BAPTIST HOSPITALS OF SOUTHEAST TEXAS	
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SUBJECT: RESTRAINT/SECLUSION FOR VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR ("BEHAVIORAL RESTRAINTS")

POLICY:

Baptist Hospitals of Southeast Texas respects the rights and dignity of its patients. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion 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.

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 video equipment.

Only staff who have met the training requirements and demonstrated competencies may initiate personal restraint in a behavioral emergency. Only a physician, registered nurse, or physician assistant in accordance with a physician's delegated authority, may initiate mechanical restraint or seclusion.

DEFINITIONS:

PHYSICAL RESTRAINT

Physical restraint is 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. Under this definition, commonly used devices and other practices could meet the definition of a restraint, such as:

- Tucking a patient's sheets in so tightly that the patient cannot move.
- Use of a "net bed" or an "enclosed bed" that prevents the patient from freely exiting the bed.
- Use of "Freedom" splints that immobilize a patient's limb.
- Using side rails to prevent a patient from voluntarily getting out of bed; or
- Geri chairs or recliners, only if the patient cannot easily remove the restraint appliance and get out of the chair on his or her own.

General Exceptions to the Definition of Physical Restraint

Generally, if a patient can easily remove a device, the device would not be considered a restraint. In this context, *"easily remove"* means that the manual method, device, material, or equipment can be removed

intentionally by the patient in the same manner as it was applied by the staff (e.g., side rails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the patient's physical condition and ability to accomplish objective (e.g., transfer to a chair, get to the bathroom in time).

A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this policy.

Physical Hold

Holding a patient in a manner that restricts the patient's movement against the patient's will is considered restraint. Physically holding a patient during a forced psychotropic medication procedure is considered a restraint.

The physical holding of a patient for the purpose of conducting routine physical examinations or tests is not considered a restraint. A staff member picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient is not considered restraint.

SECLUSION

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

Seclusion is not just confining a patient to an area but involuntarily confining the patient alone in a room or area where the patient is physically prevented from leaving. If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception

that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether the door is actually locked or not. In this situation, the patient is being secluded.

Exceptions to the Definition of Seclusion

A patient physically restrained alone in an unlocked room does not constitute seclusion. Confinement on a locked unit or ward where the patient is with others does not constitute seclusion.

Timeout is not considered seclusion. Timeout is an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses

CHEMICAL RESTRAINT

Chemical restraint is 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.

Exceptions to the Definition of Chemical Restraint

Drugs or medications that are used as part of a patient's standard medical or psychiatric treatment and are administered within the standard dosage for the patient’s condition are not considered chemical restraint.

Whether or not an order for a drug or medication is PRN or a standing-order does not determine whether or not the use of that drug or medication is considered a restraint. The use of PRN or standing-order drugs or medications is only prohibited if the drug or medication meets the definition of a drug or medication used as a restraint.

Criteria used to determine whether the use of a drug or medication, or combination of drugs or medications is a standard treatment or dosage for the patient's condition includes all of the following:

- The drug or medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters.
- The use of the drug or medication follows national practice standards established or recognized by the medical community, or professional medical associations or organizations; and,

- The use of the drug or medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's or other licensed practitioner's (LP) knowledge of that patient's expected and actual response to the medication.

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.

Types of Behavioral Restraints – Personal Restraint (Hold), Restraint Chair (applied per manufacturer guidelines), Seclusion, Personal Hold for Emergency/Court Ordered Dose Medication
(See policy NUR.01.09.0047 *EMERGENCY DOSE MEDICATION ADMINISTRATION*)

Alternatives to the use of Restraint or Seclusion

The use of restraint or seclusion is limited to those situations for which there is adequate and appropriate clinical justification

- The use of restraint or seclusion is based on the assessed needs of the patient. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient and/or others from harm.
- The use of restraint or seclusion occurs only after alternatives to such use have been considered and / or attempted as appropriate. Such alternatives may include, but are not necessarily limited to:
  - Re-orientation
  - De-escalation
  - Limit setting
  - Increased observation and monitoring
  - Use of a sitter
  - Change in the patient's physical environment
  - Review and modification of medication regimens

Process for Obtaining Restraints:

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. When patient(s) exhibit violent or self-destructive behavior a Code

White may be called to promote safe restraint of the patient. 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.
(See PE.04.03.0001 *Crisis Intervention: Code White* and ADM.01.09.0034 *Code One to One*, if needed).

