CENTER OF SPECIAL CARE
POLICY & PROCEDURE

| **TITLE**: RESTRAINT / SECLUSION FOR AGGRESSIVE OR UNSAFE BEHAVIOR (VIOLENT RESTRAINTS) | **EFFECTIVE/REVISED DATE**: _ 12/02/2022 |
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| **LAST REVIEWED WITHOUT CHANGES DATE:** 03/22/2022 | |
| **RESPONSIBLE DEPARTMENT/COMMITTEE**: BEHAVIOR MANAGEMENT OVERSIGHT COMMITTEE | |
| **APPROVED BY**: BEHAVIOR MANAGEMENT OVERSIGHT COMMITTEE, CHIEF OF PSYCHOLOGY | |
| **CITATION/REFERENCE:** 42 CFR 482.13(e), (f) and (g); Joint Commission Standards PC 03.05.01 - PC 03.05.19; CGS 46a-150 to 46a-154 | |
| **REPLACES/PREVIOUS TITLE:** Aggressive Behavior Management, Optimal Therapeutic Environment, OTE Restraint Seclusion Violent Behavioral Management, Pediatric Safety Guidelines OTE Risk Assessment (components of), Adult Safety Guidelines OTE Risk Assessment (components of), Restraints Seclusion Behavioral Management | |

PURPOSE: To provide guidelines for interventions with aggressive patients in order to assure the immediate physical safety of the patient and the staff or to manage imminent threat.

POLICY: HSC utilizes the least restrictive means to provide a safe environment for patients, staff and visitors when an individual displays aggressive, threatening or dangerous behaviors and non-physical interventions are not viable or are ineffective.

Least restrictive interventions for behavior management are utilized first, before considering restraint and/or seclusion. 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 or seclusion is limited to emergency situations to ensure the physical safety of patients, staff or others and is only initiated if less restrictive interventions, including continuous supervision and continuous observation have been determined to be ineffective.

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 the patient will be incorporated into aggressive behavior management.

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.

It is the policy of the Hospital for Special Care to monitor the use of these interventions through the established Quality Improvement Program.

Universal body substance precautions will be maintained.

DEFINITIONS:

1. **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.

2. **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. The patient is monitored with continuous observation.

    2.2 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 getting out of bed or to permit the patient to participate in activities without the risk of physical harm.
    2.3 For additional information and examples of medically necessary interventions that do not meet the definition of restraint, refer to policy: "Restraint for Safety Assurances (Non-Violent).

3. **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. The patient is monitored with continuous observation.

4. **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.

5. **Seclusion**: The involuntary confinement of a person in a room or area where the person is physically prevented from leaving. This patient is monitored with continuous observation.

6. **Time Out**: The restriction of a patient for 30 minutes or less to a designated area from which the patient is not physically prevented from leaving and for the purpose of providing the patient an opportunity to regain self-control consistent with the patient's treatment plan.

7. **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.

8. **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 or through use of audiovisual monitoring

where permitted and appropriate, by trained staff, and hands-on physical assessment of the patient is conducted at required intervals. This includes intimate personal care, i.e. toileting, showers.

9. **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 defined medical staff privileges and Hospital protocols.

PROCEDURE **INITIATION**

INPATIENT OR PARTIAL HOSPITAL PROGRAM

1. When a patient becomes aggressive, agitated and/or combative in the inpatient or partial hospital setting, the staff will utilize appropriate Safety Care techniques in an attempt to de-escalate the behavior(s).

2. If behavior modification interventions are part of the patient's plan of care, options per the individualized plan are given to the patient as alternatives to the demonstrated behaviors.

3. If the patient continues to reject the alternatives given, and it is determined that he/she poses an immediate and serious risk, (i.e., may cause harm to themselves or others), it may be determined that a physical intervention is the only appropriate action. Patients in these circumstances may require a physical intervention and/or emergency restraint application in order to assure safety for all parties.

4. Safety Care trained staff must be present if it is deemed necessary to use physical interventions or emergency restraint, in order to assure the safe application and monitoring of the patient during the restraint intervention.

