BAPTIST HOSPITALS OF SOUTHEAST TEXAS	
Policy Manual:	Nursing Administration
Policy Number:	NUR.01.09.0015
Original Date:	09/99
Review Date:	1/13, 11/13, 01//2015, 3/18, 6/19
Reviewed By:	MEC
Revision Date:	1/13, 4/13, 11/13, 01/2015, 9/15, 3/18
This Policy Supercedes:	9/17/96
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SUBJECT: RESTRAINTS

POLICY:

Baptist Hospitals of Southeast Texas respects the rights and dignity of its patients; following the mission of providing quality healthcare in a Christian environment. The employees delivering care to the patients will use alternative means whenever possible to protect the patient's health, well-being, and safety prior to the use of restraints and/or seclusion while complying with agency standards and statutory regulations. Baptist Hospitals of Southeast Texas staff will limit the use of restraints to those situations when their use is essential to protect the patient from harming themselves and/or others, provided other interventions/alternatives have been attempted and have been unsuccessful. The use of physical restraints will not be used for the purpose of discipline or staff convenience.

DEFINITIONS:

Restraints – use of a physical or mechanical device to involuntarily restrain the movement of the whole or a part of a patient's body as means of controlling physical activities to protect the patient or others from injury. Restraint differs from the use of mechanisms usually and customarily employed during medical, diagnostic or surgical procedures that are considered a regular part of such procedures. Restraints require a physician's order, justification for the restraint, a start time and a time limit.

Protective Device – mechanisms intended to compensate for a specific physical deficit to prevent injuries not related to cognitive dysfunction. These mechanisms usually include bed rails, tabletop chairs, protective helmets, or, at time, halter type devices (i.e., to prevent a cognitively intact patient from rolling out of bed at night). These are not considered restraints as identified in this policy.

Adaptive Support Devices – mechanisms intended to permit a patient to achieve maximum normative bodily functioning. These mechanisms usually include orthopedic appliance, braces, wheelchairs or other appliances or devices used to posturally support the patient and are not considered restraints.

Medical Immobilization Device – mechanisms usually and customarily employed during medical, diagnostic or surgical procedures/tests that are considered a regular part of such procedures/tests. These mechanisms usually include body immobilization during surgery, arm board placement during IV therapy and use of "restraining device" while the patient is still under post-op/post-anesthetic care, this instance ceases as soon as the patient is recovered from the effects of the anesthesia. Physically holding a patient during a forced psychotropic medication procedure is considered a restraint.

Chemical Restraint -- The use of any chemical including pharmaceuticals, through topical application, oral administration, injection, or other means, for purposes of restraining an individual and which is not a standard treatment for the individual's medical or psychiatric condition. The use of chemical restraint is prohibited.

Emergency Dose--Nothing in this policy is intended to preclude the administration of psychoactive medication to any patient in a psychiatric emergency. If a physician issues an order to administer psychoactive medication to a patient without the patient's consent because of a psychiatric emergency, then the physician will document in the patient's clinical record in specific medical or behavioral terms: why the order is necessary: other less intrusive forms of treatment, if any, that the physician has evaluated but rejected; and the reasons those treatments were rejected.

Treatment of the patient with the psychoactive medication will be provided in the manner, consistent with clinically appropriate medical care, which is least restrictive of the patient's personal liberty.

The definition of psychiatric emergency is as follows:

A situation in which, in the opinion of the physician, it is immediately necessary to administer medication to improve the signs and symptoms of a patient's mental illness and to prevent: imminent probable death or substantial bodily harm to the patient because the patient is threatening or attempting to commit suicide or self-inflict serious bodily harm. Or is behaving in a manner that indicates that the patient is unable to satisfy the patient's need for nourishment, essential medical care, or self-protection; or imminent physical or emotional harm to others because of threats, attempts, or other acts the patient makes or commits.

Or the individual is currently under a court order allowing the facility to administer medication without consent of the individual, the individual is refusing medication, and the medication ordered is permitted by the court order; the purpose of administering medication is active treatment to reduce symptoms of a diagnosed mental illness; using medication to reduce specified symptoms of a diagnosed mental illness is standard clinical practice.
The specific medication and dosage ordered can be clinically justified as in keeping with standard clinical practice and are appropriate for reduction of specified target symptoms.

