

CONNECTICUT VALLEY HOSPITAL

OPERATIONAL PROCEDURE MANUAL

SECTION I:	PATIENT FOCUSED FUNCTIONS
CHAPTER 2:	Provision of Care, Treatment and Services
PROCEDURE 2.27:	Restraint Use for the Management of Violent or Self Destructive Behavior
REVISED:	11/19/09; 01/10/10; 12/2010; 08/22/11; 03/30/12; 03/15/13; 02/18
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PURPOSE: To operationalize all standards for the provision of safe and legal use of restraint when necessary to prevent the patient from harming self or others after all less restrictive measures have failed.

SCOPE: All Physicians; RNs; LPNs; MHAs; Rehabilitation Therapists and other clinical staff applying, caring for, assessing or monitoring a patient in restraint.

POLICY:

All patients have the right to be free from physical or mental abuse and/or corporal punishment. All patients have the right to be free from restraint, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. No patient is to be restrained in the prone position (face down). Chemical restraint is prohibited

The hospital is committed to preventing, reducing, and striving to eliminate to the degree possible the use of restraint. Performance Improvement processes seek to identify opportunities to reduce the risks associated with restraint use through preventive strategies, innovative alternatives, and process improvements.

Definitions:

- A. *Restraint* – 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.
- B. *Chemical Restraint* – A drug or medication when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and it is not a standard treatment or dosage for the patient's condition.

PROCEDURE:

I. Permitted Physical Restraints

Physical restraints permitted for use at the hospital include the approved Collaborative Safety Strategies (CSS) techniques of Secure Guide Escort, Third Person Assist, and Take Down.

II. Permitted Mechanical Restraints

Mechanical restraints approved for use at the hospital include four-point restraint, ambulatory restraint, mittens and soft limb holders. The use of Posey Net Restraint and ambulatory restraint requires prior authorization from the Chief of Professional Services (COPS) and the Nurse Executive to ensure appropriate indications for use based on clinical and safety considerations.

- A. The use of camisoles or body bags for restraint is prohibited.
- B. If the patient is assessed to require a type of restraint not addressed in this policy, the Attending Psychiatrist/designee obtains approval for such device from the COPS and the Nurse Executive through the Division or Service Medical Director and Chief of Patient Care Services.
- C. If approved, an interim procedure is developed by the Nurse Executive/designee to ensure safe utilization of the approved restraint device.

III. Initial Assessment at Admission

- A. An initial assessment of each patient is conducted at the time of admission to obtain information about the patient which could help minimize the use of restraint.
- B. The initial assessment identifies:
 - 1. coping strategies, techniques, methods or tools that would help the patient control his/her behavior. When appropriate, and if possible, the patient and/or family assist in the identification of such techniques. This is a determination of the patient's personal safety preferences which are documented on the Admission Nursing Assessment and Annual Nursing Re-Assessment, and when indicated on Personal Safety Preference Form [CVH-469](#) or [CVH-469 Spanish](#).
 - 2. pre-existing medical conditions or physical disabilities/limitations that would place the patient at greater risk during restraint; and
 - 3. history of sexual or physical abuse that would place the patient at greater psychological risk during restraint.
- C. At the time of the initial assessment:
 - 1. the patient and/or family is informed of the hospital's philosophy on the use of restraint if sharing this information is not clinically contraindicated at that time; and
 - 2. the role of the family, including their notification of a restraint episode, is discussed with the patient and as appropriate with the family. This is done with respect to the patient's right to confidentiality.

IV. Use of Less Restrictive Therapeutic Interventions

Prior to the initiation of restraint, therapeutic interventions are employed considering patient-specific triggers as a means to help the patient regain control of his/her behavior. The patient's Personal Safety Preferences are utilized to inform staff in selecting therapeutic interventions that the patient has identified as being helpful to manage his/her current crisis and/or behavioral dyscontrol.

