CENTER OF SPECIAL CARE
POLICY & PROCEDURE

TITLE: Restraint for Safety Assurances (Non-Violent)	**EFFECTIVE/REVISED DATE:** 12/23/25
LAST REVIEWED WITHOUT CHANGES DATE: 12/22/23	
RESPONSIBLE DEPARTMENT/COMMITTEE: BEHAVIOR MANAGEMENT COMMITTEE	
APPROVED BY: BEHAVIOR MANAGEMENT COMMITTEE, CHIEF OF PSYCHOLOGY	
CITATION/REFERENCE: 42 CFR 482.13(e), (f) and (g); TJC Standards PC.03.05.01- PC.03.05.19	
REPLACES/PREVIOUS TITLE:	

Purpose: To provide guidelines for the appropriate use of restraints to ensure the physical safety of patients with non-violent behaviors which may cause unintentional self-harm.

Policy: HSC utilizes the least restrictive means to provide a safe environment for patients when the patient displays potentially self-injurious harmful behaviors for medical reasons not related to a mental health/behavioral issue such as pulling at lines, tubes or tracheostomies, removal of equipment or dressings with an inability to respond to direct requests to stop the behavior.

Least restrictive interventions are utilized first, before considering restraint. The type of intervention selected considers information learned from the patient's initial assessment whenever possible. The decision to utilize restraint will be a team decision based on the patient's assessed needs. Restraint is limited to situations to ensure the physical safety of patients, staff or others and is only initiated if less restrictive interventions have been determined to be ineffective.

Changes in supervision may be considered, understanding that this may not be least restrictive or most effective given the impact on patient privacy.

The use of life-threatening physical restraints is prohibited. An awareness of the cultural, ethnic, religious, language and age related/developmental, underlying medical and dignity needs of each patient will be incorporated into all treatment decisions.

Staff will order, apply, monitor and document restraint in accordance with law and regulation and the steps outlined in the procedure below. At no time will restraint or seclusion be used a means of coercion, discipline, convenience or retaliation.

Any concerns regarding patient rights or dignity should be directed to the unit manager or Risk Management.

Universal body substance precautions will be maintained.

Definitions:

Restraints: In the broadest context, restraint is any manual, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move his or her arms, legs, body or head freely including material or equipment attached or adjacent to the patient's body that he or she cannot easily remove in order to control behavior.

Physical Restraint: Any manual method or mechanical device, material, or equipment attached to or adjacent to the patient's body that he or she cannot easily remove that restricts movement or normal access to one's body.

> A restraint does NOT include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that do not involve physical holding of a patient for the purpose of conducting routine examinations or tests, or to protect a patient from out of bed or to permit the patient to participate in activities without the risk of physical harm. See appendix A for further examples.

Chemical Restraint: Any medication used to restrict the patient's freedom of movement in a medical or post-surgical situation or for the emergency control of behavior, and is not the standard treatment for the patient's medical or psychiatric conditions. This does not include PRN medications and is NOT an appropriate solution for chronic or long term (greater than one shift) behaviors.

Life Threatening Restraint: Any physical restraint or hold of a person that restricts the flow of air into a person's lungs, whether by chest compression or any other means

Advanced Practice Provider ("APP") APPs are appropriately licensed physician assistants (PA) or advanced practice registered nurses (APRN) who are qualified by academic and clinical training to order restraint/seclusion, evaluate patients, and provide patient care services within well-defined clinical privileges and Hospital for Special Care (HSC) protocols.

Continuous Supervision (CS): When the patient is in line of sight of staff for a designated period to monitor patient activities. Based on care team assessment, certain patient activities may not require line of sight such as intimate personal care.

