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|  | **Mind Springs Inc.** | | | |
| **Policy and Procedure** | | | |
| Policy name: | **Seclusion and Restraints** | | | |
| Policy number: | **700-00-79** | | | |
| Proponent: | **Hospital Quality Manager** | | | |
| Company: |  | Mind Springs Inc. |  | Mind Springs Asset Management, LLC |
|  |  | West Springs Hospital |  | Health Services Program, Inc. |
|  |  | Transitions at West Springs |  | Whole Health, LLC |
|  |  | Mind Springs Health |  |  |
| Statutes/Standards: |  | CARF: |  | OBH: |
|  |  | CDPHE: |  | JC: |
|  |  | CMS: |  | HIPAA: |
|  |  | CRS: |  | OTHER: |
|  |  |  |  |  |

**PURPOSE**

To protect the health, safety, rights, dignity and well-being of all patients; to designate the criteria by which it can be determined that the use of seclusion or restraint is warranted; to outline the procedures to be implemented by staff to assure the safe use of seclusion and restraint (S/R); and to ensure that criteria and procedures meet the regulations of the Colorado Department of Human Services-Office of Behavioral Health, Colorado Department of Public Health and Environment-Health Facilities and Emergency Medical Services Division.

**POLICY**

1. All patients will be assessed upon admission and on a continual basis throughout their hospitalization at West Springs Hospital (WSH) for behavior that might indicate a potentially dangerous risk of harm to self or others.
2. Patients being detained on a 72-hour hold (M-1) or 90 day certification (M-8) may be secluded or restrained over their objection, otherwise there must be a signed informed consent for such an intervention for all individuals admitted voluntarily.
3. A safe environment will be provided for all patients by implementing the procedures associated with the S/R policy in a manner congruent with the need.
4. All patients have the right to be free from S/R, of any form, imposed as a means of coercion, punishment, discipline, staff convenience or retaliation, nor as an alternative to treatment.
5. All patients will receive considerate and respectful care, free of unnecessary seclusion or restraints. Less restrictive methods of intervention will be utilized and exhausted prior to the initiation of any S/R measure whenever possible.
6. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, staff or others and must be discontinued at earliest possible time.
7. Physical restraint may be used where the individual presents a serious, probable imminent threat of bodily harm and has the ability to affect such harm on self or others.
8. Seclusion may be used only for the management of violent or destructive behavior that jeopardizes the safety of the patient, a staff member or others.
9. **Mechanical restraints may be only used for the purpose of preventing such bodily movement that is likely to result in imminent physical injury to self.**
10. Any decision to use seclusion or restraint shall be based on current clinical assessment. The decision to use seclusion or restraint may also be based on other reliable information including information that was used to support the decision to take the person into custody for treatment and evaluation. The fact that a person has been detained for the purposes of evaluation and treatment under C.R.S. 27-10 will not be the sole justification for the use of seclusion or restraint.
11. Patient safety and dignity are of utmost importance. Staff will be aware of the risks associated with vulnerable populations, such as pediatric, geriatric patients and those with cognitive or physical limitations.
12. Staff will recognize how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a patient reacts to physical contact, seclusion or restraint.
13. Staff is responsible for and will ensure that no person will harm or harass a person who is secluded and/or restrained.
14. Emergency medical care and cardiopulmonary resuscitation for patients who are restrained or secluded will be available at all times and follow the *Emergency Medical Care* policy of WSH.
15. In the case of seclusion or restraint of minor, age eighteen (18) or younger, the patient’s family, or legal guardian must be notified of the episode.
16. The decision to discontinue an S/R intervention should be based on a current assessment and the determination that the patient’s behavior is no longer a threat to self or others.

17. All episodes of S/R will be documented in a timely manner in the appropriate sections of the patient’s record of care.

18. The Hospital V.P, Quality Manager, Director of Nursing and Hospital Administrator on Call will be notified before the end of the shift, either by email or voicemail that a seclusion or restraint episode has occurred.