V. Initiation of Restraint

- A. In the presence of immediate physical danger to the patient, staff or others, a physician or, in the physician's absence, a Registered Nurse (RN) may initiate restraint.
- B. The RN ensures that sufficient staff is available to assist in the restraint process in order to prevent injury to the patient, staff, or others.
- C. The RN assesses the situation and employs one of the following physical restraint techniques:
 - 1. the Secure Guide Escort which may be used to contain dangerous behavior while providing the opportunity to engage the patient in calming techniques, or may be used to move the patient;
 - 2. the Third Person Assist which serves as added physical containment of dangerous behavior and also provides the opportunity to engage the patient in calming techniques or provides staff time to prepare for a Take Down if needed; and
 - 3. the Take Down to lower the patient to the floor and if necessary, proceed to lift the patient to the (restraint) bed.
- D. The RN notifies the Nurse Supervisor as soon as possible to review the emergency/immediate need for restraint whenever restraints are utilized.

VI. Orders

- A. The RN obtains a Telephone Order from the physician no later than 15 minutes after initiating restraint when the physician is not immediately available.
- B. The RN describes the emergency/immediate risk, his/her direct assessment of the patient and justification for the type of restraint utilized.
- C. The RN documents and reads back the Telephone Order for restraint, including date and time of order, time limit of the order, type of restraint and the rationale for restraint use on the Physician Orders for Seclusion or Restraint Form ([CVH-8R/S](#)).
- D. Orders written for the application of restraint must include the date and time of the order, must be time-limited, and specify the type of restraint utilized. The Physician describes the patient's specific behaviors which are observable and measurable necessitating immediate risk, any physical and/or psychological risk considerations to the use of this intervention, and the behavioral criteria necessary for release/discontinuation from restraint on the Physician Orders for Seclusion or Restraint ([CVH-8R/S](#)).
- E. Time limits for restraint orders are not to exceed:
 - 1. twenty minutes for physical restraint; and
 - 2. two hours for mechanical restraint
- F. PRN orders for restraint are prohibited.
- G. The Physician must sign the Telephone Order within one hour of the application of restraint.

VII. Exceptions to the Prohibition on Use of Standing or PRN Orders for Restraint

- A. Situations may arise where a patient is assessed to require continued restraint to prevent self injury given severe medical or psychiatric conditions such as repetitive self-mutilating behavior. Such situations may qualify for exceptions to the prohibition on use of PRN order for restraint. These exceptions shall be in keeping with CMS Regulations and Interpretive Guidelines for Hospitals Section A-0169 482.13 (e)(6).

In these situations, the Attending Psychiatrist consults with the Division Medical Director to review the plan of care. If the Medical Director concurs with the need for continued restraint use, the Chief of Professional Services is consulted for approval of the use of restraints in accordance with specific parameters identified in the patient's individualized treatment plan. In these situations, a PRN order for restraint to be applied in accordance with specific parameters established in the treatment plan is permitted.

- B. If the Chief of Professional Services concurs, the specific requirements related to the 1-hour face-to-face evaluation, time-limited order and evaluation every two hours for the management of violent or self-destructive behavior may not apply. Rather, these will be conducted in accordance with the specific parameters identified in the patient's individualized treatment plan.

VIII. Patient Safety Considerations

- A. Whenever a patient is physically restrained, another staff member is assigned to observe the patient and ensure his/her safety through direct observation of the Secure Guide Escort, Third Person Assist and Take Down.
- B. Staff ensures that the restraint room has been checked and cleared of all non-permissible items prior to use.
- C. Staff ensures that the patient's clothing is checked for any potentially harmful objects prior to his/her placement in restraint. Items such as eyeglasses worn to correct vision need to be evaluated by the RN and may be removed only if patient safety is jeopardized.
- D. Material or equipment used as restraint devices shall have been manufactured solely for that purpose and are used only in accordance with the manufacturer's instructions.
- E. Mechanical restraints utilized must be in good repair and clean.
- F. Elevate the head of the bed to enhance respirations and to allow for drainage of secretions when using mechanical restraints.
- G. Due to the risk of asphyxiation, the use of any item such as a towel, washcloth, or pillowcase over the face or mouth of a patient who may bite or spit is not permitted. Face shields for staff and patients (when indicated) are available on each unit. The use of such personal protective gear is recommended in these instances.
- H. During hours of darkness, staff ensures that the night light in the restraint room is lit at all times to allow for viewing of the patient and to ensure safety of staff when entering the room.