A brief physical hold for purposes of administering an emergency dose to a patient that exhibits behavior that meet the above definition is still considered a restraint and must meet all the requirements for behavioral restraint.

When the psychiatric emergency is no longer imminent or present, medication prescribed without consent on an emergency basis must be safely discontinued. If continued use of medication is recommended on a regular basis, the physician must comply with provisions outlined in The Texas Administrative Code relating to Patients Committed to Mental Health Facilities Under Provisions of the Texas Health and Safety Code, or under provisions other than those found in the Texas Health and Safety Code such as the Code of Criminal Procedure, and Family Code, as appropriate.

Excited Delirium (ExDs) – ExDs is a unique medical issue characterized by the acute onset of agitation, aggression, distress, and possibly sudden death. Recent research points toward central nervous system dysfunction of dopamine signaling as a cause of the delirium and fatal autonomic dysfunction. Victims of Excited Delirium Syndrome usually die from cardiopulmonary arrest, although the exact cause of such arrest is likely multifactorial thus ExDs is a medical emergency not a psychiatric or behavioral.

The treatment plan may include rapid sedation, followed closely by external cooling, IV fluids, monitoring, and treatment of potential medical complications is likely critical to decrease morbidity and mortality. Sedation with or without intubation (and use of restraint if necessary to prevent the patient from pulling at lines and tubes), is understood to be for management of the patient's medical condition.

Delirium tremens (DTs) - is the most severe form of ethanol withdrawal manifested by altered mental status (global confusion) and sympathetic overdrive (autonomic hyperactivity), which can progress to cardiovascular collapse. DT is a medical emergency with a high mortality rate, making early recognition and treatment essential. Large amounts of sedatives may be required to achieve adequate control of symptoms. Sometimes, the airway must be controlled to permit the safe administration of adequate doses of sedatives.

Seclusion -- Involuntary confinement of a person alone in a room or where the person is physically prevented from leaving. A situation where a patient is restricted to a room or area alone and staff are physically intervening to prevent the patient from leaving the room or area is also considered seclusion. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff members, or others.

Licensed Independent Practitioner – for the purposes of this policy, this practitioner is one who is permitted by law and by the bylaws of the medical staff of the organization to provide patient care without direction or supervision within the scope of his or her license and in accordance with individually granted clinical privileges.

Forensic Devices – Handcuffs, leg cuffs, and/or other devices used by law enforcement officials not employed or contracted by the hospital for criminal custodial purposes are not considered restraints.

Excessive or prolonged use of restraints is defined as any patient restrained for 14 days or longer.

Types of Restraints – Extremity restraints, and/or hand/finger restraints. Note: Only commercially available restraints will be used (no bed liners, kerlix, etc.) An object may be a restraint by functional definition. Anything that prevents the patient access to his or her body, moving their arms, legs, or ambulating in a normal manner is a restraint.

A device is considered a restraint if it is applied to someone who is physically able to get up and they are prevented from doing so by the device. Under this definition, many commonly used hospital devices and practices could meet the definition of a restraint.

Personal Restraint -Use of trained personnel to physically hold a patient with the intended purpose of restricting a patient's movement. A prone or supine hold shall not be used during a personal restraint. Only authorized staff who has demonstrated competency may initiate in a behavioral emergency, and a staff member who is not applying the personal restraint must maintain continuous face to face observation. Any physical hold will be considered a personal hold and will require a physician's order and face to face evaluation.

Physical Hold for Forced Medications - The application of force to physically hold a patient, in order to administer a medication against the patient's wishes, is considered restraint. A court order for medication treatment only removes the patient's right to refuse the medication. If physical holding for forced medication is necessary with a violent patient, the 1-hour face-to-face evaluation requirement applies.

PROCEDURE-RESTRAINT APPLICATION:

"All restraints should be applied according to the manufacturer's instructions."

