraints such as hand cuffs or shackles that are applied by law enforcement are not a restraint, but staff may want to consider monitoring to make sure these do not harm the patient

IV. Selection of Intervention

The choice of intervention should be individualized to the patient's needs and wishes, be therapeutic, and should always be based on a clinical assessment. An assessment can identify medical problems that could be causing behavioral changes, such as increased temperature, hypoxia, low blood sugar, electrolyte imbalance, drug interactions, as well as the risk of slipping, tripping or falling that can be treated without restraints. If the assessment indicates the need for restraints, it must be documented and specific as to the reasons for restraints or seclusion. (NOTE: Restraints are not considered a routine part of a falls prevention program.) If possible, the patient should be offered a choice as to the intervention.

Both CMS and The Joint Commission require an order for restraints or seclusion and an individualized plan of care. The ongoing authorization of restraint or seclusion is generally not allowed. However, there are three exceptions:

- Geri chair – if a patient requires the use of a Geri chair with the tray locked in place in order for the patient to safely be out of bed
- Raised side rails – if a patient's status requires that all bedrails be raised while the patient is in bed. (Remember, raising all 4 side rails is only a restraint if the patient is unable to lower them.)
- Repetitive self-mutilating behavior – if a patient is diagnosed with a chronic medical or psychiatric condition and the patient engages in repetitive self-mutilating behavior, a standing or PRN order applied in accordance to parameters established in treatment plan would be permitted

Restraints can only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm, and this must be documented. When choosing a restraint, alternatives should be considered to prevent using restraints, such as nonphysical intervention skills (a sitter or family member staying with the patient, or using distractions such as video games). If restraints must be used, the least restrictive type or technique must be applied, and it must be documented as the least restrictive intervention to protect patient safety based on the assessment, and the effects of this intervention.

<u>If selecting restraints, consider the following</u>:

- Assess the patient's risk factors for physical injury

Consider whether the patient has medical issues such as low blood pressure and cardiac problems, head or spinal injury, or a history of fracture or surgery. Seizure disorder, medications with sedating effect, and pregnancy, as well as respiratory or asthma problems may also contraindicate various types of restraints.

- Skin integrity
- The size of the patient

If they are small or large, there may be trouble with the right fit.

- Whether the patient is a victim of abuse
- How aggressive or violent the patient is acting, and how much protection staff and others need from the patient

If the patient is entering a behavioral health unit, conduct an assessment to determine the patient's risk of hurting self or others, and select interventions that could minimize the use of restraints or seclusion. As appropriate, the patient and family can help identify these techniques. In addition, determine whether the patient has a Health Care Advance Directive and ensure that direct care staff are aware of the advance directive.

<u>Least to Most restrictive interventions</u>:

1. Medications

   If at all possible, the use of medication should be considered first when appropriate. Medication use may be effective and could avoid the use of seclusion or mechanical restraints. Medications can help the patient safely calm or manage his or herself, be more open to interpersonal interaction, and aid concentration.

2. Seclusion

   Seclusion is more restrictive than the use of medications. Remember that CMS says seclusion may only be used for the management of violent or self-destructive behavior. Patients in seclusion must be routinely observed by staff.

3. Mechanical restraints

   Mechanical restraints are the most restrictive form of intervention and may be used in situations where staff can remain safely with the patient and offer calming strategies. Patients who are at high-risk for self-injurious behavior such as head-banging are often better managed with the use of mechanical restraints to prevent further injury.

Examples of Less vs. More restrictive mechanical restraints include:

- Lap board vs. Geriatric chair
- Soft wrist/ankle vs. neoprene wrist/ankle
- Mitts vs. 2 point soft restraints
- 2 point soft restraints vs. 3 or 4 point soft restraints

When placing a patient in restraints or seclusion, never attempt to do so alone. Always call for assistance and use a team approach. Apply restraints according to manufacturer directions.

When restraints are used, it is important to involve the family or caregiver in the plan of care as soon as possible. Explain to them the behavior that initiated the use of the restraints, the alternatives that were tried, and assure the safety and comfort of the patient. Be sure to document in the patient record the specifics of the conversation with the family, and the education provided.