- I. If evacuation is necessary in a building emergency, ensure that the patient in restraint is quickly and safely evacuated. Follow specific fire and evacuation procedures as posted on the unit and maintain alertness to the patient's needs.
 - J. Mechanical restraint is not used in combination with seclusion.
- IX. Special Considerations
- A. Any pre-existing medical conditions or physical disabilities that would place the patient at greater risk during restraint must be considered and documented by the Physician and RN.
 - B. Any history of sexual or physical abuse that would place the patient at greater risk during restraint must be considered and documented by the Physician and RN.
- X. Patient Assessment
- A. The RN conducts a behavioral and physical assessment of the patient for whom restraint is being considered.
 - B. The RN ensures that therapeutic interventions (Personal Safety Preferences) identified by the patient have been employed. The specific patient responses to each intervention are documented on Part 1, Seclusion/Restraint Initial Assessment by RN and Physician, ([CVH-480a](#)).
 - C. The RN considers whether other less restrictive interventions can be offered. When the patient's personal preferences are not used the clinical justification for so doing is documented.
 - D. Nursing staff offer the patient the opportunity to walk to the designated area before using the Secure Guide Escort.
 - E. The RN considers any special needs of the patient based on the history or presence of medical conditions, physical disabilities, and/or trauma experiences.
 - F. The RN reviews with the patient, as appropriate, the behavioral criteria/conditions necessary for release from restraint as ordered by the Physician.
 - G. The RN Supervisor performs a direct assessment of the patient and reviews with the assessing RN and staff member monitoring the patient the continuing presence of immediate risk.
 - H. The RN conducts a physical and behavioral reassessment of the patient in restraint at both the first 15 and 30 minutes interval and hourly thereafter to determine if restraint can be discontinued.
 - I. The Physician conducts a face-to-face behavioral and physical assessment of the patient within 60 minutes of the initiation of restraint.
 - J. The Physician documents his/her face-to-face assessment of the patient including:
 - An evaluation of the patient's immediate situation
 - The patient's reaction to the intervention
 - The patient's medical and behavioral condition
 - The need to continue or terminate the restraint or seclusion
 - K. When a Physician other than the Attending Psychiatrist orders the restraint, the Attending is consulted as soon as possible but no longer than two hours after the initiation of the restraint.

- L. The Physician and RN review their respective assessments, the identified release criteria, patient status and consider additional de-escalation and engagement strategies including medication.

XI. Observation and Care of the Patient

- A. The patient who is restrained is monitored on continuous observation by competently* trained nursing staff.
- B. The 15-minute observation and care interventions include, as appropriate to the type of restraint:
 - 1. signs of any injury associated with the application of restraint;
 - 2. hydration/nutrition;
 - 3. circulation, skin integrity and range of motion to the extremities;
 - 4. vital signs;
 - 5. hygiene and elimination;
 - 6. physical status and comfort;
 - 7. mental status and patient's preference for conversation, silent companionship, distraction such as music, use of sensory modalities; and
 - 8. readiness for discontinuation of restraint.
- C. Staff provide interventions to help the patient meet behavioral criteria for the discontinuation of restraint.
- D. If the patient meets behavioral criteria for removal from restraints when a RN is not present, the assigned MHA must notify the RN so that the patient can be removed from restraints as soon as possible.
- E. Observation and care of the patient is documented on Seclusion/Restraint, Part II, Nursing Observation and Care of the Patient ([CVH-480b](#)).

XII. Documentation

- A. The medical record contains documentation of each episode of restraint on the Physician Orders for Seclusion or Restraint ([CVH-8R/S](#)), Seclusion/Restraint Part I, Initial Assessment by RN and Physician ([CVH-480a](#)), Part II, Nursing Observation and Care of the Patient ([CVH-480b](#)), Part III, Reassessment by RN and Physician and Reorder of Seclusion/Restraint by Physician ([CVH-480c](#)), as applicable. The following are documented:
 - 1. A description of the emergency/immediate risk behaviors;
 - 2. Antecedents and precipitating factors that led to the behaviors;
 - 3. Description of therapeutic interventions attempted and/or considered;
 - 4. Patient response to each intervention attempted;
 - 5. The rationale for the type of restraint;
 - 6. Written orders for use;
 - 7. A description of behavioral criteria/conditions necessary for release;
 - 8. Face-to-face assessment and re-assessment of the patient;
 - 9. Fifteen minute observation and care interventions;

**Staff competence is defined as current certification in Collaborative Safety Strategies (CSS), Restraint Application Training (RAT), CPR/AED and First Aid.*