   4.1 For HSC New Britain Campus, inpatients: A "Behavior Response" must be called per the Behavior Response policy. Staff should dial "299" and tell the operator "Behavior Response , and give the specific location. This may also be initiated by activation of the Patient/Nurse call alert.

   4.2 For HSC Hartford Satellite Campus: Security must be called. Staff should dial "77" and tell the operator "Code 1" or "Security needed STAT" and give the specific location.

OUTPATIENTS and MEMBERS

When a patient or member becomes aggressive, agitated and/or combative, de-escalation techniques will be used to minimize the behavior(s). If the patient or

member continues to reject the alternatives given, and it is determined that he/she poses an immediate and serious risk the following processes will be followed:

1. For the HSC Outpatient Autism Center located at the Research and Education Center, staff will activate their ELPAS badge to alert the HSC Security department that support will be needed to assure a safe environment for patients and/or staff.
   - 1.1 A "Behavior Response " will be called overhead.
   - 1.2 911 will be activated.
   - 1.3 Responding staff will not utilize hands-on restraint unless the patient poses an immediate risk for self-injury or the injury of others or elopement, and patient and staff safety cannot be managed with less restrictive interventions. Blocking mats, floor mats, and/or physical hold by the caregiver should be attempted/considered prior to any HSC staff applying restraint of any kind.
   - 1.4 When emergency responders arrive, they will assume control of the situation with guidance from the clinical team.

2. For the HSC Aquatic program and the HSC outpatient clinics, staff will dial "299" to alert the HSC Security department that support will be needed to ensure a safe environment for patients and/or staff. 911 will be activated.

   - 2.1 "Behavior Response" will be called overhead.
   - 2.2 911 will be activated.
   - 2.3 Responding staff will not utilize hands-on restraint unless the patient poses an immediate risk for self-injury or the injury of others or elopement, and patient and staff safety cannot be managed with less restrictive interventions. Blocking mats, floor mats and/or physical hold by the caregiver should be attempted/considered prior to any HSC staff applying restraint of any kind.
   - 2.4 When emergency responders arrive, they will assume control of the situation with guidance from the clinical team

3. For Manes and Motions, staff will dial 911 as their first point of contact for response.
   - 3.1 For the Manes and Motions location, staff will not utilize hands-on restraint unless the patient poses an immediate risk for self-injury or the injury of others or elopement, and patient and staff safety cannot be managed with less restrictive interventions. Response should be defensive and protectionary. Blocking mats, floor mats and/or physical hold by the caregiver should all be attempted/considered prior to any HSC staff applying restraint of any kind.
   - 3.2 When emergency responders arrive, they will assume control of the situation with guidance from the clinical team.

**APPLICATION**

1. Remove all unnecessary equipment/furniture from the area.

2. Direct all visitors and all other patients and staff to leave the immediate area.
   2.1 Security will be requested to escort anyone from the area that refuses to leave.

3. Initiate/attempt physical interventions as directed by the team leader. Follow procedures as taught in Safety Care as needed. Restraint devices will only be applied, tested, monitored, and removed by qualified staff that are knowledgeable and competent on the safe and effective use of these devices.

4. Device application is discussed in "Guidelines for Application of Restraint Devices"

**ORDERS**

1. Emergency restraints may be applied to ensure patient safety by a registered nurse (RN) and/or other staff members who have received specific training in Safety Care techniques and the application of restraints, but the attending or covering physician must be notified immediately. An order must be obtained from a physician or Advanced Practice Provider (APP) within minutes of application. A face-to-face evaluation must be conducted by a physician, an APP, or trained RN within one hour of initial application.

   1.1 This face-to-face evaluation is a comprehensive assessment that includes:
   - A physical assessment to identify medical problems that may be causing behavior changes in the patient
   - What the possible causes of the incident were
   - Whether the intervention was appropriate to address the behavior
   - A review of the patient's physical and psychological status with staff
   - Potential ways to help the patient regain control
   - Whether there is a continued need for intervention and restraint/seclusion
   - The EMR Restraint Progress Note will be used to document this assessment.