Wrist and Ankle Restraints should be padded.

a. Wrist Restraints: secure to non-moveable part of bed below waist level of bed by pulling the long tie through the buckle attachment. With quick release feature wrap the webbing of the female end around the frame of the bed or stretcher, feed the female end of the buckle through the loop of the webbing and insert the male end of the buckle and tighten to desired tension. Do not over tighten as to compromise circulation.
b. Ankle Restraints: secure to non-moveable part of the bed below knee level of bed by pulling the long tie through the buckle attachment.
c. Fasten restraint snugly around the extremity, buckle the restraint. Pull the long tie through the loop on the restraint. Attach the long tie to a non-moveable part of the bed using the buckle.

d. Immediate release at the wrist or ankle and at the point of attachment can be accomplished by pulling up on the buckle or squeezing quick release buckle.
e. Hand mittens can be used as an alternative to or in addition to wrist restraints. Secure to non-moveable part of bed below knee level of bed by pulling the long tie through the buckle attachments.
f. Elbow immobilizers must be placed with consideration of altering the effectiveness or associated injury with tubing's and devices that may in place and compressed by the immobilizer.
g. Restraint Chair (Behavioral Health) has integral wrist and ankle cuffs and waist belt. The two finger rule applies. Order of placing in restraint: 1. Waist, 2. Wrist, 3. Ankles, 4. Harness (chest) 5. Retighten Waist. Order of releasing restraint: 1. Waist, 2. Wrist, 3. Ankles, 4. Harness (chest), 5. Retighten Waist.

PATIENT SELECTION: The focus of care should always be to preserve the rights and dignity of the patient. Patients should be assessed to determine that the use of less intrusive measures are ineffective in protecting the patient and or others from harm and pose a greater risk for harm than the risk of using restraint or seclusion. Restraint use associated with non-violent or non-self destructive behavior may be indicated, but only when it directly supports medical healing. When a patient exhibits violent or self-destructive behavior that presents an immediate and serious danger to the patient or others immediate action is needed. In these instances although the least intrusive intervention should be utilized staff must consider all interventions available and select the intervention that will be effective in protecting the patient and others from harm.

CLINICAL RESTRAINTS: (non-violent or non-self-destructive behavior) an example of clinical restraint is to prevent the removal of tubes/drains/devices that are associated with patient injury/death upon traumatic removal (e.g. ET tubes, IABP, chest tubes) to prevent patient injury/death.

RESTRAINT FOR VIOLENT OR SELF DESTRUCTIVE BEHAVIOR: Behavioral/ Emergency restraints are utilized only to manage a sudden, unanticipated aggressive or destructive behavior that places the patient or others in imminent danger. Restraint and seclusion

may not be used simultaneously unless the patient is continually monitored face-to-face by an assigned trained staff member; or continually monitored by trained staff using both audio and video equipment.

Alternative Strategies: Based on the assessed needs of the patient, the following will be used independently or jointly prior to use of restraints:

a. Patient education; orientation/reorientation; 1:1 verbal intervention.
b. Direct observation; involvement of family.
c. Medications as ordered by physician; pain management review.
d. Consult with pharmacy about the patient's present medications and possible impact on the patient's confusion.
e. Environmental assessment and modification (i.e., light, sound, music, location of room, use of cushions/pads). Provide and environment that avoids the use of aggression,
f. Present a non-threatening posture of helpfulness.
g. Re-direct the patient's activities that are potentially harmful toward safer alternatives utilizing 1:1 communication. Explore the patients' emotions, identify the unacceptable behavior, discover the source of distress and verbalize understanding through reflection.
h. Relocate the patient to lessen barriers that may agitate the patient.
i. Suggest clinical Time Out.
j. Remind patient he/she can utilize quiet time.
k. Modification of footwear to help prevent slipping if the patient gets up during the night.
l. Overdressing of IV sites, dressing, etc.
m. Concealing devices to limit patient access to catheters, tubes, IV's, etc.
n. Assess toileting, nutritional, and/or fluid needs.
o. Bed alarms

The above alternatives are suggestions and should be tried, although the staff should be open and creative in attempts to protect the patient from any danger prior to the use of restraints. The use of restraints should be a last resort and used only when alternatives and less restrictive measures are determined ineffective. Restraints may be used in response to emergent, violent or self destructive behavior as an adjunct to planned care to meet the patient's individual clinical needs.

Process for Obtaining Restraints: ***Use of restraints will be based upon the assessed needs of the patient, and consideration of pertinent information obtained from the initial admission assessment and reassessments.*** Assessments should include a physical assessment to identify medical problems that may be causing behavior changes in the patient (hypoxia, elevated temperature, drug interactions or side effects, electrolyte imbalances etc.), and should address the risks associated with vulnerable patient populations, such as emergency, pediatric and cognitively or physically limited patients. Assessments should also consider behavior, history and environmental factors.