ORDERS FOR RESTRAINT/SECLUSION FOR VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR:

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 as soon as possible post application of restraints and a verbal or written order entered into the patient's medical record. If the physician who ordered the intervention is not the treating/attending physician, the physician ordering the intervention shall consult with the treating/attending physician or physician designee as soon as possible. The physician who ordered the intervention shall document the consultation in the individual's medical record.

While the attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion, when the attending physician of record is unavailable, responsibility for the patient must be delegated to another physician, who would then be considered the attending physician.

This policy does not specify that consultation with the attending physician be face-to-face. The consultation can occur via telephone.

Only a physician, registered nurse, or physician assistant in accordance with a physician's delegated authority, may initiate mechanical restraint or seclusion.

Use of Restraint or Seclusion Protocols, Standing Orders, or PRN Orders is not permitted.

Discontinuing a restraint or seclusion intervention and then re-starting it under the same order, or initiating a "trial release" constitutes a PRN use of restraint or seclusion, and, therefore, is not permitted.

A temporary, directly supervised release, however, that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) is not considered a discontinuation of the restraint or seclusion intervention. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint or seclusion.

Orders for Restraint in Violent or Self-Destructive Behavior Shall:

- Designate the specific interventions and procedures authorized (type of restraint), including any specific measures for ensuring the individual's safety, health, and well-being
- Specify the date, time of day, and maximum length of time the intervention and procedures may be used, consistent with the time limitations provided below
- Describe the specific behaviors which constituted the behavioral emergency which resulted in the need for restraint or seclusion
- Be signed and dated, including the time of the order, by the physician or the registered nurse who accepted the prescribing physician's telephone order
- 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

Time Limits for Patients in Restraints for Violent or Self-Destructive Behavior

Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others may only be renewed in accordance with the following 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

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.

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:

- Personal restraint beyond 15 minutes total from the time of initiation of the original personal restraint;

- 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;
- 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
- 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.

Renewal documentation. The physician shall document the clinical justification for continuing the restraint or seclusion before issuing or 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 VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR:

- 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:
        - individual's immediate situation;
        - individual's reaction to the restraint or seclusion;
        - individual's medical and behavioral condition; and
        - 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 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.

- 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.
- Family Notification
  - A staff member shall notify as soon as possible, but no later than 12 hours following the initiation of the restraint or seclusion, the legally authorized representative of a minor under age 18 who is not or has not been married; and in cases where an adult individual has consented to have one or more specified family members informed regarding the individual's care, and the family member or members have agreed to be informed, a staff member will inform the family member or members of the restraint or seclusion episode within the time frame determined by prior agreement between the individual and specified family member(s).
  - The date and time of notification and the name of the staff member providing the notification must be documented in the individual's 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.
- Communication: As soon as feasible after restraint or seclusion has been implemented in response to a behavioral emergency, the staff member shall refer to the individual's declaration for mental health treatment, if any, as a reference in determining and implementing an individual's preferences. The staff member shall communicate reassurance and commitment to the individual's safety on an ongoing basis, including inquiring as to how the staff member can assist the individual to de-escalate.

