Olive View-UCLA MEDICAL CENTER

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

Policy Title:	**RESTRAINTS AND/OR SECLUSION**		
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PURPOSE:

The purpose of Olive View-UCLA Medical Center's restraint and/or seclusion policy is to:

- Minimize the use of restraint and/or seclusion through prevention and use of alternatives.
- Serve as a guideline when use of restraints and/or seclusion is necessary.
- Provide consistency in the management of restraint and/or seclusion use in the acute care setting.
- Comply with regulatory standards.
- Provide the least restrictive intervention that is effective to protect the patient and others from harm.
- Assure patient's rights and the safety of the patients, family and staff while facilitating the process of care delivery.
- Provide consistent, appropriate level of care throughout the medical center.

Philosophy

Olive View-UCLA Medical Center recognizes that restraint and/or seclusion use has the potential to produce serious consequences such as physical and/or psychological harm, loss of dignity, and the violation of an individual's rights. Therefore, the hospital disallows the use of any procedure that could physically harm or place the patient at psychological risk. The patient has the right to be free from restraint or seclusion of any form that are not clinically justified or that are imposed for coercion, discipline, convenience, or retaliation by staff. It is the organization's intent to:

- Provide a physical, social, and organizational environment that limits restraint and/or seclusion use to clinically appropriate and adequately justified situations.
- Seek to identify opportunities to reduce risks associated with restraint use through the introduction of preventive strategies, innovative alternatives, and process improvements.
- Protect the patient's rights, dignity and well-being including, but not limited to:
  - Treating the patient in a respectful manner.
  - Providing a safe and clean environment.
  - Allowing patient continued participation in care, as feasible.
  - Protecting modesty, privacy and safety.

- Meeting patient's individual needs during restraint and/or seclusion use through continuous monitoring by assigned competent qualified staff.
- Provide early reduction or removal of restraints and/or seclusion as soon as the unsafe situation ends.

DEFINITION(S):

Alternatives or other less restrictive interventions refer to any action initiated by staff in an attempt to avoid the use of restraints and/or seclusion. Less restrictive behavior measures include, but are not limited to:

1. Verbal de-escalation – talking calmly to the patient, assessing the situation and what the client considers to be his or her need, and giving clear options.

2. Environmental manipulation, including orientation/reorientation to patient's environment, redirection and/or separation; remove patient from the stimuli that result in agitation or undesirable behavior. This may be accomplished either by moving the patient (e.g. away from a roommate, closer to the nurse's station, etc.), or by diversional activities; giving the patient something new on which to focus (e.g. television, reading, music, exercise/ambulation, craft project).

3. Family involvement/companionship – requesting a family member to sit with or talk to a patient. Parents and/or family members are strongly encouraged to remain with children, adolescents, elderly and physically and/or emotionally impaired patients, rather than resorting to the use of physical restraints to restrict or control unsafe behavior.

4. Medication – administration of medication that is considered standard treatment or dosage for the patient's condition. Medication can be offered to the patient who is becoming out-of-control.

5. Explain the consequences for not changing behavior.

6. Verbal contracting – provide a mutually agreed upon verbal contract with the patient to change behavior.

7. Teaching – educating the patient, family and/or significant other about the purpose of restraints and seclusion, as consistent with confidentiality requirements.

8. Frequent observation (an act of checking on and/or conducting observations of the patient(s) frequently) such as the use of a sitter who provides one-on-one observation of the patient.

9. Time out – a therapeutic technique wherein the patient chooses to go to a quiet room on the inpatient psychiatric unit to decrease stimulation in an attempt to calm down and regain control of his/her emotions and behavior.

Restraint is 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; or a drug or medication when it is 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.

1. **Types of Physical Restraints:**
   a. Soft restraint is defined as a body vest, soft cuff restraint for wrists and ankles.
   b. Hard restraint is defined as locked leather restraints applied to waist, wrists and/or ankles.

2. **A restraint does not include the following:**
   a. Orthopedically prescribed devices, surgical dressings or bandages
   b. Protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations 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.
   c. Adaptive devices or mechanical supports used to achieve proper body position, balance or alignment to allow greater freedom of mobility than would be possible without the use of such a mechanical support. For example, some patients are unable to walk without the use of leg braces, or are unable to sit upright without neck, or back braces.
   d. Age or developmentally appropriate protective safety interventions such as stroller, safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers that a safety conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool aged child.

Full side rails are considered restraints if all four side rails are pulled in the upright position, and used with the intent of restricting the patient's movement.