Continuous Observation (CO): When a staff member is assigned to a patient for a designated period of time to monitor and observe patient activities no greater than 8 feet away from patient at all times. This includes intimate personal care, i.e. toileting, showers

Procedure:

Initial Application

1. Staff member observes and identifies patient behaviors that may put the patient at risk of self-harm (for example, pulling on a g-tube or tracheostomy)
2. Observing staff member reports behavior to RN
3. RN determines if patient is able to be redirected from behavior
4. If patient is unable to be redirected, RN is responsible for leading attempts at less restrictive interventions to reduce the behavior (See Appendix B for examples of less restrictive interventions)
5. If less restrictive interventions are unsuccessful, RN determines type of restraint to be used.
    a. Single or bilateral hand mitts with or without straps
    b. Bed side rails up
    c. Safety belt for wheelchair that patient is unable to remove
    d. Lap tray
    e. Locked wheel chair
    f. other
6. Restraint is applied
7. RN Calls physician or APP immediately upon application of restraint
8. RN completes note in medical record utilizing the "Restraint Note" Document in EMR:
    a. Enter order on behalf of provider using link in document
    b. Observed behavior necessitating restraint
    c. Less restrictive options tried
    d. Type of restraint applied, by whom and at what time
    e. Time physician or APP notified
9. RN Updates Nursing Care Plan using the "Restraint Note" Document
10. Within ONE hour of restraint application, physician or APP evaluates patient face to face, completes the restraint document and signs the order in the EMR.
11. If the physician or APP who orders the restraint is not the patient's attending physician, then the attending physician (or covering physician) will be consulted as soon as possible, but no later than the end of the day shift of the next day.

Documentation of Restraint Use

1. Patients in restraints for safety assurances will be checked regularly using the appropriate flow sheet in the EMR
2. Nurse will check patients every two hours for the following and document accordingly using the EMR:

a) Patient demonstrated behavior indicating ongoing need for restraint
b) Skin under restraint uninjured without sign of pressure, moisture or loss of circulation
c) Modesty and dignity maintained
d) Physical needs assessed: hydration, nutrition, elimination, range of motion, comfort / repositioning,
e) Restraint equipment intact and functioning properly

Re-Evaluation of Restraint Use and Ongoing Orders

1. At least every 30 days, the patient is evaluated by the physician or APP and the RN. Utilizing the "Restraint Note" document in the EMR, and selecting the Non-Violent Restraint Renewal option the following is completed and documented:
    a. The physician or APP evaluates patient face to face, completes restraint order and notes in the medical record the behavior requiring restraint, alternatives attempted and type of restraint
    b. RN completes the Non-Violent Restraint Renewal note in the EMR specifying:
    c. Observed behavior necessitating restraint
    d. Evidence of continued need
    e. Type of restraint applied
    f. Patient / family education provided
2. A restraint may be released based on the staff's assessment of the patient's condition. If the patient later exhibits behavior that jeopardizes the immediate physical safety of the patient, a new restraint may be applied only by following the steps outlined above, as this would be considered a new episode of restraint.
    a. A temporary, directly supervised release from the restraint that occurs for the purpose of caring for a patient's needs (e.g. toileting, feeding or range of motion exercises) is not considered a discontinuation of the restraint. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint.

Additional Information and Reporting Requirements

1. Family or other designated responsible party must be notified immediately following restraint application via telephone or other documented communication preferences.

2. Family members or trained volunteers may provide assistance with safety in the context of nonviolent restraints, e.g. when sitting with patient at bedside and have the ability to redirect or report to staff if behavior is demonstrated. If the patient requires re-introduction of restraints following the visit, the steps above must be followed as this would be considered a new restraint episode.

3. Explanation and education to the patient and/or family, and or significant other should be ongoing during the use of the device as appropriate, at least every 30 days. This education includes the reason for the use of the device and the impact of the patient's behavior on his or her safety. Explanation/education will be documented in the medical record accordingly.