OBSERVATION, MONITORING, AND CARE OF THE INDIVIDUAL IN RESTRAINT OR SECLUSION:

- Observation
  - A staff member of the same gender as the individual shall maintain continuous face-to-face observation of an individual in mechanical restraint, unless the individual's history or other factors indicate this would be contraindicated (e.g., sexual or physical abuse perpetrated by someone of the same gender, in which case a staff member of the opposite gender may be used).
  - A staff member who is not physically applying personal restraint shall maintain continuous face-to-face observation of an individual in personal restraint.
  - A staff member shall maintain continuous face-to-face observation of an individual in seclusion for at least one hour. After one hour, the staff member may monitor the individual continuously using simultaneous video and audio equipment in close proximity to the individual
- Monitoring. A staff member shall ensure adequate respiration and circulation of the individual in restraint at all times.
  - Respiratory status, circulation, and skin integrity must be monitored continuously and documented every 15 minutes (or more often if deemed necessary by the ordering physician). Cardiac status must be monitored and documented hourly (or more often if deemed necessary by the ordering physician).
  - An assigned staff member must perform range of motion exercises for each extremity, one extremity at a time, for at least five minutes no less frequently than every 60 minutes that an individual is in mechanical restraint.
- Care-A staff member must provide for the hygiene, hydration, nutrition, elimination needs, and safety of an individual in restraint or seclusion. The individual in restraint or seclusion shall be provided:
  - bathroom privileges at least once every two hours (or more frequently, if requested and not contraindicated, or otherwise required by the individual's circumstances and physical or medical needs)
  - an opportunity to drink water or other appropriate liquids every two hours (or more frequently, if requested and not contraindicated, or otherwise required by the individual's circumstances and physical or medical needs);
  - an opportunity to bathe at least once daily (or more frequently, if clinically indicated or in the presence of incontinence);

- medications and medical equipment as ordered
- regularly scheduled meals and snacks served on dishes that are appropriate for safety;
- an environment that is free of safety hazards, adequately ventilated during warm weather, adequately heated during cold weather, and appropriately lighted.

TRANSFER OF PRIMARY RESPONSIBILITY FOR INDIVIDUAL IN RESTRAINT OR SECLUSION

- At the time of transfer of primary responsibility between staff members for the individual in restraint or seclusion, including transfer of responsibility at the change of shift, the staff member with primary responsibility must meet with the staff member who will assume primary responsibility to review the individual's status. A staff member shall monitor the individual during the transfer process.
- The review shall be documented and shall include:
  - information regarding the time a restraint or seclusion was initiated;
  - the nature of the circumstances requiring restraint or seclusion;
  - the current status of the individual's physical, emotional, and behavioral condition;
  - any medication administered; and
  - the type of care needed.

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:

- The patient is no longer in danger to self or others.
- Alternative methods are appropriate to maintain patient safety and safety to others.
- 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.
- The nurse should ensure that when restraints have been discontinued 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.

INTERVENTIONS FOLLOWING THE RELEASE OF RESTRAINT OR SECLUSION FOR VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR:

- Immediately following the release of an individual from restraint or seclusion, a staff member shall:
  - Take action, if appropriate, to facilitate the individual's reentry into the social milieu by providing the individual with transition activities and an opportunity to return to ongoing activities;
  - observe the individual for at least 15 minutes; and
  - document in the individual's medical record the steps taken and observations made of the individual's behavior during this transition period.
- 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, taking into consideration suggestions from the individual and the individual's declaration for mental health treatment, if any
  - Ascertain whether the individual’s well-being and psychological comfort, including trauma, and right to privacy were protected or otherwise addressed, as applicable
  - Counsel the individual(s) in relation to any trauma that may have resulted from the episode
  - Modifications to the treatment plan will be made as indicated.
  - If the debriefing is not conducted, the reasons for not completing it shall be documented
- Following an episode of restraint or seclusion, the facility shall conduct, or attempt to conduct, the following debriefings
  - Staff members who were involved in the episode, other staff members who the facility determines are appropriate, and supervisors shall debrief together as a support mechanism and to identify successes, problems, or necessary modifications as soon after the episode as is practicable in light of facility operations.
  - When clinically indicated and at a time when the individual has cognitive capacity to understand what could have been done differently to avoid restraint or seclusion, a staff member or members shall conduct a private discussion with the individual, the individual's LAR, if practicable, and family members, if clinically appropriate and available, with the consent of the individual

- If the episode was a restraint, when clinically indicated or upon request of individuals who witnessed the restraint, a staff member or members shall have a private discussion with individuals who witnessed the restraint.