V. Time Limit Orders

Both CMS and TJC require an order for restraints or seclusion, to be used in accordance with a written modification to the plan of care. The practitioner who orders restraints or seclusion can be a physician or Licensed Independent Practitioner (LIP), as allowed by state law and hospital policy. If the practitioner who orders the restraint is someone other than the attending physician, the attending physician must be notified as soon as possible, and this must be documented. "As soon as possible" is defined by hospital policy according to the needs of their patient population.

Time limits apply when restraints or seclusion are used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff members or both.

For both CMS and TJC, orders and renewals are limited to:

- 4 hours for adults
- 2 hours for ages 9-17
- 1 hour under age 9

Be sure to document in the patient record the time limit of the original order and any renewal orders.

CMS and TJC no longer differ regarding the renewal of orders and require the following:

- Original orders may be renewed by a physician or licensed independent practitioner (LIP) within these limits for a total of 24 hours.
- Before an order expires, the attending physician or LIP must evaluate the patient in person.
- Remember that state law can be more restrictive and require the physician or LIP to re-evaluate the patient within a shorter timeframe.
- Each new order must be renewed as authorized by hospital policy.
- If the need for restraints or seclusion use needs to continue beyond expiration of the time limited order, a new order must be obtained from the attending physician or LIP.
- If the order for restraints or seclusion is discontinued and there is still time left on the clock and the same behavior occurs, a new order is necessary to reinstate restraints or seclusion.
- A temporary release that occurs for the purpose of caring for a patient's needs such as feeding, toileting or providing range of motion exercises is not considered a discontinuation of the intervention.

VI. The 1 Hour Face-To-Face Evaluation of the Violent/Self-Destructive Patient

Both CMS and TJC require an in-person evaluation of the patient within 1 hour of the initiation of the intervention for any patient who is violent or self-destructive.

The practitioner who conducts the 1 hour face-to-face evaluation can be a Registered Nurse, physician, physician's assistant, nurse practitioner or other Licensed Independent Practitioner (LIP), as allowed by state law and facility policy. The practitioner must be able to complete both a physical and psychological assessment of the patient in order to rule out possible underlying causes or contributing factors to the patient's behavior. If the person doing the one hour face to face is a trained RN, advanced practice nurse, or physician assistant, they must consult the attending physician or other LIP who is responsible for the patient's care as soon as possible after completing the 1 hour evaluation. The person conducting the face-to-face evaluation should be familiar with the requirements listed below.

The 1 hour face-to-face evaluation should include:

- The patient's immediate situation
- The patient's reaction to the intervention
- A complete evaluation of the patient's medical condition. This would include:
  – A complete review of systems assessment
  – A review of the chart to look for any evidence of an electrolyte imbalance, sepsis or hypoxia that could be causing the violent behavior
- A behavior assessment
- A review of any drugs or medications to determine if there is a drug interaction
- The need to continue or terminate the restraints or seclusion

VII. Assessment and Monitoring

In addition to the 1 hour face to face assessment for violent or self destructive patients, the patient in restraints or seclusion must be assessed, monitored and re-evaluated regularly.

CMS and TJC no longer require a specific time frame for assessments and reassessments. CMS says the frequency of monitoring and assessment will be based on hospital policy and the individual needs of the patient, taking into consideration variables such as the patient's condition, cognitive status, risks associated with the use of the chosen intervention and other relevant factors. Hospital policies should address frequencies of monitoring and assessment; assessment content; providing for nutritional needs, range of motion exercises and elimination needs; and mental status and neurological evaluations. If the patient is under both restraints and seclusion they must be monitored continuously one-on-one by assigned, trained staff, or continually monitored by trained staff using both video and audio equipment in close proximity to the patient.

Many hospitals still have it in their policy that patients who are violent and/or self-destructive are assessed every 15 minutes, and non-violent and non-self-destructive patients are assessed every two hours. Remember that many state laws from the Department of Mental Health may require 15 minute assessments. CMS and TJC will hold the hospital to the provisions contained in their policies and procedures even if they exceed CMS regulations or TJC requirements.

Ongoing assessments look for:

- Signs of injury
- Nutrition and hydration needs
- Toileting needs
- Circulation and range of motion in extremities
- Vital Signs
- Hygiene and elimination needs
- Physical and psychological status
- Readiness for discontinuation of restraints or seclusion

Be sure to document this information in the patient's medical record.