Enclosure Bed – is a bed enclosed with a net. This bed is considered a type of restraint if used with the intent of restricting the patient's freedom to and from the bed.

Forensic restraints such as handcuffs, or other restrictive devices applied by law enforcement officials for custody, detention and public safety reasons are not considered health care restraint devices.

Prohibited Restraint Technique refers to the following techniques:

- Use of a physical restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or respiratory capacity, including techniques in which a staff member places pressure on a person's back or places his or her body weight against the person's torso or back.
- Use of a pillow, blanket, or other item covering the person's face as part of a physical or mechanical restraint or containment process.
- Placing a person in a facedown position with the person's hands held or restrained behind the person.
- Use of a prone mechanical restraint on a person at risk for positional asphyxiation.

Seclusion is the involuntary confinement of a patient alone in a room or area in which the patient is physically prevented from leaving for a period of time. Seclusion is utilized in the psychiatric emergency room and inpatient psychiatric units only.

POLICY:

Restraint and/or seclusion are used only as a last resort when less restrictive interventions have been determined to be ineffective to protect the patient, staff or others from harm.

The least restrictive type or technique of restraint or seclusion that is effective to protect the patient or others from harm and meet the individualized needs of the patient must be used in accordance with safe and appropriate restraining techniques.

The use of a restraint must be in accordance with the order of the physician or clinical psychologist who is responsible for the care of the patient. The physician responsible for the care of the patient must be consulted as soon as possible within one (1) hour of restraints or seclusion if the physician or clinical psychologist did not order the restraint or seclusion.

Orders for restraint or seclusion must be time limited, tailored to the individual needs of the patient and in accordance with a written modification to the patient's plan of care. Order cannot be written as standing orders or on an as-needed (PRN) basis.

The condition of a patient in restraints or seclusion must be assessed, monitored and re-evaluated by a physician, psychologist, or other trained staff based on the individualized needs of the patient and type of restraint used.

Direct patient care staff must be trained and demonstrate competencies initially as part of orientation, and annually in accordance with their classification and area in which they provide care before participating in the application of restraints, implementation of seclusion, assessment, and the provision of care for a patient in restraints or seclusion.

Deaths associated with the use of restraint will be logged and the documentation retained by Risk Management, as required and reported to the Centers for Medicare and Medicaid Services (CMS).

PROCEDURE:

I. Initiation – Restraint or Seclusion

A. A physician or clinical psychologist must order the use of restraint or seclusion after determining that less restrictive interventions have been ineffective to protect the patient or others from harm.

B. In an emergency, an authorized, trained registered nurse (RN) may initiate use of restraints or seclusion before an order is obtained from a physician or clinical psychologist. In these emergency application situations, a telephone or a verbal order

must be obtained during the emergency application of the restraint immediately or within 1 hour after the restraint or seclusion has been applied.

C. If the restraint or seclusion was used for the management of self-destructive or violent behavior, a face-to-face evaluation by a physician or clinical psychologist must be done within an 1 hour after the initiation of the restraint or seclusion.

D. If restraints are used for the management of non-violent behaviors, an in person assessment by a physician or clinical psychologist must be done within 24 hours of initiating restraints.

E. Restraint or seclusion orders for management of violent or self-destructive behavior (behavioral management) are limited to:
   - Four (4) hours for adults 18 years of age or older
   - Two (2) hours for children and adolescents nine to 17 years of age
   - One (1) hour for children under nine years of age.

F. Restraint order must be tailored to the individual needs of the patient. Patient's characteristics such as age, history, size, medical and/or mental condition and preferences should be the basis of the intervention. Special considerations are given to those patients identified, through initial assessment, with age specific needs (e.g., geriatric and pediatric), patients with a history of sexual or physical abuse and vulnerable populations such as the physically, cognitively, and/or emotionally impaired (e.g. for the hearing-impaired patient, restraints will be removed more frequently to allow patient to communicate/sign).

II. Renewal – Restraints or Seclusion

A. The restraint order for the management of non-violent or non-self-destructive behavior (medical management) must be renewed by the end of the following calendar day.

B. The restraint or seclusion order for the management of violent or self-destructive behavior (behavioral management) may only be renewed in accordance with the following time limitations:
   - Four (4) hours for adults 18 years of age or older
   - Two (2) hours for children and adolescents nine to 17 years of age
   - One (1) hour for children under nine years of age.

C. The registered nurse (RN) must evaluate all interventions and patient's response.

D. The registered nurse (RN) consults with the physician for continuation or renewal of the restraint or seclusion and a written or verbal/telephone order must be obtained from the physician or psychologist if the restraint is to be continued.

E. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

F. If discontinued prior to expiration of previous order, a new order must be obtained before reinstating restraint or seclusion.

III. Role of the Physician or Clinical Psychologist

The responsibilities of the physician or clinical psychologist include:

1. Provide an order for restraint or seclusion.
   a. type and location of restraint
   b. justification for restraint and seclusion

2. Completing a face-to-face evaluation of the patient's current clinical condition within 1 hour after the initiation of restraints or seclusion for the management of violent or self-destructive behaviors, to evaluate the following:
   a. Patient's immediate situation
   b. Patient's reaction to the intervention
   c. Patient's medical and behavioral condition
   d. The need to initiate, continue, or terminate the restraint or seclusion

3. Completing an in-person evaluation within 24 hours after the initiation of restraints for the management of non-violent behaviors.

4. Completing an in-person evaluation with renewal orders if the patient remains in restraints after 24 hours.

5. Participating in daily reviews of restraints and/or seclusion use related to his/her patients.

6. Reduce the number of restraints or discontinue restraints or seclusion based on patient's behavior.

IV. Role of Nursing Personnel

A registered nurse's responsibilities include:

1. Assessment of the patient's situation, responses to least restrictive alternatives tried and patient's behavior necessitating the use of restraints.

2. Assessment of any pre-existing conditions, disabilities, limitations that may place the patient at greater risk of harm during period of restraint. For example, the patient's age, gender, ethnicity, history of physical or sexual abuse, and vulnerable populations such as the physically and/or emotionally impaired.

3. Initiating restraints or seclusion in an emergency situation.

4. Physician notification, and obtaining a verbal/telephone order either during the emergency application of the restraint immediately or within 1 hour after the restraint or seclusion has been applied.

5. Ensuring the patient is advised on the purpose of restraint or seclusion and the circumstances under which the restraints or seclusion shall be discontinued.

6. Completing and documenting an initial assessment and ongoing reassessments.

7. Ensuring that patient in restraints or seclusion is appropriately monitored and assessed.

8. Ensuring that patients in restraints or seclusion receive necessary interventions and is released from restraint or seclusion at the earliest possible time.

9. Ensuring that the behavior necessitating use of restraints and alternatives considered/tried are documented in the medical record.

10. Patient reassessment, MD notification, consultation, and obtaining verbal/telephone order for need to continue or renew the restraint or seclusion in accordance with the time limitation.

11. Ensuring that the medical record has a documentation of the date and time the death related to restraints and/ or/ seclusion was reported to CMS.

The RN may delegate the monitoring and assessment of patients in restraint or seclusion to other properly trained members of the health care treatment team.

V. Monitoring and Assessment

A. Restraint for Non-Violent or Non-Self Destructive Behavior:
Direct patient care staff will monitor patient by observation, interaction or direct examination upon initiation and:

1. Every 2 hours or sooner for:
   a. Nutrition and hydration
   b. Signs of injury to restraint site
   c. Physical and psychological well- being including but not limited to mental, neurological, respiratory and circulatory status and skin integrity
   d. Range of motion and extremity movement
   e. Hygiene and elimination
   f. Readiness for discontinuation of restraint

2. Vital Signs when indicated by physical or psychological assessment or per unit structure standards whichever is sooner

B. Restraint or Seclusion for Violent or Self-Destructive Behavior:

Seclusion is utilized in the psychiatric setting only. Direct patient care staff monitor by observation, interaction, or direct examination upon initiation and:

1. Every 15 minutes for:
   a. Signs of any injury to restraint site including restraint type and location
   b. Respiratory rate
   c. Behavioral health patient's activity

2. Every 2 hours or sooner for:
   a. Nutrition and hydration
   b. Range of motion and extremity movement
   c. Hygiene and elimination
   d. Readiness for discontinuation of restraints
   e. Physical and psychological well-being including but not limited to mental, respiratory, neurological and circulatory status and skin integrity.

3. Vital signs when indicated by physical or psychological assessment

Continual monitoring by: face-to-face or using both video and audio equipment is required when restraint and seclusion are used simultaneously for the management of violent or self-destructive behavior.