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:

- Demonstrate competency in ordering restraint or seclusion; and
- Receive training and refresher training in:
  - the use of alternatives to restraint or seclusion; and
  - how to reduce the physical and emotional harm caused by restraint or seclusion.

DOCUMENTING, REPORTING, AND ANALYZING RESTRAINT OR SECLUSION:

The Nursing Supervisor or designee will complete the *Assessment of Alternatives* 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.

Facility documentation. The facility shall document the assessment, monitoring, and evaluation of an individual in restraint or seclusion on a facility approved form. Documentation in an individual's medical record shall include:

- The date and time the intervention began and ended;

- The name, title, and credentials of any staff members present at the initiation of the intervention, with identification of the staff member's role in the intervention, including as an observer, or status as an uninvolved witness, as applicable;
- The name of the individual restrained or secluded and the type of restraint or seclusion used;
- The time and results of any assessments, observation, monitoring, and evaluations, including those required under this subchapter, and attention given to personal needs;
- The physician's documentation of the order authorizing restraint or seclusion
- Any specific alternatives and less restrictive interventions, including preventive or de-escalatory interventions that were attempted by any staff member prior to the initiation of restraint or seclusion, and the individual's response to any such intervention;
- The individual's response to the use of restraint or seclusion; and
- Other documentation relating to an episode of restraint or seclusion otherwise required by the Texas Administrative Code, Title 26, Part 1, Subchapter C

For the patients in our main facility (Non-behavioral Health) monitoring of patients in restraints for VIOLENT OR SELF DESTRUCTIVE BEHAVIOR will be documented every 15 minutes on the checklist portions of the "PHYSICIANS ORDER SHEET FOR BEHAVIORAL EMERGENCY RESTRAINT".

In the Behavioral Health units, patient monitoring will be documented using the visible hands device and reports.

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

Staff must report daily to the Chief Nursing Officer (CNO), or designee, each use of involuntary intervention. The CNO, or designee, shall take appropriate action to identify and correct unusual or unwarranted utilization patterns on a systemic basis, and shall address each specific use of restraint or seclusion that is determined or suspected of being improper at the time it occurs

The CNO, or designee, shall maintain a central file containing the following:

- Age, gender, and race of the individual
- Deaths or injuries to the individual or staff members
- Length of time the intervention was used
- Types and dosage of emergency medications administered during the restraint or seclusion, if any
- Type of intervention, including each type of restraint used

- Name of staff members present for the initiation of the intervention
- 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:

- Each death that occurs while a patient in restraint or seclusion.
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
- 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.

Each death referenced above must be reported by staff to the Nursing Administration. It will be reviewed and submitted to CMS by either Nursing Administration or Quality Management, who will report the death to CMS no later than the close of business the next business day following knowledge of the patient's death. Nursing Admin will document in the patient's medical record the date and the time the death was reported to CMS.

For procedures involving restraints for VIOLENT OR SELF DESTRUCTIVE BEHAVIOR that are not described in this policy, staff will follow the requirements as outlined in the Texas Administrative Code, Title 26, Part 1, Subchapter C

References

Texas Administrative Code. *Texas Department of Health Services* (Title 26, Part 1, Subchapter C ed.). https://texas-sos.appianportalsgov.com/rules-and-meetings?$locale=en_US&interface=VIEW_TAC_SUMMARY&queryAsDate=05%2F07%2F2025&recordId=222968

CIHQ Accreditation Standards for The Use of Restraints and Seclusion

BAPTIST HOSPITALS OF SOUTHEAST TEXAS	
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SUBJECT: RESTRAINTS FOR NON-VIOLENT, NON-SELF-DESTRUCTIVE BEHAVIOR ("CLINICAL" RESTRAINTS)

POLICY:

Baptist Hospitals of Southeast Texas respects the rights and dignity of its patients. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. 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.