2. A physician or Advanced Practice Provider (APP) order will be necessary for each episode of physical restraint, chemical restraint or seclusion.

PRN orders or incomplete orders for physical or chemical restraint or seclusion will not be accepted. Orders will be completed using the "Restraint, Violent" order form in the EMR and must include:

2.1 Type of physical restraint or seclusion.

2.2 For chemical restraint; name of drug, dosage, route, indication and frequency of dosage.

2.3 Reason for use (type of behavior that requires use of restraint).

2.4 Clearly defined time limit of restraint or seclusion. The maximum time limits allowed are:

- Adults: 4 hours
- Ages 9 to 17 years: 2 hours
- Ages 8 years and under: 1 hour

The original order can only be renewed in accordance with these time limits for up to a total of 24 hours. Orders may be written for shorter increments of time, as deemed appropriate by the physician/APP.

2.5 Should restraint/seclusion use be required beyond the 24-hour timeframe, a physician or APP face-to-face reassessment must be completed.

2.6 If any patient requires the continued use of restraints or seclusion, a physician or APP must re-evaluate the patient face-to-face at least every eight (8) hours for adults and every four (4) hours for children ages 17 and younger, at which time the physician or APP can give new orders for restraints and seclusion to be continued.

3. All RN telephone orders for behavioral restraints shall be authenticated promptly by the attending/ordering physician or APP; timeframes for authentication of medication orders must follow Hospital policy.

4. If the physician or APP who orders the behavioral 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.

**MONITORING AND ASSESSMENT**

1. An immediate assessment by the nurse of the patient will be done to ensure that restraints were safely and correctly applied and documented according to the patient's medical record. Use the EMR Restraint note document.

2. Observation should include an assessment every 15 minutes which includes monitoring of patient status and need for RN assessment or intervention, and behavioral observations of the patient. Use the EMR Violent Restraint Flow Sheet.

3. When any chemical, physical restraint and/or seclusion is used, the patient is monitored with continuous observation and evaluation by team members, and an ongoing hourly assessment by the RN. The RN assessment may be done more frequently based on patient needs.

Documentation is completed on the EMR Restraint Flowsheet and RN assessment includes the following:

3.1 signs of any injury associated with the application of behavioral restraint or signs of any incorrect application of restraints
3.2 nutrition/hydration/skin integrity
3.3 circulation and range of motion in the extremities
3.4 vital signs and interpreting their relevance to the physical safety of the patient
3.5 hygiene and elimination
3.6 physical, psychological, cognitive status
3.7 comfort or level of distress and/or agitation
3.8 readiness for discontinuation of restraint or seclusion
3.9 assisting patients in meeting behavior criteria for the discontinuation of restraint or seclusion

Certain aspects of this monitoring may be performed by trained, unlicensed personnel (e.g., checking vital signs, hydration and circulation; the patient's level of distress and agitation; or skin integrity) and may also provide general care needs (e.g., eating, hydration, toileting, and range of motion). However, the level of supervision will be appropriate to meet the safety needs of the patient who is at a higher risk for injury (e.g., self-injurious, suicidal).

4. Any patient who is restrained for aggressive or violent behavior must be assessed by a physician, APP or RN specifically trained to perform this assessment within one hour.
   4.1 Specifically trained and competent RN may perform this assessment under the following circumstances
      4.1.1 The restraint was completed with minimal or no struggle
      4.1.2 The episode did not include self-injurious behavior (SIB) with injury or potential injury
      4.1.3 If there was floor control, it did not last longer than 5-10 minutes
      4.1.4 There have been no more than three events with the same patient during the shift in which the event occurs
   4.2 In the event that the faced to face assessment is completed by a competent RN within an hour of restraint event, the patient must be seen by physician / APP as soon as possible, following the RN assessment, and a note documented.
   4.3 If the patient recovers and is released before the physician/APP arrives to perform the assessment, the physician/APP must still do a face-to-face assessment within one hour.

5. Behavioral restraint may be removed by staff earlier than indicated by physician order if ongoing assessment indicates a reduction in the behaviors that necessitated the restraint. If restraints are re-initiated, a new order is required.

