February 23, 2013

Dear Senator,

I am sending you a copy of Dartmouth Health restraint policy.

At Rutland Regional Medical center we have a weak or none policy with regard to the mutual protection of the patient and staff.

to date a conservative estimate of injuries to RRMC staff is over 100. this must stop.

There are many reasons these occur But Implementing this policy would Help... Please Help us.

Steven Wohl
Respiratory therapist

Dartmouth Health

Policy Title	Restraints Policy - Dartmouth Health	Policy ID	27577
Keywords	Restrain, Restraints, Seclusion, Chemical, Forensic, Violent, Self, Destructive, Behavior		

I. Purpose of Policy

To establish standardized decision-making criteria and practical procedures for the use and discontinuation of restraint and seclusion to protect the patient's health and safety and the safety of others, as well as to preserve the patient's dignity, rights, and well-being.

II. Policy Scope

☒Mary Hitchcock Memorial Hospital	☒Alice Peck Day Memorial Hospital
☒Dartmouth-Hitchcock Clinic (Lebanon)	☒Cheshire Medical Center/D-H Keene
☐Dartmouth-Hitchcock Clinic (Southern CGP)	☒Mt. Ascutney Hospital and Health Center
	☒New London Hospital
	☐Visiting Nurse and Hospice of VT/NH (VNH)

III. Definitions

Authorized Licensed Provider (ALP) – A Physician, APRN, or PA (as delegated by a physician) who is acting within the scope of their licensure to write orders for restraint and seclusion and has been trained on this policy.

Chemical Restraints: 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. Not all DH organizations use chemical restraints; those that do will have a separate organization-specific policy and procedure that guides its use. Medication orders that are used to treat a medical or psychiatric condition are not considered chemical restraint. The application of physical force to administer a medication (against the patient's wishes) is considered a physical restraint and requires a separate order for each occurrence.

Cognitive Impairment: Patient not able to comply with therapy AND where failure to comply could result in injury to self or others (e.g. the patient who is confused, disoriented and continues to pull at intravenous line, feeding tubes, etc. despite continued re-orientation).

Forensic Restraints: Restrictions (e.g. handcuffs or shackles) used for security purposes in the presence of law enforcement or correctional facility officers. Forensic restraints are **NOT** clinical restraints and do **NOT** require orders or flowsheet documentation.

Non-restraint Protective Devices: Devices used to protect the patient without restraining him/her. Includes chair wedges, arm supports/pediatric welcome sleeves, intravenous arm board, pommel cushions, self-release chair belts, netted cribs.

Physical 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. Types of physical restraint include: medication administration (see chemical restraint), soft limb restraint, neoprene locking limb restraint, restraint chair, bed rails, safety belt, and geriatric/cardiac chair in certain circumstances. Neoprene locking limb restraints are limited to Violent/Self-Destructive Behavior.

Violent/Self-Destructive Behavior: Patient is actively exhibiting, verbally or non-verbally through gestures or behavior, actions indicating an imminent risk of injury to the patient or others. The behavior actively poses a threat (e.g. lifting a fist in a threatening manner) which puts another person in immediate danger of harm.

Seclusion: The involuntary confinement of a person alone in a room or area where the person is physically prevented from leaving. Seclusion may be used only for management of violent or self-destructive behavior. Seclusion is not used for cognitively impaired patients. Seclusion is not used in all DH member organizations; in those that allow the use of seclusion, it is restricted to use within the Emergency Department.

IV. Policy Statement

Use of restraint and seclusion is limited to situations in which it is necessary to ensure the immediate physical safety of the patient, staff members, or others. Restraint and seclusion are used only with appropriate and adequate clinical justification when less restrictive interventions are ineffective and the least restrictive means of restraint or seclusion to ensure safety are applied. It is not used as a means of coercion, discipline, convenience, or staff retaliation. Discontinuation of restraint and seclusion occurs as soon as possible, based on an individualized patient assessment and re-evaluation, regardless of the scheduled expiration of the order.

RNs and Paramedics (in the ED setting) may initiate physical restraints or seclusion when warranted for the immediate safety of the patient, staff, or others. The need for physical restraints or seclusion is based on the patient's assessed needs and discussed with the patient and/or family (as appropriate).

Any physical restraint or seclusion of patients has the potential for emotional and/or physical harm for those patients, as well as serious injury or death; risks shall be reasonably mitigated.

- Special considerations are given for the use of restraint or seclusion in patients with preexisting medical conditions, physical disabilities and/or a history of sexual/physical abuse that would place the patient at greater psychological or physical risk.
- The use of restraint or seclusion is undertaken as a last resort in the management of the patient's violent/self-destructive behavior or cognitive impairment with risk of harm to self or others.
- The patient will be engaged (if not clinically contraindicated) in identifying alternative safety enhancements/interventions to minimize, and possibly avoid, the use of restraints or seclusion.
- Significant others and/or family members identified as regularly involved in the care of the patient may participate in the process of identifying alternative safety enhancements/interventions.
- Some patients may have signed Advance Directives for Behavioral Healthcare. The patient's expressed desires in this document, if present, will be incorporated into the patient's plan of care.
- It is important that the patients and their identified support systems understand that if initiation of physical restraints or seclusion is determined to be warranted, it will be in the service of patient safety or the safety of others and not as a form of coercion, punishment or disrespect.