(For restraints or seclusion for violent, self-destructive behavior, see policy NUR.01.09.0045 *RESTRAINT/ SECLUSION FOR VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR ("BEHAVIORAL RESTRAINTS")*

DEFINITIONS:

PHYSICAL RESTRAINT

Physical restraint is 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. Under this definition, commonly used devices and other practices could meet the definition of a restraint, such as:

- Tucking a patient's sheets in so tightly that the patient cannot move.
- Use of a "net bed" or an "enclosed bed" that prevents the patient from freely exiting the bed.
- Use of "Freedom" splints that immobilize a patient's limb.
- Using side rails to prevent a patient from voluntarily getting out of bed; or
- Geri chairs or recliners, only if the patient cannot easily remove the restraint appliance and get out of the chair on his or her own.

General Exceptions to the Definition of Physical Restraint

Generally, if a patient can easily remove a device, the device would not be considered a restraint. In this context, *"easily remove"* means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff (e.g., side rails are put down,

not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the patient's physical condition and ability to accomplish objective (e.g., transfer to a chair, get to the bathroom in time).

A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this policy.

Types of Clinical Restraints – Clinical Restraints used at BHSET are listed below, however, any object or device used to prevent the patient from accessing his or her body, moving their arms, legs, or ambulating in a normal manner is a restraint. An example of clinical restraint is to prevent the patient from removing medically essential tubes/drains/devices that are associated with patient injury/death upon traumatic removal (e.g. ET tubes, IABP, chest tubes). Restraints commonly utilized at BHSET are: soft wrist or ankle restraints, mittens (secured or unsecured), elbow, knee immobilizers, padded bedrail gap fillers (when used to prevent patients from climbing through the bedrails).

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

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.

Excessive or Prolonged Use of restraints is defined as any patient restrained for 14 days or longer.

If an assessment reveals non-violent, non-self-destructive behavior the facility shall use the least restrictive intervention that effectively protects the individual from harm. If the intervention is a restraint, it shall only be used in the following circumstances:

- ordered by a physician
- needed to ensure the individual's safety; and
- used only after less restrictive interventions have been considered, or attempted and determined to be ineffective, or are judged to be unlikely to protect the individual or others from harm.

Alternative/Less Restrictive Strategies: Based on the assessed needs of the patient, alternative strategies will be used independently or jointly prior to use of restraints. Examples are listed below 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 to be ineffective.

- Patient education; orientation/reorientation; 1:1 verbal intervention.
- Direct observation; involvement of family.
- Medications as ordered by physician; pain management review.
- Consult with the pharmacy about the patient's present medications and possible impact on the patient's confusion.
- Environmental assessment and modification (i.e., light, sound, music, location of room, use of cushions/pads).
- Overdressing of IV sites, dressing, etc.
- Concealing devices to limit patient access to catheters, tubes, IVs, etc.
- Assess toileting, nutrition, and/or fluid needs.
- Bed alarms

Process for Obtaining Restraints:

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 Alternatives for Restraints* for each patient. When determination has been made that restraints are clinically justified, and a physician order has been obtained, the Nursing Supervisor, or designee, will distribute the appropriate restraint to the unit.

ORDERS FOR RESTRAINTS FOR NON-VIOLENT, NON-SELF-DESTRUCTIVE BEHAVIOR:

Prior to the application of a restraint for the management of non-violent, non-self-destructive behavior, an assessment of the individual shall be done to determine that the risks associated with the use of the restraint are outweighed by the risks of not using it. The order for the restraint shall be followed by consultation with the individual's treating physician if the restraint was not ordered by the individual's treating physician. The consultation shall be documented in the individual's medical record no later than the next business day, except that it shall be done sooner, when an earlier consultation is clinically indicated.

The physician's order for the restraint shall specify:

- A time limit on the use of the restraint (One calendar day for adult and pediatric patients)
- Any special considerations for the use of restraint
- The specific type of restraint to be used
- Who is responsible for implementing the restraint
- Instructions for monitoring the individual

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.

