Safe Use of Restraint and Seclusion: A Person-Centered Approach

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Overview

- Maintain a physical, social, and cultural environment which limits use
- Seclusion or restraint use occurs only in response to emergent, dangerous behavior where there is an imminent risk of the patient physically harming him/herself or others, including staff
- Seclusion or restraint is only to be used when less restrictive interventions have failed or been determined to be ineffective
- Seclusion or restraint must be discontinued at the earliest possible time
Key Definitions

- Restraint is any manual method, physical or mechanical device, material or equipment, that immobilizes or reduces the ability of a person to move his or her arms, legs, body or head freely.

- Chemical restraint is a drug or medication that is used as a restriction to manage the person’s behavior or restrict the person’s freedom of movement and is not a standard treatment or dosage for the person’s condition.

- Seclusion is the involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving.
Devices

- Devices that are not considered restraints:
  - Orthopedically prescribed devices
  - Surgical dressings or bandages
  - Protective helmets
  - Methods that involve physical holding for physical exam, test, or to protect patient from falling out of bed
Possible Triggers

Triggers to circumstances where there is imminent risk of a person harming self and/or others:

- Person is paranoid, psychotic, confused, or in withdrawal from substance(s)
- Person has transference reaction toward staff member
- Person is in need of medication adjustment
- Person views staff as threatening or frightening
- Loud, toxic milieu activity escalates patient
- Another person escalates the person
- Staff member has a countertransference reaction toward the person
- Staff’s culture, bias, values and perceptions influence their response to a behavioral emergency and staff behavior may escalate a possibly unpredictable situation
Nonphysical, Less Restrictive Interventions

- Use de-escalating techniques
- Provide structured programming throughout the day and evening
- Assess the environment and modify as needed
  - i.e. lights, sound
- Offer 1:1 interaction/companionship with staff/family
  - i.e. education, orientation, and therapeutic rec.
- Utilize diversional activities
  - i.e. cards, exercise, other activities
Nonphysical Interventions (cont.)

- Request re-evaluation of medications or medicate as ordered
- Meet basic needs
  - i.e. nutrition, fluids, showering
- Move patient to a room closer to nurse’s station
- Time out – must be VOLUNTARY
- Individualize the care plan
  - i.e. what does patient/family report helps patient when upset
- If patient has conflict with another patient assist with mediation, problem solving
If Preventive Interventions Fail...

PROCEED AS FOLLOWS WITH SAFE CARE AS THE TOP PRIORITY!
Safe Application of Restraints

- Consideration is given to the patient’s physical and psychological well-being before, during and after utilization of a restrictive intervention
  - i.e. any pre-existing medical conditions that would place the patient at greater risk
  - i.e. obese, frail, dually diagnosed; persons with developmental disabilities, those whose challenging behaviors result in incomplete assessments
Safe Application of Restraints

- A person with known history of physical or sexual abuse is at greater psychological risk with restraint
- Maintain person’s confidentiality, privacy, and dignity
- Avoid weight or pressure on person’s body parts
- Check for tightness of wrist and ankle cuffs
  - i.e. avoid interfering with circulation
- Use all equipment with strict adherence to manufacturer’s guidelines
- Check patient pockets
Never use 1 point restraint or 2 point restraints on the same side of the body

- The least number of restraint points to safely secure limbs must be utilized

Raise head of bed to 45 degree angle, if possible

May offer medication before or after securely in restraints

Give reassurance to the patient

- Explain 1:1 observation will occur and explain criteria for release
Patient Monitoring

- Maintain the person’s rights and safety
- Assess the rationale for restraint or seclusion on an ongoing basis and facilitate release
- The patient is continuously assessed and monitored for their physical and psychological well-being
- Staff monitoring the patient are physically present and trained in the use of emergency safety interventions, including CPR and first aid
- Documentation occurs on the person at least every 15 minutes
Patient Monitoring (cont.)