In the case of a patient presenting with both cognitive impairment and violent/self-destructive behaviors, a clinical decision must be made as to which order set and procedure best meets the current safety needs of the patient, staff or others.

A. Violent/Self-Destructive

Restraints or seclusion must be ordered by an ALP upon the use of restraint or seclusion prior to, or during/immediately following restraint application. PRN orders and standing orders are not acceptable.

An ALP performs a face-to-face evaluation of the patient within one (1) hour after initial restraint application or placement in seclusion and thereafter as more specifically described below.

Orders for restraint and/or seclusion shall be time limited based on the patient's age:

- Adult patients: The order shall be no longer than 4 hours.
- Patients 9-17 years of age: The order shall be no longer than 2 hours.
- Patients less than 9 years of age: The order shall be no longer than 1 hour.

RN documentation at the time of each order shall include:

- Alternatives attempted
- Justification for restraint and/or seclusion
- Patient assessment
- Restraint/seclusion type

Orders may be renewed for one time period without re-evaluation (an additional 4 hours for adults, an additional 2 hours for patients 9-17 years of age, and an additional hour for patients less than 9 years old).

If needed, orders for restraint and/or seclusion may only be renewed once as per above, the ALP will perform a face-to-face evaluation within 1 hour of the order beginning anew.

Patients in restraints and/or seclusion need to be monitored by staff who have demonstrated competency in the care of patients in restraint or seclusion including how to maintain safety and signs of distress. Patients in restraints and/or seclusion need to be continuously monitored; patients need to be monitored for safety; staff are to intervene as soon as any distress is noted. That continuous monitoring needs to be documented in the health record at a minimum of every 15 minutes.

An RN or Paramedic (in the ED setting) who has demonstrated competency in restraint and/or seclusion assesses the patient at a minimum of every 2 hours in the case of patients 9 years of age and older and a minimum of every one hour for patients under the age of 9.

The RN or Paramedic (in the ED setting) assesses the patient for:

- Circulation and skin integrity of restrained extremity(ies)
- Level of consciousness/behavior of the patient
- Need for release for eating, toileting, comfort, and range of motion
- Need for continued restraint and/or seclusion
- Continued appropriateness of the type and level of restraint and/or seclusion

The patient is removed from restraint and/or seclusion as soon as the violent/self-destructive behavior has resolved and the patient is able to contract for his/her safety and the safety of others. Release from restraints and/or seclusion is performed under the direction of an RN and Paramedic (in the ED setting) who has demonstrated competency in restraints and/or seclusion.

If the patient needs to be placed back into restraints or seclusion, the RN will obtain a new order.

B. Cognitive Impairment (Non-Violent/Non-Self Destructive)

The RN or Paramedic (in the ED setting) who has demonstrated competency in the use of restraints may apply restraints for a patient who is:

- Cognitively impaired, i.e. not able to comply with therapy **AND** where failure to comply could result in injury to self or others (e.g. the patient who is confused, disoriented and continues to pull at intravenous line, feeding tubes, etc. despite continued re-orientation), **AND**
- Attempts have been made to use less restrictive measures prior to the use of restraints.

Restraints must be ordered by an ALP upon the use of restraint prior to, or during/immediately following restraint application. PRN orders and standing orders are not acceptable. An ALP performs a face-to-face evaluation of the patient within one (1) hour after initial restraint application. Orders for restraint shall be no longer than 24 hours in duration and each subsequent renewal order must be within 24 hours from the previous order. An RN or Paramedic (in the ED setting) who has demonstrated competency in restraint assesses the patient at a minimum of every 2 hours.

The RN or Paramedic (in the ED setting) assesses the patient for:

- Circulation and skin integrity of restrained extremity(ies)
- Level of consciousness/behavior of the patient
- Need for release for eating, toileting, comfort, and range of motion
- Need for continued restraint and/or seclusion
- Continued appropriateness of the type and level of restraint and/or seclusion

Patients in restraints need to be observed per the restraint Manufacturer's Instructions For Use (MIFU) or if the MIFU are silent, a minimum of every 2 hours or as needed to ensure patient safety.

The patient is removed from restraint as soon as the cognitively impaired behavior has resolved and the patient is able to comply with therapy. Release from restraints is performed under the direction of an RN who has demonstrated competency in restraints.

If the patient needs to be placed back into restraints, the RN will obtain a new order.

V. References

- Restraint and Seclusion Standards. The Joint Commission. PC.03.05.01 – PC.03.05.19
- State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Rev. 200, 02-21-20) §482.13(e)

Responsible Owner:	System Clinical Practice Committee		
Approved By:	Office of Policy Support, Office of Policy Support (OPS), System Clinical Practice Committee (System CPC), Anne Tyrol, Cherie Holmes, Jessica Lussier, Kirk Dufty	**Version #**	1
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