Whenever a restraint is ordered by a physician, the ordering physician shall prescribe the frequency of assessment required for the individual during restraint and how the individual's circulation, hydration, elimination needs, level of distress and agitation, mental status, cognitive functioning, cardiac functioning, skin integrity, nutrition, exercise, and range of motion of extremities are to be assessed and addressed during restraint.

Continuation/Renewal 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.

Use of Restraint or Seclusion Protocols, Standing Orders, or PRN Orders is not permitted.

Discontinuing a restraint or seclusion intervention and then re-starting it under the same order, or initiating a “trial release” constitutes a PRN use of restraint or seclusion, and, therefore, is not permitted.

A temporary, directly supervised release, however, that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) is not considered a discontinuation of the restraint or seclusion intervention. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the 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.

Monitoring of Restrained Patients:

- All patients who are restrained will be assessed and monitored for the following:
  - Continued need for restraints
  - Safety of patient; appropriate application/removal
  - Emotional and physical needs of patients.
  - Significant changes in the patient's condition
- Patients with Clinical Restraints are released every two hours x 10min. and assessed for: circulation, hydration, elimination, level of distress and agitation, mental status, cognitive functioning, cardiac functioning, skin integrity, nutrition, exercise, and range of motion of extremities.
- Frequent efforts to communicate verbally with patients to assure him/her of availability of assistance as needed.

Release of Restraints:

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 restraints utilized for clinical reasons and 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.. 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

DOCUMENTATION:

The Nursing Supervisor or designee will complete the *Assessment of Alternatives for 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.

The RN, LVN, Nurse Extern, or Nurse Aide who have demonstrated competency in caring for restrained patients will document every 2 hour patient monitoring for clinical or non-violent and non-self-destructive behavior on the electronic *Restraint End of Shift Note*.

The Administrator or designee must take appropriate action to identify and correct unusual or unwarranted utilization patterns.

The Administrator, or designee, shall maintain a central file containing at least the following:

- Patient name, visit number, age, and gender
- Date and time implemented and discontinued
- Type of restraint used
- Name of House Supervisor and RN

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:

- Each death that occurs while a patient in restraint or seclusion.
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
- 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.

Each death referenced above must be reported by staff to Nursing Administration. It will be reviewed and submitted to CMS by either Nursing Administration or Quality Management, who will report the death to CMS no later than the close of business the next business day following knowledge of the patient's death. Nursing Admin will document in the patient's medical record the date and the time the death was reported to CMS.

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 (2-point soft wrist restraint), and no seclusion was

used, any death that occurs while a patient is in such restraints or any death that occurs within 24 hours after a patient has been removed from such restraints is not required to be reported to CMS, but will be recorded in an internal log. Entries in the internal log must:

- Be made not later than seven days after the date of death of the patient
- 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 Nursing Administration will document in the patient's medical record the date and time the death was recorded in the internal log.

The information must be made available in either written or electronic form to CMS immediately upon request.

References

Texas Administrative Code. *Texas Department of Health Services* (Title 26, Part 1, Subchapter C ed.). https://texas-sos.appianportalsgov.com/rules-and-meetings?$locale=en_US&interface=VIEW_TAC_SUMMARY&queryAsDate=05%2F07%2F2025&recordId=222954

CIHQ Accreditation Standards for The Use of Restraints and Seclusion

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

BAPTIST HOSPITAL BEAUMONT HOSPITAL	
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This Policy Supersedes:	BHC.10.02.0000
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SUBJECT: EMERGENCY DOSE MEDICATION ADMINISTRATION

POLICY STATEMENT
To establish guidelines for the utilization and documentation of the use of emergency medications.

PROCESS:
Definitions:

Emergency Psychoactive Medication--A psychoactive medication administered to a patient in a psychiatric emergency that is used to exercise an immediate effect on the central nervous system.