VIII. Signs of Distress

It is important that healthcare providers become familiar with the physical and psychological signs of distress, and know how to respond appropriately.

Some of the physical signs of distress include:

- Reduced or impaired respirations/Respiratory distress

This can present as decreased rate and depth of respiration, labored breath, tachycardia, nasal flaring, cyanosis, confusion, anxiety, loss of consciousness, and difficulty speaking due to labored breathing.

- Reduced peripheral circulation
- Skin breakdown or tears
- Constipation and/or incontinence
- Strangulation
- Potential for decline in function such as joint problems
- Rhabdomyolysis
- Restraint asphyxia

Rhabdomyolysis is the toxic breakdown of muscle fibers due to a patient's physical struggle with prolonged restraint use. This condition is treatable with early intervention through aggressive and early hydration with IV fluids. Signs include high fever, muscle rigidity or weakness, and dark colored urine. Diagnosis is confirmed by lab values.

Asphyxia may occur when a patient is placed in a prone position and excessive weight is applied on the patient's back; by placing towels or sheets over the head of a biting or spitting patient; or by improperly restraining the patient's arm over the neck and obstructing the airway. With asphyxia, the contents of the abdomen are forced upwards, putting pressure on the diaphragm. This is most likely to occur if the patient is obese, drug or alcohol intoxicated, has respiratory syndromes, cardiovascular disorder, psychoses, or after a prolonged struggle. This is why a patient should never be restrained in the prone position.

When responding to signs of distress, the intervention will depend on the signs or symptoms. For example, if there is reduced circulation, the restraints may be repositioned so as not to hurt the patient further, or a range of motion exercise conducted. If there are signs of skin breakdown, the restraints may not be properly applied, or the type of restraints should be reconsidered.

Signs of psychological distress include:

- Mental distress, such as anxiety or increased agitation
- Flashback of past abuse
- Regressive behaviors

If the patient is anxious and increasingly distressed, provide calm reassurance to sooth the patient. If the patient remains unpredictable and violent or agitated, additional medication may be warranted. The goal is to stabilize the patient's condition as quickly as possible so that he/she can be released from restraints or seclusion.

IX. Case Scenario

Let's use a case scenario to discuss how to conduct a typical 1 hour face-to-face assessment. A thorough assessment is the key to a successful outcome. If a restrained or secluded patient is cared for appropriately, complications can be avoided.

Bob is a 30-year old male with a known history of alcohol abuse and dependence who was admitted to the hospital 48 hours ago. He is now in an acute stage of alcohol withdrawal. He is severely agitated and paranoid, thinking that he is being chased by gang members. Because of his confused state, he is unable to follow directions and misinterprets every attempt by the staff to calm him down. He responds to calm verbal cues by throwing punches at the staff, yelling at them and demanding they leave. He required 4 point restraints to prevent him from hurting himself and others after he picked up a chair next to his bed and attempted to throw it at the nurse assistant.

First, it is critically important to treat the cause of the agitation – in this case, alcohol withdrawal delirium. Therefore, Bob is offered lorazepam so that he can regain control.

It has now been 30 minutes, and Sylvia, a registered nurse, will use all of her senses and astute observation skills to conduct a thorough and complete assessment of the patient and his needs. A trained staff member has been monitoring Bob continuously since the restraints have been applied, checking on him every 15 minutes.

In addition, Sylvia will need to remember the most important fact of all: that she is the main intervention that will help her patient regain control and elicit the most successful therapeutic outcome. How she interacts with the patient will determine how well the patient will respond to the process.

When dealing with the violent or self destructive patient, keep the following in mind:

- Maintain a calm demeanor while showing concern and caring
- Avoid being authoritarian by using requests rather than demands
- Set limits so that the patient has an expectation of the desired behavior
- Always be aware of how your look and tone of voice can be perceived

To begin, Sylvia will evaluate the patient's immediate situation, and the patient's mental well-being and response to the intervention. How would she categorize the mental status of the patient? Does Bob seem agitated, tense, distraught, or calm? Are there signs of psychological distress? The goal is to stabilize the patient's condition as quickly as possible so that he/she can be released from restraints or seclusion. Therefore, if Bob is anxious or distressed, Sylvia can provide calm reassurance to sooth the patient. She may, however request additional medication if Bob remains unpredictable, violent or agitated.