4. Restraints must be discontinued at the earliest possible time, regardless of timeframe identified in the order. Staff members are expected to assess and monitor the patient's condition on an ongoing basis to determine whether restraint or seclusion can safely be discontinued. RN's, physicians or APP's are authorized to discontinue restraint via discontinuing the order. If a staff member who is not a RN, physician or APP believes the restraint may be safely discontinued, they may reach out to the RN, physician or APP to discuss.

5. In accordance with the requirements at 42 CFR 482.13(g), Death Reporting Requirements, all patient deaths associated with restraint and/or seclusion (except 2-point soft wrist restraints that must be recorded in an internal hospital log or other system) are required to be reported to the Centers for Medicare and Medicaid Services (CMS). Any deaths that occur while a patient is restrained or in seclusion or that are related to the use of restraints, as well as any patient's death that occurs within 24 hours after restraint and/or seclusion has been discontinued, will be reported to the HSC Director of Risk Management and Quality, who will coordinate submission of mandatory reports to the Center for Medicare and Medicaid Services (CMS). Reports to CMS will be made by the next business day following knowledge of patient's death by the Hospital. Additionally, each death known to the hospital that occurs within 1 week after restraint or seclusion where it could be reasonable that the use of restraint contributed directly or indirectly to the patient's death must also be reported. The electronic Form CMS-10455, Report of a Hospital Death Associated with the Use of Restraint or Seclusion must be submitted at the following link in the above circumstances:

CMS Restraint Death Reporting Form

6. Any physical injury resulting from the use of physical restraint or seclusion must be reported to the Director of Risk Management and Quality, who will coordinate reports to the Connecticut Department of Public Health as required by state law.

7. The Hospital must report to the FDA and to the device manufacturer, if known, within 10 working days of becoming aware of information that reasonably suggests that a device has or may have caused or contributed to a death. The Hospital must report to the manufacturer or, if manufacturer is not known, to the FDA, within 10 working days of becoming aware of information that reasonably suggests that a device has caused or contributed to a serious injury. This report will be made by Risk Management.

EDUCATION AND COMPETENCY

All staff who apply restraint or are responsible for monitoring the condition of the patient must receive education including the following:

1. Methods for choosing the least restrictive intervention
2. Demonstration of correct application of restraint used the patient population served
3. Recognition of nutritional / hydration needs
4. Monitoring of vital signs based on clinician practice standards and its relevance to the physical safety of the patient in restraint or seclusion
5. Checking circulation and range of motion in the extremities
6. Addressing hygiene and elimination
7. Addressing physical and psychological status and comfort
8. Assisting patients in meeting behavior criteria for the discontinuation of restraint or seclusion
9. Recognizing readiness for discontinuation of restraint and seclusion by identifying changes in the patient's behavior or clinical condition needed to initiate removal of restraints
10. Recognition of the signs of physical distress
11. Recognition of when to contact the physician / APP
12. Recognition of whether the restraint has been appropriately applied, removed, or reapplied.

In addition, staff who are authorized to initiate restraint/seclusion and /or perform evaluations / re-evaluations are certified in Cardiopulmonary Resuscitation (CPR) and are trained to:

1. Recognize how age, developmental considerations, gender issues, ethnicity and history of abuse my affect the way a patient responds to physical contact
2. Use behavioral criteria for discontinuation of restraint or seclusion and how to assist patients in meeting these criteria

Physicians and APPs who order restraint or seclusion have, at a minimum, a working knowledge of the Hospital's policy regarding the use of restraint and seclusion.

A record of training will be maintained in the Professional Development department for each staff member who receives training.

Appendix A

Examples of Interventions NOT Considered to be Restraints

include, but are not limited to:

1. All four side rails raised to protect a patient who is physically unable to get out of bed, or to protect a patient from falling out of bed for reasons such as seizures or involuntary movements, or on certain types of therapeutic beds such as circulator or specialty beds designed to prevent skin breakdown

2. Side rails on a stretcher due to the stretcher being a narrow, elevated platform causing increased fall risk or seatbelt during transport on a stretcher or wheelchair

3. Age or developmentally appropriate protective safety interventions such as stroller safety belts, raised crib rails or crib covers

4. Mechanical supports to achieve body position balance or alignment, such as leg braces or splints

5. IV arm board to stabilize IV line, unless arm board is strapped to the bed or another surface, or the entire limb is immobilized such as the patient cannot access his or her own body.