VI. Documentation

Clinical staff shall assure the adequate documentation of the following:

1. The face-to-face evaluation within 1 hour of initiation of restraints or seclusion for the management of violent or self-destructive behaviors, and reevaluation

2. In person evaluation within 24 hours of initiating restraints for the management of non-violent behaviors.

3. Alternatives or less restrictive interventions attempted (as applicable to meet the unique needs of the patient)

4. A description of the patient's behavior and the interventions used

5. The patient's condition or symptoms that warranted the use of the restraint or seclusion

6. The patient's response to the intervention used, including the need for continued use of the intervention

7. Patient advisement of the criteria for discontinuation of restraints or seclusion

8. Assessment / reassessments of the patient's status

9. Interventions implemented to assist patient in meeting behavior criteria for the discontinuation of the restraint or seclusion

10. Monitoring (see Monitoring and Assessment)

11. Injuries sustained, treatment received for injuries or death

12. Notification of Centers for Medicare and Medicaid Services (CMS) of patient death related to restraints and /or seclusion including the date and time that the patient's death was reported.

VII. Notification

A. Notification in the psychiatric setting
   1. Nurse manager, charge nurses and physician will be informed:
      a. where there are multiple episodes of restraint/seclusion
      b. restraint episode greater than 12 hours
      c. two (2) or more separate episodes within 12 hours and
      d. every 24 hours if behaviorally indicated

VIII. Patient/Family Education

A. Inform the patient/family of the hospital's philosophy on restraint and seclusion use

B. Advise the patient/family of the reasons for restraints or seclusion

C. Communicate conditions for removal. Examples of behavior criteria for discontinuation may include:
   1. an individual's ability to contract for safety
   2. whether an individual is oriented to the environment
   3. cessation of verbal threats

D. Assist patient (and family if patient authorizes) in identifying behaviors and/or clinical conditions requiring restraint; in identifying appropriate alternatives; and in treatment planning if available and/or appropriate.

IX. Staff Training

Workforce members will be trained by individuals who are qualified by education, training and experience in principles and techniques used to address patients' behavior. Competency validation is done during orientation and every 2 years thereafter in accordance with the employee's classification and area in which they provide care. Training will include the following:

- Techniques to identify staff and patient behaviors; events and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
- Underlying causes of threatening behaviors.

- Medical conditions that may cause a patient to exhibit aggressive behavior.
- The use of non-physical intervention skills.
- Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition.
- Take down procedures.
- The safe application, use and removal of all types of restraint or seclusion used in the hospital, including duration of its use.
- How to recognize and respond to signs of physical or psychological distress.
- Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
- Monitoring and addressing the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to respiratory and circulatory status, range of motion, skin integrity, hygiene, elimination and vital signs.
- Inclusion of viewpoints of patients who have been restrained or secluded

Training and demonstration of competency will be documented in the staff personnel records.

X. Performance Improvement

In keeping with the hospital's performance improvement plan, leadership and/or designees are responsible for monitoring the use of restraint and seclusion and aggregate the data for analysis to identify opportunities for improving performance and implement identified improvements to enhance patient safety and quality care. Reports of restraint/seclusion use are presented to the hospital's Quality Assessment and Improvement Committee.

XI. Reporting

The hospital Risk Management shall report any death that:

1. Occurs while a patient is in restraint or in seclusion at the hospital.
2. Occurs within 24 hours after the patient has been removed from restraints or seclusion and
3. Occurs within one (1) week after restraint or seclusion where it is reasonable to assume that the use of restraints or placement in seclusion contributed directly or indirectly to a patient's death.

   The hospital will provide the report to the State Department of Public Health Licensing and Certification Division, LACDMH, and Los Angeles County DHS Quality Improvement and Patient Safety Program. The hospital shall report each death to the CMS regional office by telephone no later than the close of business the next business day following knowledge of the patient's death.

ATTACHMENTS/FORMS:

None

REFERENCE(S)/AUTHORITY:

- CMS Manual System, Pub 100-07 State Operations Provider Certification, 10/17/2008
- 42 Code of Federal Regulations, Chapter IV, Part 482.13(Centers for Medicare and Medicaid Services (Conditions of Participation for Hospitals: Patient Rights)
- Department of Health Services Behavioral Restraint and/or Seclusion Policy #321.1
- Center for Medicare/Medicaid Services, Section 428.13 (Code of Federal Regulation, Title 42, Section 428)
- Joint Commission Standards (Care of Patients)
- California Code of Regulations, Title 22, Sections 70059, 70213, 70577 and 70737
- California Code of Regulations, Title 9, Section 865.4
- California Code of Regulations, 71545 (2016)
- California Penal Code, Section 830
- California Health and Safety Code, Section 1180 – 1180.5
- ValleyCare Policy 802, “Reporting Incidents”

APPROVED BY:

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