Sylvia also checks to see if Bob has any nutrition or hydration needs, or requires hygiene or elimination. Per CMS, a temporary release that occurs for the purpose of caring for a patient's needs such as toileting is not considered a discontinuation of the intervention.

Next, Sylvia will conduct a clinical assessment of the patient's medical condition which she will document in the hospital's restraints form. Sylvia will look at Bob's current vital signs, compare with previous records if available, and note any abnormalities. Since Bob is in mechanical restraints, a circulation check will be made to make sure there are no restrictions, and he is repositioned if necessary. Sylvia will then make sure the restraints are properly applied and are not too tight or too loose.

Because there are so many complications that can occur due to the use of restraints or seclusion, Sylvia should look carefully for any signs of injury or physical signs of distress and respond accordingly.

Finally, Sylvia will assess the patient's readiness to be released from the restraints.

X. Discontinuation

It is important to remember that restraints or seclusion should only be used while the unsafe situation lasts. The goal is to help the patient regain control and release the patient from restraints or seclusion at the earliest possible time – regardless of the length of time identified in the order. This means the patient should be assessed and monitored on an ongoing basis to determine readiness for discontinuation. Once the unsafe condition is no longer present, the use of restraint or seclusion should be discontinued.

The clinical criteria for discontinuation may include:

- Improved mental status
- Capacity to understand the behavior that precipitated the need for the intervention
- Capacity to adhere to expected behavior
- Availability of direct supervision
- The patient is no longer a danger or threat to him/herself or others
- If the situation is medically therapeutic in nature, tubes and lines may be discontinued after medical treatment has been completed

XI. Debriefing

Once the patient is deemed able to be released from restraints or seclusion and the crisis is over, facilities may consider conducting a debriefing with both the patient and the staff. While debriefing is no longer required by CMS or TJC, it is a standard of practice with behavioral health patients and is still required by some of the state mental health departments on the behavioral health unit. When a violent or self-destructive patient requires an intervention of this sort, it can be traumatic for both parties, and should be acknowledged as such. Debriefing also allows for discussion of "lessons learned" from the experience.

When debriefing, it is important to recognize this as an opportunity to emphasize a partnership between the patient and caregiver. It is not a time for scolding or finding fault, but rather a chance to ask the patient what could have been done to help them maintain control. The debriefing may uncover stressors in the healthcare environment that are triggers for unwanted behavior, and these can be addressed in a new treatment plan.

A staff debriefing may follow each episode of restraints or seclusion, and may include the assessment of the factors leading to restraints or seclusion, the steps to reduce future need, and the clinical impact of the intervention. During the debriefing, clinical data is reviewed and a treatment plan revised if needed to meet the highly individual needs of the patient. Some behavioral health units have the debriefing procedure as two discrete events. The first one is a

post-acute event analysis that occurs immediately with all involved parties, including those witnessing the vent. The second debriefing is a formal rigorous event analysis that takes place 24 to 48 hours following the event and includes participation of key professional, administrative and support staff as well as the patient. By examining all the factors around the event, it is easier to anticipate and prevent another episode. Caregivers may also examine and share their feelings and perceptions around the incident in order to process and learn from the experience.

In addition, be sure to consider the impact of the violent behavior on other patients in the unit. Debriefing with these patients may help you respond to their needs, or answer questions.

XII. Documentation

Both CMS and The Joint Commission require that there be full documentation when restraints or seclusion are applied. This allows for more complete communication with all staff involved in the care of the patient, and helps facilities comply with regulations, laws and standards.

Remember that restraints or seclusion must be used in accordance with a written modification to the patient's plan of care. In addition, be sure to document the following:

- The patient's condition, symptom(s) or specific activity that warranted the use of the restraints or seclusion (i.e. the reason for the restraint)
- A detailed description of the patient's physical and mental status assessments and of any environmental factors that may have contributed to the situation at the time of the intervention
- Alternatives or less restrictive interventions attempted, as applicable
- The type of intervention(s) used
- The patient's response to the intervention
- The 1 Hour face-to-face medical and behavioral evaluation

Documentation should support a continued need for the restraint/seclusion, and ensure the needs of the patient are being met such as offering fluid, toileting, range of motion, skin integrity, etc.