6. The Unit Manager or designee at a minimum is immediately notified of any instance in which a patient is placed in behavioral restraint. The Unit Manager or designee will ensure that the maximum ordered timeframes are adhered to and the monitoring and assessment is complete.

7. If the patient is in a physical hold, a second staff person who is not directly in the physical hold is assigned to observe the patient and maintain patient safety.

**DOCUMENTATION AND REPORTING**

1. A Restraint Progress Note will be completed by the physician or APP and the RN who evaluated the patient (Physicians and APPs utilize the Restraint Progress Note in the EMR). The RN will utilize the Restraint Note document in the EMR. Documentation must reflect the need for initial application of restraint and determine ongoing appropriateness of the intervention. Documentation in the medical record will include:
   - 1.2 The patient's behavior and the intervention used;
   - 1.3 The rationale for the use of the restraint or seclusion;
   - 1.4 The patient's response to the use of the restraint or seclusion;
   - 1.5 Which less intrusive interventions were considered or attempted prior to use of the restraint or seclusion;
   - 1.6 Behavioral criteria for discontinuation;
   - 1.7 Evaluations and re-evaluations.

2. A restraint or seclusion is considered a change in condition, even when the patient is part of a behavioral program. Therefore, a review of the patient's Plan of Care must be conducted following an episode of restraint or seclusion and documentation must be made on the Plan of Care concerning the review of the current plan or adjustments that are made based on the change in condition.

3. 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

4. Any physical injury resulting from the use of physical restraint or seclusion must be reported to Director of Risk Management and Quality who will ensure that HSC submits a report to the Connecticut Department of Public Health, as required by state law.

5. HSC 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 Director of Risk Management and Quality will ensure that HSC reports 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.

**DEBRIEF**

1. Once the patient is deemed manageable and no longer poses a threat, the Behavioral Response team will be debriefed. The Quality Assurance monitor which is embedded in the Occurrence Reporting system, should be completed before team is dismissed by the team leader.

2. All instances of the initiation of Behavior Response or "Code 1" calls, emergency restraint applications and/or physical interventions will be reviewed. The patient's care plan should be reviewed for more specific behavioral approaches. A consultation with the behavior specialist and/or psychology may be warranted.

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

4. Explanation and education to the patient and/or family/personal representative/significant other, should be ongoing during the use of the device as appropriate. This education includes the reason for the use of the device and the desired behaviors that will enable discontinuation of the device, and any changes to the plan of care. Explanation/education will be documented in the medical record accordingly.

4.1 There may be instances in which family participation may be inappropriate due to deleterious effects on the patient and/or his/her rights to limit the sharing of information regarding his/her treatment. In these instances, an explanation of why family involvement is contra-indicated should be documented and the notice required by section 3 above is not necessary.

4.2 Patient / Employee safety supersedes the patient's or patient representative's desire not to apply restraints / seclusion. The team will meet with family / representative to review and discuss treatment plan and recommendations.

**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 will have, at a minimum, a working knowledge of the Hospital's policy regarding the use of restraint and seclusion.

Unit managers will ensure that an adequate number of staff on each shift from designated units are trained in Safety Care.

Employees are trained by certified instructors according to the guidelines of the Safety Care curriculum, and Safety Care trained staff will be revalidated annually.

Professional Development will provide an ongoing calendar of certification and revalidation classes, which will be made available in the HSC monthly training calendar.

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

Staff members in Outpatient Autism, Manes and Motions and Aquatics will receive annual de-escalation techniques education and records will be maintained by the respective department managers.

Restraint - Downtime Order Form - Aggressive or Unsafe Behavior (Violent Restraint)

Restraint - Downtime Physician or APP Progress Note - Aggressive or Unsafe Behavior (Violent Restraint)

Restraint - Downtime Observation Flow Sheet - Aggressive or Unsafe Behavior (Violent Restraint)

Restraint - Downtime RN Assessment - Aggressive or Unsafe Behavior (Violent Restraint)

Restraint - Downtime Restraint Log - Aggressive or Unsafe Behavior (Violent Restraint)