After attempts to use available alternatives are determined to be ineffective, staff will consult the Nursing Supervisor, who will complete an independent assessment of the patient and an assessment of the use of alternative strategies for each patient. In particular those patients who are in the Intensive care unit will be assessed by the supervisor for LOC and level of agitation to determine if the patient is not alert enough to present a danger to themselves or is too sedated to require restraint. When determination has been made that restraints are clinically justified, the Nursing Supervisor or designee will distribute the appropriate restraint to the unit. The patient should be restrained in a private room or if a private room is not available the curtains should be drawn between patients. This reduces external stimulation, which generally assists the patient in regaining control, and provides the patient increased privacy, loosen tight clothing, and remove shoes. When the patient is appropriately restrained, explain to the patient the behavior(s) required to be released from restraint. Inform the patient's family of the need for restraint if they are authorized to have such information. When patient(s) exhibit violent or self destructive behavior a code White may be called to promote safe restraint of the patient. Approach the patient according to crisis intervention training and explain to the patient the need for restraint. When mechanical restraint is used for violent or self destructive behavior, immediately initiate one-to-one observation/care which will be continued until the patient is released from restraint.

Restraint Orders:

An order for restraint or seclusion must be obtained prior to the application of restraints except in emergency situations when the need for intervention must occur quickly. The order must be obtained immediately (as quickly as possible) post application of restraints and a verbal or written order entered into the patient's medical record. In situations where the

physician giving the restraint order is not the patient's treating physician, the treating physician is notified of restraint usage as quickly as possible/prudent.

1. **Orders for Restraints for Non-Violent, Non-Self Destructive Behavior/Clinical Restraints:**
   a. Must have a start time and must be time-limited
   b. One calendar day for adult and pediatric patients
   c. Must be written or verbal by an independent licensed practitioner
   d. If restraint or seclusion was ordered by telephone, the ordering physician shall personally sign and date the telephone order, including the time of the order, within 48 hours of the time the order was originally issued.
   e. PRN orders will not be accepted
   f. Orders must contain a clinical justification

2. **Continuation of Orders for Clinical Restraints:** ***Orders for continued restraint are to be obtained each calendar day and are based on the continued need for restraint to meet the clinical needs of the patient.***

3. **Orders for Restraint in Violent or Self-Destructive Behavior:**
   a. Designate the specific interventions (type of restraint)
   b. Must have a start time and must be time-limited
   c. Describe specific behaviors that resulted in the need for restraint
   d. Describe specific release behaviors to discontinue restraint
   e. Must be written or verbal by an independent licensed practitioner
   f. Verbal orders must be authenticated by the LIP within 48 hrs.
   g. PRN orders will not be accepted
   h. Time Limits for patients in Restraints for Violent or Destructive Behavior

   The physician's ***original order*** for emergency restraint for violent or self-destructive behavior will have the following time limits:
   - 15 minutes for a personal restraint
   - One hour for mechanical restraint for individuals under the age of 9 years;
   - Two hours for mechanical restraint for individuals age of 9-17 years;

- Four hours for mechanical restraint for individuals age of 18 years and older;

4. ***Renewal of Orders***: If the original order has not yet expired and the registered nurse has evaluated the individual face-to-face and determined the continuing existence of a behavioral emergency, the registered nurse must contact the physician. The physician shall conduct a face-to-face evaluation before issuing an order that continues the use of the restraint or seclusion. A physician may renew the original order provided it would not result in the use of:
    a. personal restraint beyond 15 minutes total from the time of initiation of the original personal restraint;
    b. mechanical restraint or seclusion beyond two hours total from the time of initiation of the original mechanical restraint or seclusion, for individuals under age 9;
    c. mechanical restraint or seclusion beyond four hours total from the time of initiation of the original mechanical restraint or seclusion, for individuals ages 9 - 17; or
    d. Mechanical restraint or seclusion beyond eight hours total from the time of initiation of the original mechanical restraint or seclusion, for individuals age 18 and older.
5. Renewal documentation. The physician shall document the clinical justification for continuing the restraint or seclusion before renewing an order that continues the use of restraint or seclusion.