10. Assistance provided to the patient to help meet the behavioral criteria for discontinuation of restraint;
 11. Debriefing of the patient with staff;
 12. Any injury sustained and treatment provided for injury; and
 13. Notification of restraint use to family, significant other or designated advocate as identified and authorized by the patient.
- B. The Nursing Supervisor reviews the required documentation to ensure accuracy and completion and signs [CVH-480a](#), [CVH-480b](#), and [CVH-480c](#) accordingly.
- XIII. Notification of the Patient's Family and/or Conservator
- A. When the patient has consented to have family, a significant other, or designated advocate informed, the identified individual is notified, as agreed upon, each time restraint is initiated.
 - B. The conservator of person is notified when the patient is restrained per the agreement made between the conservator and the Treatment Team. Notification also applies to the patient's health care agent and/or legal advocate.
 - C. These notifications are documented on Seclusion/Restraint Part I (CVH-480a) or Part III (CVH-480c).
- XIV. Discontinuation of Restraint
- A. Physical restraints are discontinued:
 1. as soon as immediate risk subsides and the patient meets the behavior criteria as outlined in the Physician Orders.
 2. the patient regains control no longer presenting immediate risk necessitating the application of mechanical restraint.
 - B. Mechanical restraint is discontinued as soon as immediate risk subsides and the patient meets the behavioral criteria for discontinuation as outlined in the Physician Orders. The RN will document the rationale for release should a circumstance exist where all behavioral criteria for release were not met.
 - C. The RN documents the discontinuation of restraint on the Seclusion/Restraint Part II, Side 2, Discontinuation/Continuation of Seclusion/Restraint (CVH-480b).
- XV. Reorder of Restraint/Physician Reassessment of Patient
- A. If the patient continues to present immediate risk to self or others beyond the time limit of the initial order, a new time-limited order is required to continue the restraint.
 - B. The Physician must conduct a face-to-face behavioral and physical assessment of the patient within 60 minutes of the reorder of restraint.
 - C. The Physician must notify the Service Medical Director of the reorder of restraint and the RN must notify the Nursing Supervisor of the reorder.
 - D. The Nursing Supervisor must notify the Chief of Patient Care Services of the reorder of restraint.
 - E. The Service Medical Director and Chief of Patient Care Services provide oversight through a review of the continuing circumstances necessitating restraint and suggest alternative interventions to progress to discontinuation of restraint.

XVI. Patient Debriefing

- A. The patient and a licensed staff member participate in a debriefing about the restraint episode in order to reduce the recurrent use of restraint.
- B. The patient and, if appropriate and available, the patient's family participates in the debriefing with staff who were involved in the episode.
- C. Each episode is debriefed as soon as possible and appropriate, but no longer than 24 hours after the episode, and documented on the Seclusion/Restraint Patient Debriefing form ([CVH-480d](#)).
- D. Debriefing is used to assist the patient in:
 - 1. identifying what led to the incident and what could have been handled differently;
 - 2. ascertaining that the patient's physical well-being, psychological comfort and right to privacy were addressed;
 - 3. counseling the patient for any trauma that may have resulted from the incident; and
 - 4. when indicated, modifying the patient's treatment plan.

XVII. Focused Treatment Plan Review (FTPR)

- A. When a restraint occurs the physician on duty and the charge RN will collaboratively assess the event and discuss the need for changes in the patient's plan of care; these will be documented in detail by both the physician and the RN in the Integrated Progress Notes, including any follow-up issues to be addressed. The treatment changes will be communicated to all unit staff through the inter-shift report process.
- B. The treatment team will convene on the next business day to do a Focused Treatment Plan Review (FTPR), which includes a review of the restraint episode looking at the predisposing, precipitating and perpetuating factors, any changes in the treatment plan in response to the episode, or the rationale for not making changes.

The FTPR is documented in the Recovery Management System (RMS), printed, signed and filed in the Treatment Plan section of the medical record that day.

XVIII. Staff Debriefing

- A. Staff directly involved in the restraint episode review all aspects of the episode with their clinical peers with an emphasis on circumstances leading up to the episode, how the episode was handled by the involved staff and whether anything could have been handled differently.
- B. The debriefing occurs prior to the end of the shift in which the restraint episode occurred.
- C. The debriefing is documented on the Staff Debriefing Form ([CVH-480e](#)).