Be sure to document:

- The order for restraints or seclusion
- Results of monitoring
- Reassessments
- Unanticipated changes in the patient's condition

XIII. Reporting

In addition, both CMS and The Joint Commission have reporting requirements around any injuries or deaths related to the use of restraints or seclusion.

Facilities must report to CMS any patient death that occurs:

- During the use of restraints or seclusion
- Within 24 hrs after removal from restraints or seclusion
- Within 1 week after restraint or seclusion where it is reasonable to assume that use of restraints or seclusion directly or indirectly contributed to the death.

"Reasonable to assume" includes - but is not limited to - deaths related to restrictions of movement for prolonged periods of time, deaths related to chest compression, restriction of breathing or asphyxiation.

Reports must be made by phone to the CMS regional office by close of the next business day. The date and time of the call must be documented in the medical record. A report by phone needs to be made even if the hospital has faxed in the restraint worksheet to the regional CMS office.

Hospitals should report deaths to their accrediting organization in accordance with their standards.

TJC reporting requirements:

- Report injuries and deaths to the hospital's leadership and appropriate external agencies consistent with applicable law and regulation. The federal Safer Medical Devices Act (SMDA) requires reporting of any injury or death due to a restraint device.
- Under the Sentinel Event reporting process, facilities should report all events which result in an unanticipated death, serious physical or psychological injury or the risk thereof, or major permanent loss of function unrelated to the person's illness or underlying condition. Reporting is voluntary, but hospitals need to do a thorough, credible and acceptable root cause analysis (RCA) within 45 days.

XIV. Information Review with Case Scenarios

Let's summarize with three scenarios that apply what we have learned.

Case Study #1

A patient stops taking his psychotropic drugs and goes out drinking on a Friday night. He is brought into the emergency department by the police. He is aggressive and out of control and attempted to attack two of the police officers. He is placed in seclusion on the behavioral health unit. Because the patient is violent, a one hour face to face assessment was conducted by the trained RN. The patient is admitted and the attending physician is notified by the trained nurse. A staff member has been constantly observing the patient. The hospital has a policy to document the assessments every 15 minutes. The order is good for four hours. Every four hours the nurse can call and get the order renewed if the same behavior continues. The LIP or physician must see the patient and reorder the seclusion every 24 hours.

Case Study #2

The second scenario is a patient who is intubated in the ICU. The doctor has signed intubation protocol orders. When the patient is initially intubated she does not have two soft limb restraints because she is on a Diprivan drip and is so sedated. Later in the evening the staff are decreasing sedation in hopes to extubate the patient to prevent ventilator-associated pneumonia. The patient is not quite meeting the criteria for extubation. She starts to tug at her endotracheal tube. The nurse runs over and puts on two soft limb restraints. The hospital policy allows the nurse to apply them in an emergency situation. The nurse calls as soon as possible to get the order from the physician which is good for 24 hours. The hospital policy defines ASAP as the nurse must call and get the order as soon as reasonably feasible; and if the nurse cannot call the physician within one hour, she is to notify the nursing supervisor or department director who can then make the call for the nurse. The hospital policy states that the patient will be assessed at two hour intervals. There is no need to do a one hour face to face assessment because the patient is neither violent nor self-destructive, or as Joint Commission calls it, a non-behavioral health patient.

Case Study #3

Here is the third and last scenario to see if you can correctly understand the restraint and seclusion standards. A patient in the ICU has a history of schizophrenia and has been admitted after taking an overdose of medications. The two ICU nurses hear a commotion and observe one ICU patient who is out of her bed attempting to strangulate the patient in the next bed. The two nurses do a safe take down, place the patient in her bed and apply two soft limb restraints. The hospital has a policy allowing restraints to be applied in an emergency. The ICU calls the trained RN to come to the unit to do the one hour face to face assessment since the patient was exhibiting violent behavior. The nurse conducted the one hour face to face assessment and completed the one hour form. She amends the plan of care and contacts the attending physician. An order is received and is good for four hours. The nurse must call the doctor or LIP and get a renewal order for the restraint every four hours up to 24 hours when the patient must be seen by a LIP (such as a nurse practitioner or PA who is recognized by the state and the hospital) or the attending physician. The hospital's policy says that the patient must have documented assessments every 15 minutes.

How did you do?

These three scenarios summarize the Joint Commission's 10 standards found in the Provision of Care chapter and the 50 pages of restraint standards set out by CMS in the Conditions of Participation (CoPs).