Restraint or seclusion must be ended at the earliest possible time regardless of the length of time identified in the order. Restraint or seclusion may only be employed while the unsafe situation continues.

Interventions for Patients in Restraints for Emergency Violent or Self Destructive Behavior:

1. Face-to-face evaluation. A physician, physician assistant, or a registered nurse who is trained and has demonstrated competence in assessing medical and psychiatric stability, other than the registered nurse who initiated the use of restraint or seclusion, shall conduct a face-to-face evaluation of the individual within one hour following the initiation of restraint or seclusion to personally verify the need for restraint or seclusion.

- The face-to-face evaluation required by this subsection includes, but is not limited to, an assessment of the:
  (A) individual's immediate situation;
  (B) individual's reaction to the restraint or seclusion;
  (C) individual's medical and behavioral condition; and
  (D) need to continue or terminate the restraint or seclusion.

- If a physician assistant to whom the physician has delegated the face-to-face evaluation or a registered nurse who has conducted the face-to-face evaluation, in his or her professional judgment determines that the physician should evaluate the individual due to circumstances that are outside the physician assistant's or registered nurse's scope of practice or expertise, the physician assistant or registered nurse shall contact a physician and request that the physician perform a face-to-face evaluation of the individual. The physician assistant or registered nurse shall document the determination in the individual's medical record.

- If the face-to-face evaluation is conducted by a registered nurse or physician assistant, the registered nurse or physician assistant shall consult the treating physician or physician designee who is responsible for the care of the individual as soon as possible after the completion of the one hour face-to-face evaluation and document the consultation in the individual's medical record.

2. Treatment Plan – the treatment team shall review and, when appropriate, implement and document alternative strategies for dealing with behaviors in each of the following circumstances:
- in any case in which behaviors have necessitated the use of restraint or seclusion for the same individual more than two times during the individual's facility or program admission, or within any 30-day period, whichever period is shorter;
- when two or more separate episodes of restraint or seclusion of any duration have occurred within the same 12 hour period; and
- when an episode of restraint or seclusion has reached the maximum time limit.

3. Family Notification

- A staff member shall notify as soon as possible, but no later than 12hours following the initiation of the restraint or seclusion, the legally authorized representative of a minor.
- In cases where an adult patient has identified an individual to be informed of the patient's care, a staff member will inform the individual of the restraint or seclusion.
- The date and time of notification and the name of the staff member providing the notification shall be documented in the medical record. The documentation shall include any unsuccessful attempts, the phone number called, and the name(s) of person(s) with whom the staff member spoke.

4. Communication: staff shall communicate reassurance and commitment to the individual's safety on an ongoing basis, including how the staff can assist the individual to de-escalate.

- A staff member shall document in the individual's medical record all attempts to communicate with the individual and the individual's response to these attempts.

Interventions Following the Release of Restraint or Seclusion for Violent or Self Destructive Behavior:

1. Steps may be taken to facilitate the individual's reentry into the social milieu.
   - Observe the individual for at least 15minutes
   - Document in the individual's medical record the steps taken and observations made of the individual's behavior during this transition period.
2. A debriefing shall be attempted based on the following:
   - Identify what led to the episode and what could have been handled differently
   - Identify strategies to prevent future restraint or seclusion of the individual, takin into consideration suggestions from the individual
   - Ascertain whether the individual's well-being and psychological comfort, were protected
   - Modifications to the treatment plan will be made as indicated.

- If the debriefing is not conducted, the reasons for not completing shall be documented

Monitoring of Restrained Patients:

a. ***All patients who are restrained will be assessed and monitored for the following:***
   (1) Continued need for restraints;
   (2) Safety of patient; ***appropriate application/removal***
   (3) Emotional and physical needs of patient.
   (4) ***Significant changes in the patient's condition***

b. ***Patients with Clinical Restraints are released every two hours x 10min. for:***
   (1) Assessment of respiratory status and circulation to extremity – pink, cyanotic, swollen;
   (2) Repositioning of patient;
   (3) Assessment of skin condition – dry, pale; and skin integrity.
   (4) Offering of fluids/nutrition;
   (5) Elimination needs are met.