XIX. Leadership Oversight

- A. Prior to the initiation of a second reorder for restraint, and for every subsequent reorder, the COPS through the Medical Director and Nurse Executive through the Chief of Patient Care Services will be consulted.

- B. Daily clinical reviews and monitoring of restraint reports over the last 24 hours are conducted by the Medical Director and Chief of Patient Care Services in each patient care division. The COPS and Nurse Executive will consult with the clinical leadership in the Division as necessary. The services of a behavioral consultant may be obtained to assist the treatment team in developing or revising a behavioral support plan.
- C. Clinical leadership will conduct a quality review for any patient who has 4 or more episodes of restraint within any four week period.
- D. Should a patient be involved in 12 or more episodes of restraint or remain in restraint for 48 hours or more within a one week period (with all previous efforts having been reviewed at the facility level), the COPS or his/her designee will notify the DMHAS Office of the Medical Director for review and consultation regarding the patient's ongoing care needs.
- E. The hospital ensures through its Quality and Risk Management functions that both individual and aggregate data related to restraint use are accurate, and seeks to improve the quality of care provided, as well as look for opportunities to prevent, reduce and eliminate use of this intervention.

XX. Reporting Requirements

- A. All serious patient injuries and deaths as a result of restraint use are reported via the incident reporting system to the Office of the Commissioner, through the Office of the Chief Executive Officer (CEO). (See [Operational Procedure 5.8 Patient Safety Event and Incident Management](#)).
- B. Serious injuries and deaths as a result of restraint are reported to the Office of Protection and Advocacy for Persons with Disabilities through the Office of the Commissioner. Serious injury is defined as physical harm, injury or damage requiring the intervention of a Physician or licensed medical professional, utilizing medical procedures more intensive than first aid treatment, including but not limited to: treatment in an emergency room, sutures, fractures, head traumas of a concussion level or greater, or admission to a general hospital for the treatment of serious injury. This would also include severe, multiple contusions, bruises and abrasions, and a loss of consciousness requiring examination by a licensed medical practitioner. (*CGS 46a-150-154 and Memorandum of Understanding – P&A and DMHAS – July 19, 2002*).
- C. Serious injuries and deaths related to a restraint device are reported to the manufacturer of such device and the Food and Drug Administration (FDA) as follows:
 - 1. user facility (hospital) must report to the FDA and to the device manufacturer if the manufacturer's identity is 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. A facility user must report to the manufacturer within 10 working days of becoming aware of information that reasonably suggests that a device has or may have caused or contributed to a serious injury. Such reports shall be submitted to the FDA if the device, manufacturer is not known. (*Use FDA Form 3500A or an electronic equivalent approved by FDA*).
 - 2. The CEO will initiate the notification process to the Centers for Medicare and Medicaid Services (CMS) of all patient deaths per the CMS Conditions of Participation (COP).

3. Such notification is made to the CMS Regional Office in Boston by the close of the next business day for all patient deaths during restraint, all patient deaths within twenty-four hours (24 hours) of restraint and if death occurs within seven (7) days of restraint, where it is reasonable to assume that the use of restraint directly or indirectly contributed to the death.
- A. Notification is documented on the Hospital Restraint/Seclusion Death Report Form ([CVH-636](#)) and filed in the Legal section of the patient's medical record. The Report of a Hospital Death Associated with Restraint or Seclusion ([CMS-10455](#)) is faxed to the Regional Office of CMS by the CEO's office at the time of notification.

XXI. Staff Education and Training

- A. Training will include the following:
 1. techniques to identify staff and patient behaviors, events and environmental factors that may trigger restraint use;
 2. recognition and techniques aimed at understanding the nature of age, development, gender, ethnicity and history of sexual or physical abuse as they impact physical contact;
 3. use of nonphysical intervention skills;
 4. safe use of physical restraint and application of mechanical restraint, including how to recognize and respond to physical distress;
 5. identification of behavioral changes that indicate that restraint is no longer necessary; and
 6. and monitoring the physical and psychological well-being of the patient (e.g., respiratory and circulatory status, skin integrity, vital signs).
- B. All staff involved in applying restraints and assessing, caring for and monitoring patients in restraint will be trained in CSS, Restraint Application Training, CPR/AED and First Aid. Training will be provided and competence validated annually.