6. Medical immobilization when necessary for positioning, or securing or limiting mobility temporarily during medical, dental or surgical procedures.

7. Devices the patient can easily remove independently, in the same manner they were applied, in consideration of the patient's physical condition and ability. Examples:

    a. Side rails which the patient can put down, not climb over
    b. Buckles that the patient can unbuckle intentionally, not work his or her way out of
    c. Ties or knots that the patient can untie intentionally

Appendix B

Examples of Less Restrictive Interventions

include, but are not limited to:

1. Address comfort / physiologic needs
    a. Positioning
    b. Toileting
    c. Pain
    d. Nutrition / Hydration
    e. Ambulation
    f. Consider evaluation of medication regime

2. Alter environment to meet patient needs
    a. Increase or decrease visual and auditory stimuli such as television
    b. Brighten or dim lights
    c. Personalize area around patient
    d. Disguise equipment
    e. Relocate patient closer to nurses' station

3. Address social needs
    a. Family / friend or volunteer at bedside
    b. Frequent checks
    c. Frequent reassurance, encouragement
    d. Engage in Therapeutic Recreation activities

4. Identify precursors to identified unsafe behaviors and mitigate if possible

Appendix C

Downtime Forms: Non-Violent Restraint Log: Submit to Quality Department Weekly

Med. Rec. #	Patient Name	Type of Restraint	Initiation Date/ Time	Discontinuation Date/ Time	Injury with the APPLICATION of the restraint (YES/NO) Specify:
					Staff _____ Patient_____
					Staff _____ Patient_____
					Staff _____ Patient_____
					Staff _____ Patient_____
					Staff _____ Patient_____
					Staff _____ Patient_____
					Staff _____ Patient_____

Appendix C
Downtime Forms: Order

Hospital for Special Care **PATIENT LABEL**

NON-VIOLENT RESTRAINT ORDER FORM

Start Date: _____ Start Time: _____

Purpose of Restraint: Minimize risk of injury to self

Medical Reasons:

- ☐ Agitation
- ☐ Impaired judgement
- ☐ Impulsive Behaviors
- ☐ Interference with Treatment Devices
- ☐ Other _____

Restraint Type:

- ☐ All Side Rails
- ☐ Hand Mitt Right
- ☐ Hand Mitt Left
- ☐ Hand Mitt Bilateral
- ☐ Lap Tray
- ☐ Other:_____
- ☐ Locked Wheelchair
- ☐ Safety Belt for Wheelchair
- ☐ Soft Wrist Restraints
- ☐ Soma Enclosure Bed
- ☐ Velcro Belt

Nurse Assessment Frequency: every 2 hours

Special Instructions:

_____

Signature Date/Time

Appendix C
Downtime Forms: Non-Violent Restraint Document

Hospital for Special Care **PATIENT LABEL**

Nurse Note

The patient presents with the following behaviors relating to a behavioral or mental health condition:

- ☐ Attempts to get out of bed /chair unassisted
- ☐ Removal of protective equipment inappropriately
- ☐ Interference with medical devices
- ☐ Other:

The following less restrictive interventions were performed:

- ☐ Family / Social Support
- ☐ Patient specific interventions from care plan
- ☐ Other:
- ☐ Remove other patients from area
- ☐ Silence / reduce environmental stimuli

The patient's response to less restrictive interventions included:

- ☐ Continued Self-Injurious Behavior
- ☐ Physical Aggression
- ☐ Other:

Less restrictive interventions have been determined to be inadequate to protect patient from harm and a restrictive intervention (restraint) is necessary to ensure safety.