- At least every two hours, assessment and documentation is completed
  - i.e. vital signs including oxygen saturation, ROM, circulation, hydration and elimination needs, mental status, skin integrity and effectiveness, etc.
- Supine restraint: risk of airway obstruction
- Prone restraint: risk of positional asphyxiation
- Note: Follow hospital policy as relates to assessment
Criteria for Immediate Release

- Shortness of breath
- Pale or blue coloring
- Chest pain
- Choking
- Signs of patient having a stroke, cardiac event, or some other medical emergency
- Patient is struggling and then goes limp
- Patient having a seizure
Seclusion Tips

- Work as a team and know your assignment
- Check the room for cleanliness, comfortable temperature, and safety
- Check the patient’s pockets
- Back out of the room
- Assign a staff member to maintain continuous visual observation
- Avoid use for person with unknown medical status, person with delirium, person with drug overdose, or person with uncontrollable self-mutilating behavior
Face to Face Evaluation of the Patient

- Within one hour of the initiation of the restraint or seclusion
- Conducted by a physician, LIP, or trained, competent RN (if hospital policy permits by RN)
- Note: If the one hour evaluation is conducted by a trained RN, the attending physician or other LIP responsible for the care of the patient must be consulted as soon as possible
Components of the One Hour Face to Face Evaluation

- Patient’s immediate situation
- Patient’s reaction to the intervention
- Patient’s medical and behavioral status
- Need to continue or terminate the restraint or seclusion
The Guide to Orders

- No standing or PRN orders
- Consult the attending physician if he/she did not order the episode
- Each order may only be renewed up to a total of 24 hours with the length of orders as follows:
  - 4 hours: adults age 18 years or older
  - 2 hours: children and adolescents 9 to 17 years old
  - 1 hour: children under 9 years old
The Guide to Orders (cont.)

- After 24 hours, a physician or LIP must see and assess the patient before writing a new order.
- If a patient was recently released from restraint and exhibits behavior that can only be handled by the reapplication of restraint or seclusion, a NEW ORDER would be required.
Criteria for Release

- Explain criteria to patient
- Examples of Behavioral Criteria for Release:
  - Responds to safe limit setting
  - Cessation of threats
  - Contracts for safety
  - Cooperative to direction
  - Other individualized indicators that are worthy of review and evaluation for release
    - For example, behavior that was not specified in the release criteria but may indicate ready for release
The Responsibilities of the RN

- RN assessment at initiation and reassessment at least hourly thereafter
- Check for any sign of injury from the initiation of seclusion or application of restraint
- Assess for any signs of cardiac or respiratory problems
- Evaluate the person’s response to other interventions to lead to release
- Interact with the person to develop a plan to expedite release
The Responsibilities of the RN (cont.)

- Care includes the maintenance of hydration, nutritional needs, skin integrity, circulation, hygiene, need to eliminate, and addressing physical discomfort or emotional distress.
- Anticipate the person’s need for fluids, food, mouth care or bathing
- Check the room for safety issues, comfortable temperature, and proper ventilation
Debriefing with Persons Who Have Been in Restraints or Secluded

- Determine the person’s receptiveness to involving family, caregivers, or others in the interaction
- Identify behaviors or methods/approaches to prevent a reoccurrence of seclusion/restraint
- Hear and document the person’s perspective on the situation
- Consider what could be managed in another way to prevent the use of restraint or improve the outcome
- Ascertains that the patient’s physical well-being, psychological comfort and right to privacy were addressed
- Counsels the person for any trauma that may have resulted from the episode
Documentation of the Restraint or Seclusion Episode

To include:

- Circumstances and behavior that led to their use
- Consideration or failure of nonphysical interventions
- Notifications of attending physician or LIP and guardian
- Notification of the patient’s family, when appropriate and the patient has given written consent
- Written and telephone orders (if hospital policy permits) for use
To include:

- Details of the occurrence, time of initiation, specific physical holds and evaluation of the person’s response to the intervention
- Behavioral criteria for discontinuation
- Informing the person of the behavioral criteria for discontinuation
- Each in-person evaluation and reevaluation by the trained RN, physician or LIP
- Assistance provided to the person to help him/her meet the behavioral criteria for discontinuation
Documentation (cont.)

To include:
- Continuous monitoring
- 15-minute documentation of patient’s status
- Debriefing the patient
- Any injuries and treatment for these injuries
- Any death and related notifications
APNA Standards of Practice: Seclusion and Restraint

Standards of Professional Performance

➤ Leadership

➤ Standard: Psychiatric-mental health nurses provide leadership to create a culture that minimizes the use of seclusion or restraint, while promoting a safe environment for persons served as well as staff.