c. Frequent efforts to communicate verbally with patient to assure him/her of availability of assistance as needed.

d. ***When restraint or seclusion is used for violent and self-destructive behavior*** continual one-to-one observation will be initiated and continued until the patient is released from restraint. A staff member of the same gender as the patient must maintain continuous face to face observation of the patient unless the patient's history or other factors indicate this is contraindicated (i.e. history of sexual or physical abuse by someone of the same gender), in which case a staff member of the opposite gender may be used. All above monitoring parameters will be in place with the following exceptions:
   (1) Patients behavior will be monitored and documented every 15 minutes based on clinical condition.
   (2) Respiratory status, circulation (pulse and respiration) and skin integrity must be monitored continuously and documented every 15 minutes (or more often if deemed necessary by the attending physician).

(3) Cardiac status (pulse and respiration checks) must be monitored and documented hourly.
(4) Bathroom privileges and an opportunity to drink water or other appropriate liquid at least every 2 hours (or more frequently if requested and not contraindicated).
(5) Opportunity to bather at least daily
(6) Regularly scheduled meals, snacks, medications, and other treatments will be provided.
(7) Staff will initiate appropriate actions to facilitate the patient's re-entry into the social milieu following the release from restraint to include actions such as:
    a. Providing the patient an opportunity to discuss the experience privately within 24 hours
    b. Providing an appropriate transition and the opportunity to return to ongoing activities
    c. Observing the patient for at least 15 minutes with observations documented in patient's record.
(8) Assigned staff must perform ROM exercises for each extremity, one extremity at a time for at least five minutes during every hour that an individual is in mechanical restraint.

Release of Restraints: Restraints may be released prior to expiration of time limit at the direction of the RN, based upon the assessment of the patient, if it has been determined that:

a. Patient is no longer in danger to self or others.
b. Alternative methods are appropriate to maintain patient safety and safety to others.
c. When a Patient who is restrained for violent/self-destructive behavior falls asleep in restraint, the restraint must be released. A staff member shall maintain continuous face-to-face observation until the individual is awake and re-evaluated by the registered nurse.
d. The nurse should ensure that when restraints have been discontinued and the date and time are noted and documented appropriately.

If restraint or seclusion is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating the use of restraint or seclusion this

applies to both restraint utilized for clinical reasons and or restraints for violent/self-destructive behavior.

Education:

The restraints device policy will be reviewed with all patient care staff in employee unit orientation and annually. Training will include the application of restraints and seclusion, monitoring, assessment and providing care for the patient in restraints or seclusion. Competency will be reassessed annually. Registered Nurses, Advanced Practice Nurses and Physicians Assistants that are selected to perform face-to-face evaluations of patients that exhibit violent or self-destructive behaviors are identified and trained to evaluate and document; the patient's immediate situation; the patient's reaction to the intervention, the patient's medical and behavioral condition including a review of systems, patient history, medications, lab results and the need to continue or terminate the restraint or seclusion. Competency for performing face-to-face evaluations will be assessed annually. Physicians and other LIP's authorized to order restraint or seclusion will be provided with review and a copy of the policy and procedure at orientation and annually. For physicians who may order restraint or seclusion for violent or destructive behavior, the facility's credentialing and privileging processes must require that such physicians:

(1) Demonstrate competency in ordering restraint or seclusion; and
(2) Receive training and refresher training in:
(A) the use of alternatives to restraint or seclusion; and
(B) how to reduce the physical and emotional harm caused by restraint or seclusion.
When appropriate, patient and family education will be provided with respect to the privacy and dignity of the patient.

Performance Improvement:

Recognizing that restraints are high risk and problem prone, the hospital will collect aggregate data regarding the use of restraint. The data will be analyzed to identify patterns and trends to ensure that only clinically necessary restraints are used with

consideration of patient safety, including patterns of excessive use, use of restraint as a substitute for adequate staffing or failure to assess or investigate patient behavior and identify opportunities to decrease the use of restraint and increase compliance with standards, justification and meeting patient needs. Excessive or prolonged use of restraints is defined as any patient restrained for 14 days or longer. On day 15 the care team will re-evaluate the continued need for restraint and determine if the benefits of continued restraint use outweigh the risk. If it is determined continued use of restraint puts the patient at risk for poor outcome the plan of care will be revised. The Nursing Supervisor or designee will also monitor each use of restraint to further enhance patient safety. The hospital will understand the root cause of restraint use and Performance Improvement activities will be geared toward appropriate use of restraints. A RCA will be conducted in the event a patient is injured associated with the use of restraint or a staff member is injured through the application of restraint.