XV. Conclusion

It is clear that healthcare professionals should avoid the use of restraints and seclusion whenever possible, and only use them as a last resort. However, the violent or self-destructive patient may challenge our ability to react with other alternatives. By following best practice approaches in the selection of interventions and evaluation of the restrained or secluded patient, and following rules and regulations by CMS, accreditation agencies such as The Joint Commission and your state, we can better protect the safety and rights of our patients, while delivering high quality and patient-centered care.

XVI. References

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14. National Association of Psychiatric Health Systems (NAPHS). "Learning From Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health." Appendix with useful forms and checklists: http://www.naphs.org/rscampaign/Appendix.pdf
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XVII. Resources

1. The American Psychiatric Association (APA) www.psych.org
2. American Psychiatric Nurses Association (APNA) www.apna.org
3. National Association of Psychiatric Health Systems (NAPHS) www.naphs.org
4. The American Hospital Association (AHA) Section for Psychiatric and Substance Abuse Services. www.aha.org
5. NAPHS and AHA Guiding Principles on Restraint and Seclusion: www.naphs.org/catalog/ClinicResources/index.html

XVIII. Post Test

1. The following can be said about the use of restraints or seclusion:

- **A** The use of restraints and seclusion must be avoided except in emergent situations, and only when all other less restrictive alternative interventions have failed.
- **B** The least restrictive yet appropriate method must be considered, and then must be discontinued at the earliest possible time.
- **C** The intervention should not be seen as an attempt to control the patient, but rather as a therapeutic intervention that will ensure the safety of the patient and staff.
- **D** All of the above.

2. A medication may be considered a restraint when:

- **A** It is used to manage the patient's behavior or restrict the patient's freedom of movement.
- **B** It is not a standard treatment or dosage for the patient's condition.
- **C** It is used to treat a specific condition.
- **D** All except C.
- **E** All of the above.

3. The following can be said about seclusion:

- **A** Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff or others.
- **B** Seclusion should only be used with chemical restraints.
- **C** Seclusion is defined as when a patient is in a room alone and can open the door and leave the room whenever they feel they can better control their behavior.
- **D** All of the above.

4. The least to most restrictive interventions are:

- **A** Seclusion, medication, mechanical restraints
- **B** Medication, mechanical restraints, seclusion
- **C** Medication, seclusion, mechanical restraints
- **D** Mechanical restraints, seclusion, medication

5. For both CMS and The Joint Commission, orders and renewals are limited to:

- **A** 6 hours for adults, 3 hours for ages 9-17, 1 hour under age 9
- **B** 4 hours for adults, 2 hours for ages 9-17, 1 hour under age 9
- **C** 2 hours for adults, 1 hour for ages 9-11, ½ hour under age 9
- **D** 3 hours for adults, 2 hours for ages 9-17, 1 hour under age 9

6. Per CMS, the 1 hour face-to-face evaluation of the Violent/Self-Destructive patient in restraints or seclusion should include an assessment of:

- **A** The patient's medical and behavioral condition
- **B** The patient's reaction to the intervention
- **C** The need to continue or terminate the intervention
- **D** All except C
- **E** All of the above

7. The following can be said about asphyxia:

- **A** May occur when a patient is placed in a prone position and excessive weight is applied on the patient's back
- **B** Can be caused by placing towels or sheets over the head of a biting or spitting patient
- **C** Is most likely to occur if the patient is obese, drug or alcohol intoxicated
- **D** All except B
- **E** All of the above

8. The clinical criteria for discontinuation may include:

- **A** Being in restraints for 8 hours
- **B** The patient is no longer a danger to himself or others
- **C** Mental status has not deteriorated
- **D** All of the above

9. The following can be said about debriefing:

- **A** Allows for a discussion of "lessons learned" from the experience for the staff and patient
- **B** Allows staff to discuss with the patient what he/she did wrong
- **C** Can address stressors in the environment that are triggers for unwanted behavior
- **D** A and C
- **E** All of the above

10. Documentation of the use of restraints or seclusion should include the following:

- **A** The type of intervention(s) used
- **B** The consideration of the most restrictive interventions
- **C** The patient's symptom(s) that warranted the use of the restraints or seclusion
- **D** A and B only
- **E** A and C only

XII. Continuing Education Application

Please print clearly and fill in all data to ensure accurate record-keeping.