➤ Standard: Psychiatric-mental health nurses provide leadership for individual and staff safety in settings providing primary or emergency care, medical or surgical treatment, rehabilitative, residential, or educational services to persons needing or utilizing behavioral health services. In addition, psychiatric-mental health nurses provide services to people who have a mental illness and are involved in the criminal justice system.

➤ For the entire standard, reference the document.
APNA Standards of Practice: Seclusion and Restraint

- Staff Training
  - Standard: Any staff providing care to persons at risk for harming themselves or others and who participate in seclusion and restraint shall have received training and demonstrate current competency in all aspects of dealing with behavioral emergencies.
APNA Standards of Practice: Seclusion and Restraint

- **Performance Improvement**
  - **Standard:** Data are systematically collected on all incidents of seclusion and restraint to both monitor performance and guide improvement initiatives.

- **Standards of Care**

- **Collaborative Work with Individuals and Caregivers upon Admission**
  - **Standard:** During the individual’s admission, the psychiatric-mental health nurse collaborates with him/her and caregivers to formulate strategies that may minimize the potential for a behavioral emergency and the subsequent use of seclusion or restraint.
APNA Standards of Practice: Seclusion and Restraint

Treatment Plans and Interventions

Standard: The nursing response to persons during evolving behavioral emergencies is non-physical and based on a comprehensive initial and ongoing assessment of the person. The assessment includes behavioral and affective presentation as well as understanding of situations that trigger escalation.
APNA Standards of Practice: Seclusion and Restraint

- Initiation of Seclusion or Restraint
  - Standard: Seclusion or restraint is initiated only when less restrictive measures have proven ineffective and the behavioral emergency poses serious and imminent danger to the person, staff or others and staff involved have been adequately trained and deemed competent to initiate these measures.
  - Standard: Persons are never restrained and left alone in a locked room. Seclusion and restraint should not be used as a means of coercion or punishment, for the convenience of the staff, or when less restrictive measures to manage behaviors are available.
  - For the entire standard reference the document.
APNA Standards of Practice: Seclusion and Restraint

Initiation of Seclusion or Restraint (cont.)

- Standard: Seclusion or restraint is initiated by qualified staff authorized by the organization to initiate seclusion or restraint in a behavioral emergency and must be followed by an order from a physician or Licensed Independent Practitioner (LIP).
- Standard: Within one hour of the initiation of seclusion or restraint the person must be seen and evaluated by a physician, LIP, or a trained and competent registered nurse or physician assistant who ascertains the person’s response and determines if seclusion or restraint is to continue. The attending physician or other LIP responsible for the care of the person must be consulted as soon as possible when the one-hour evaluation is conducted by a trained and competent RN or PA.
APNA Standards of Practice: Seclusion and Restraint

- Monitoring and Assessment of Persons in Seclusion or Restraint
  - Standard: Persons in restraint and seclusion are continuously monitored in accordance with federal, state and regulatory agency guidelines. Persons are monitored by staff trained and competent to recognize and report untoward physical and psychological reactions, as well as to facilitate release from seclusion or restraint.
  - Standard: Persons are assessed by a registered nurse at the time the seclusion or restraint is initiated and at least hourly thereafter. The registered nurse may delegate monitoring of persons in seclusion or restraint to qualified staff as appropriate.
APNA Standards of Practice: Seclusion and Restraint

- Release from Seclusion or Restraint
  - Standard: Seclusion or restraint is discontinued based on the assessment that the behavioral criteria for release are met
  - Standard: As soon as possible, following the release from seclusion or restraint, the nurse, the person and others as appropriate should participate in a debriefing
APNA Standards of Practice: Seclusion and Restraint

- **Documentation**
  - Standard: All aspects of the seclusion and restraint episode, including the behaviors and events leading up to it, the less restrictive interventions employed, the care provided during the episode and the release from seclusion or restraint are recorded in the clinical record.
References

- CMS State Operations Manual Appendix A-
- Survey Protocol for Hospitals  Rev. 9-26-14
- APNA Standards of Practice: Seclusion and Restraint Revised, April 2014
- TJC Comprehensive Accreditation Manual for Hospitals, effective January 2015
- Additional suggestions for reading
- Risks of Restraints – Understanding Restraint-Related Positional Asphyxia, Crisis Prevention Institute, 2006 (reprinted 2011)