Psychiatric Emergency--A situation in which it is immediately necessary to administer medication to a patient to prevent imminent probable death or substantial bodily harm to the patient because the patient:

1. overtly or continually is threatening or attempting to commit suicide or serious bodily harm; or
2. 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 another because of threats, attempts, or other acts the patient overtly or continually makes or commits.

Psychoactive Medication--A medication prescribed for the treatment of symptoms of psychosis or other severe mental or emotional disorders and that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state when treating the symptoms of mental illness. "Psychoactive Medication" includes the following categories when used as described in this section:

1. Antipsychotics or neuroleptics
2. Antidepressants
3. Agents for control of mania or depression
4. Antianxiety agents
5. Sedatives, hypnotics, or other sleep-promoting drugs; and
6. Psychomotor stimulants.

The psychoactive medications permitted and approved by the hospital for parenteral administration in a psychiatric emergency are:

1. Haloperidol (Haldol)
2. Ziprasidone (Geodon)
3. Olanzapine (Zyprexa)
4. Lorazepam (Ativan)
5. Benztropine (Cogentin)

Note: If the patient is agreeable and consents to a P.O. dose of medication, it is not considered an Emergency Dose.

Psychoactive medications that are used to treat the signs and symptoms of mental illness in a psychiatric emergency should ONLY be used after other appropriate, less restrictive techniques have been attempted and failed. Emergency medication administration should NEVER be employed as a punishment or for the convenience of staff with its use outweighing the known contraindications for use.

ONLY A TREATING PHYSICIAN with appropriate prescriptive authority may issue an order to administer emergency psychoactive medication without a patient's consent when less restrictive interventions have been attempted and are determined ineffective to protect the patient or others from harm.

Only Physicians, Advanced Practice Registered Nurses, and Registered Nurses who meet the educational criteria and demonstrate associated competencies listed below may administer an emergency dose of psychotropic medication and/or perform the required one-hour *BH-Face to Face Evaluation Template*.

Staff members authorized by the hospital's policies and procedures to administer an emergency psychoactive medication shall receive training on and demonstrate competency in the following:

1. knowledge of the psychoactive medications permitted and approved by the hospital for administration in a psychiatric emergency;
2. safe and appropriate administration and monitoring of an emergency psychoactive medication
3. management of emergency medical conditions, including, but not limited to:
    a. Recognizing and responding to signs of physical and psychological distress, manage and escalate a medical emergency.
    b. Monitoring the physical and psychological well being of the patient who has received an emergency psychoactive medication, including the patient’s respiratory and circulatory status, vital signs, if indicated.

A physician, Advanced Practice RN or Registered Nurse trained in accordance with the requirements specified above shall examine the patient in person within one hour after the administration of the psychoactive medication to evaluate and document in the patient's clinical record:

1. The patient's immediate situation
2. The patient's reaction to the medication
3. The patient's medical and behavioral condition; and
4. Whether to return to or modify the patient's plan of care

If a trained registered nurse conducts the in-person *BH-Face to Face Evaluation Template*, the trained registered nurse shall consult the attending physician or other licensed practitioner responsible for the patient's care as soon as possible after completing the evaluation.

BAPTIST HOSPITAL BEAUMONT HOSPITAL	
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The physician or other licensed practitioner responsible for the patient's care shall document in the patient's clinical record in specific medical and behavioral terms:

1. the patient's immediate situation
2. the patient's condition or symptoms warranting the emergency psychoactive medication
3. alternatives or other less restrictive interventions attempted, as applicable
4. the patient's response to the emergency psychoactive medication, including the rationale for continued use of the medication
5. whether to return to or modify the patient's plan of care

DOCUMENTATION:
All orders will be placed using the *Inpatient Emergency Psychoactive Dose* Order Set and the *BH-Face to Face Evaluation Template* in MedHost Experience will be used for documenting the post medication Face to Face Assessment within 1 hour post administration.

References TAC TITLE 26, CHAPTER 568, SUBCHAPTER C, RULE §568.42