Narrative Description:

Notification of Provider for completion of Face to Face Assessment:

Provider Name: _____ Date: _____ Time: _____

Attending Provider Notified (ASAP, no later than end of day shift of next day. This is N/A for AIU only)

Provider Name: _____ Date: _____ Time: _____

Signature:_____ Date: _____ Time: _____

Appendix C
Downtime Forms: Non-Violent Restraint Document

Hospital for Special Care **PATIENT LABEL**

Face to Face Assessment (Page 1 of 2)

Face to Face Assessment Completed: Date_____ Time: _____

Provider Name: _____

Patient Medical Condition:

- ☐ Baseline
- ☐ Uninjured
- ☐ Other (specify):

Patient Behavioral Condition:

- ☐ Baseline
- ☐ Other (specify):

Physical / Medical Problems that may be contributing to need for restraint:

- ☐ None Identified
- ☐ GI Upset / Constipation
- ☐ Pain
- ☐ Fatigue
- ☐ Hunger
- ☐ Other (specify):

Possible other contributing factors contributing to need for restraint

- ☐ Behavioral Demands
- ☐ Denied Access to Desired Item / Activity / Staff Member
- ☐ Confusion
- ☐ Irritation with Peer Behavior
- ☐ Unknown
- ☐ Other (specify):

Restraint Intervention Appropriate:

- ☐ Yes
- ☐ No (specify reasoning)

Patient Reaction to Intervention:

- ☐ Ongoing Behavior
- ☐ Return to Baseline
- ☐ Other (specify):

Review of Patient's Physical and Psychological Status Completed With:

- ☐ Patient
- ☐ Family
- ☐ Staff

Signature: _____ Date Time: _____

Appendix C
Downtime Forms: Non-Violent Restraint Document

Hospital for Special Care **PATIENT LABEL**

Face to Face Assessment (Page 2 of 2)

Strategies to Assist Patient in Regaining Control:

- ☐ Minimize Attention to Maladaptive Behaviors
- ☐ Assist with utilization of Coping Skills
- ☐ Medication
- ☐ Other (Specify):

At the Time of the Assessment, Patient was:

- ☐ Out of Restraint
- ☐ In Restraint – still required
- ☐ In Restraint -terminated at time of assessment

Behavioral Criteria for Discontinuation of Restraint:

- ☐ Behavioral Baseline
- ☐ Following Instructions
- ☐ Calm
- ☐ Other (Specify):

Narrative Discussion of Events Leading to Restraint and Assessment of Patient

Signature: _____ Date Time: _____

Appendix C

Downtime Forms: Non-Violent Restraint Flowsheet

Hospital for Special Care **PATIENT LABEL**

Time + Date	Monitored Skin under restraint, assessed circulation, modesty/dignity maintain, physical needs assessed, equipment intact and functioning	1. Ongoing need for restraint assessed 2. Behavior baseline 3. Calm 4. Follows Instructions 5. Sleeping / Resting	Nurse Initials

Nurse Signature: _____ Initials:_____

Nurse Signature: _____Initials: _____

Nurse Signature: _____ Initials:_____

Appendix C

Downtime Forms: Non-Violent Restraint Nursing Care Plan

Problem: Risk of Harm to Self

Related to:

- Alcohol / substance abuse
- History of self-destructive behavior
- Impulsivity
- Delirium / Confusion
- Suicidal ideation / behavior
- Severe depression / hopelessness / despair

Goal:

- Demonstrates calm / appropriate behaviors
- Reduced suicidal ideation
- Verbalizes / demonstrates positive coping behaviors
- Remains injury free
- Remains in safe environment

Interventions:

- Restraints, apply per policy
- Coping skills, assist in learning positive
- Medications, administer as ordered
- Suicide precautions as needed
- Assertive vs manipulative behavior, assist in learning
- Environment, ensure safe
- Suicidal ideation, monitor

Nurse Signature:_____ Date:_____