DOCUMENTATION:

The Nursing Supervisor or designee will complete the Assessment of alternative to restraints prior to issuing restraints unless patient and or staff safety are in immediate jeopardy and emergent application of restraint precipitates the completion of the assessment. In these instances the assessment will be completed within minutes of the application of restraint or seclusion. RN's who have demonstrated competency will document the justification for the use of restraints including precipitating factors/behavior prior to the time the patient was placed in restraint, attempts to use lesser restrictive measures and outcomes, the date time of restraint application and release, type of restraint applied, release criteria, date and time of physician notification and receipt of orders to initiate restraint/seclusion. When restraints are applied for violent and self-destructive behavior the date and time the face-to-face evaluation was conducted must be documented. In all incidents of restraint any injury or death associated with restraint or seclusion must be documented. The use of restraint or seclusion intervention should be documented in the patient's plan of care or treatment plan as close the time of restraint application as possible and should reflect an individualized approach to promote patient health, safety, dignity, self-respect and self-worth. The plan should be updated based on the assessment and evaluation of the patient's needs.

The RN, LVN, Nurse Extern or Certified Nurse Aide who have demonstrated competency in caring for restrained patients will document patient monitoring for clinical or non-violent and self-destructive behavior on the "PHYSICIAN RESTRAINT ORDER SHEET" or on the electronic care plan Risk for injury *Restraints Clinical) every 2 hours. The documentation for RESTRAINTS FOR VIOLENT OR SELF DESTRUCTIVE BEHAVIOUR will be documented every 15 minutes on the checklist portions of the "PHYSICIANS ORDER SHEET FOR BEHAVIORAL EMERGENCY RESTRAINT" ONLY.

Staff must report daily to Administrator or designee each use of involuntary intervention.

1. The Administrator or designee must take appropriate action to identify and correct unusual or unwarranted utilization patterns.
2. The Administrator or designee shall maintain a central file containing the following:
    a. Age, gender, and race of the individual
    b. Deaths or injuries to the individual or staff members
    c. Length of time the intervention was used
    d. Type of intervention, including each type of restraint used
    e. Name of staff members present for the initiation of the intervention
    f. Date, day of the week and time the intervention was initiated.

DEATH REPORTING REQUIREMENTS

It is the policy of Baptist Hospitals of Southeast Texas to report deaths associated with the use of restraint or seclusion related events to CMS including the following:

a. Each death that occurs while a patient in restraint or seclusion.
b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
c. Each death known to Baptist Hospital that occurs within one week after restraint or seclusion, where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.

When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:

a. Any death that occurs while a patient is in such restraints.
b. Any death that occurs within 24 hours after a patient has been removed from such restraints.
c. The staff must document in the patient's medical record the date and time the death was:
    - Reported to CMS for death or
    - Recorded in the internal log or other system for deaths described in paragraph (a) of this section.
d. For deaths described in paragraph (a) of this section, entries into the internal log or other system must be documented as follows:
    - Each entry must be made not later than two business days after the date of death of the patient
    - Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis(es).
    - The information must be made available in either written or electronic form to CMS immediately upon request.

Each death referenced above must be reported by staff to the Quality Management Department, who will report the death to CMS by telephone/fax/email no later than the close of business the next business day following knowledge of the patient's death. Staff must document in the patient's medical record the date and the time the death was reported to CMS.

NOTE: All restraint forms are to be obtained from the e-forms repository.

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Policy Manual:	Nursing Administration
Policy Number:	NUR.01.09.0015
Original Date:	09/99
Review Date:	1/13, 11/13, 01//2015, 3/18, 6/19
Reviewed By:	MEC
Revision Date:	1/13, 4/13, 11/13, 01/2015, 9/15, 3/18
This Policy Supercedes:	9/17/96
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References:

Texas Department of State Health Services. (1997, January 3). *Texas Administrative Code.* Retrieved May 22, 2015, from Texas Department of State Health Services: http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=401&rl=464