Restraints, Seclusion, and the 1 Hour Face-to-Face Evaluation of the Violent/Self-Destructive Patient

LEARNING OBJECTIVES

1. Discuss Joint Commission standards and Centers for Medicare and Medicaid Services (CMS) regulations that apply to the 1 Hour Face-to-Face Evaluation of the Violent or Self-Destructive patient
2. Define seclusion and the different types of restraints
3. Identify best practice approaches to the selection of interventions
4. Recognize the importance of appropriate evaluation and care of the restrained or secluded patient
5. Determine readiness to remove from restraints and seclusion
6. Fulfill proper documentation and reporting requirements for CMS regulations and Joint Commission standards

CE CREDITS BY MAIL

This program has been approved by Envision, Inc. for 1.0 Contact Hour, Program Number 010R1HR10.

Envision, Inc. is an approved provider by the California State Board of Registered Nursing, Provider Number CEP 15437

Please complete this form in its entirety and submit to **Envision, Inc**. along with the $10.00 CE processing fee. Please mail completed forms and fee to: **Envision Inc., 644 West Iris Drive, Nashville, TN 37204.** CE certificates will be mailed within four weeks after receipt of this completed form. Thank you.

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Daytime Telehone:_____ E-mail:_____

Date of Application:_____/_____/_____ RN/LPN License #:_____ State:_____

TEST ANSWERS

Circle only one choice for your answer to each question.

1. A B C D	**6. A B C D E**
2. A B C D E	**7. A B C D E**
3. A B C D	**8. A B C D**
4. A B C D	**9. A B C D E**
5. A B C D	**10. A B C D E**

XIII. Evaluation Form

PROGRAM EVALUATION

Please circle the number that reflects your extent of agreement with each statement:

Evaluate this program in each of the categories by using the following rating scale:	**Poor**	**Satisfactory**	**Good**	**Excellent**
1. Program content resulted in achievement of the stated learning objective #1	1	2	3	4
2. Program content resulted in achievement of the stated learning objective #2	1	2	3	4
3. Program content resulted in achievement of the stated learning objective #3	1	2	3	4
4. Program content resulted in achievement of the stated learning objective #4	1	2	3	4
5. Program content resulted in achievement of the stated learning objective #5	1	2	3	4
6. Program content resulted in achievement of the stated learning objective #6	1	2	3	4
7. The content met my expectations	1	2	3	4
8. Information presented can be applied to my practice	1	2	3	4
9. Information provided is helpful in achieving my professional goals	1	2	3	4
10. Content was organized and easy to follow	1	2	3	4
11. The information presented is current and relative	1	2	3	4
12. This method of delivery met my learning needs	1	2	3	4
13. The content in this course was presented without bias of any commercial product or drug	1	2	3	4

14. To complete this self paced program, which includes watching the video presentation and reviewing the study guide, it took me _____ minutes/hours.

XVIII. Post Test Answers

1. **D. All of the above.**

2. **D. All except C.** A medication is not considered a restraint if it is used to treat a specific condition, follows national practice standards, and is used within the parameters set by the FDA and manufacturer.

3. **A. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff or others.** B is incorrect as it may be used by itself as an intervention. C is incorrect as seclusion is defined as the confinement of a patient alone in a room or area from which the patient is physically prevented from leaving by staff. The patient is not able to leave the room whenever they wish.

4. **C. Medication, seclusion, mechanical restraints.**

5. **B. 4 hours for adults, 2 hours for ages 9-17, 1 hour under age 9.**

6. **E. All of the above.** The assessment should also include an evaluation of the patient's immediate situation.

7. **E. All of the above.**

8. **B. The patient is no longer a danger to himself or others.** The other answers are not correct because CMS allows the orders for restraints to continue up to 24 hours, and the mental status of the patient needs to improve. Other criteria include the capacity to understand the behavior that precipitated the need for the intervention and to adhere to expected behavior.

9. **D. A and C.** B is incorrect as the debriefing is not a time for scolding or finding fault, but rather a chance to ask the patient what could have been done to help them maintain control.

10. **E. A and C only.** B is incorrect as documentation should reflect the consideration of the least restrictive interventions or alternatives attempted.

Notes