**PROCEDURE**

1. Seclusion and/or restraint shall be used only when other less restrictive methods have failed. Attempts to utilize non-physical, de-escalation interventions shall be documented in the patient’s record of care. De-escalation interventions may include any or all of the following:
   1. Removal of audience
   2. Engaging in 1:1 conversation or activity
   3. Redirection of behaviors
   4. Offering the patient time out in a quiet room
   5. Utilizing verbal de-escalation techniques
   6. Reminder of coping skills
   7. Offering of nourishment
   8. Offering opportunity for exercise or physical activities
   9. Setting boundaries and limits
   10. Provision of diversion activities such as music, arts
   11. Offer and provide medications
2. A “Code Gray” will be called over 2-way staff radios if de-escalation interventions were unsuccessful and a request for team assistance is required for S/R (i.e. call “Code Gray, building C dayroom”).
3. **Orders for seclusion and/or restraint (S/R)** are obtained when non-physical interventions prove ineffective and the patient continues to demonstrate harmful or destructive behaviors. Immediately upon S/R, the patient shall be given a clear explanation of reasons for S/R, the observation procedure, the desired effect and the circumstances under which the procedure will be terminated (exit criteria). This information will be verbally presented to the patient periodically throughout the S/R episode. The fact that this information was given to the patient will be documented.
   1. All episodes of S/R require an order from a Doctor within one (1) hour of starting the S/R episode. A completed *S/R Order label* will be placed in the patient’s record of care and signed by the ordering Doctor within 24 hours.
      1. In an emergency situation, a Registered Nurse (RN) may authorize seclusion or restraint. The on-call Doctor must be called by a nurse and a verbal S/R order shall be obtained within one (1) hour of initiating the S/R episode. The nurse shall sign, date and time the verbal S/R order.
      2. The initial call to a Doctor for S/R orders and notification of the *1-Hour Face-to-Face* E*valuation* will be consolidated into one call so that a full patient report may be given at one time.
      3. If the patient’s treating Provider did not order the seclusion or restraint, the treating Provider must be notified and consulted within 24 hours.
   2. **S/R orders must include the following**:
      1. Type of order: seclusion, physical restraint and/or mechanical restraint.
      2. Specific behavior for which seclusion or restraint is being applied: danger to self, danger to others and/or violent behavior. The *Assessment to Renew Orders* document must support the justification for new orders to continue the original S/R order.
      3. Date and Time of order.
      4. PRN orders are not acceptable.
      5. Time limited orders for seclusion or restraint are in effect for the following maximum time frame:
         * 1. Adults eighteen (18) and above – four (4) hours
           2. Children and adolescents ages nine (9) to seventeen (17) – two (2) hours
           3. Children age eight (8) and under – one (1) hour

c. If the patient meets the exit behavior criteria, orders for S/R do not mean that S/R must be applied for the entire length of time for which the order is written, and a doctor’s order may be obtained to discontinue the S/R episode.

**d.** If restraint or seclusion is discontinued prior to the expiration of the current order, a new order must be obtained again for reinitiating the use of restraint or seclusion.

e. If a patient is temporarily released from restraint and is under direct staff supervision for toileting, feeding or range of motion exercises, it is not considered a discontinuation of the seclusion/restraint order.

**f. A doctor’s order must be obtained and documented in the record of care to terminate seclusion or mechanical restraint prior to the patient’s release.**

**4. 1- Hour Face-to-Face evaluation** will be conducted within one (1) hour after the initiation of S/R **by** a Doctor, Provider or RN who has been trained regarding the requirements of a face-to-face evaluation.

a. The evaluationwill be documented in the patient’s record of care on the *1-Hour Face-to-Face Evaluation* form and includes the following:

* + 1. The type of intervention applied
    2. The rational supporting S/R intervention that defines the patient’s specific behaviors and the nature of the danger.
    3. The attempts made to control the patient’s behavior prior to using S/R.
    4. The patient’s current behavior once placed into S/R.
    5. The patient’s current medical condition; includes a review of recent medications, laboratory results and any medical conditions that may have contributed to the S/R episode.
    6. The circumstances under which S/R will be terminated and that the patient was verbally told the circumstances for meeting the exit criteria.
    7. That the Doctor was notified within one hour of the S/R episode.

b. The 1-hour face-to-face evaluation and the initial call to a Doctor for S/R orders will be consolidated into one call so that a full patient report may be given at one time, if the Doctor was not present to give orders when the S/R episode started.

c. If a patient who is S/R for combative, assaultive or violent behavior quickly recovers and is released the Doctor, Provider or nurse must still perform the face-to-face assessment evaluation within 1 hour after the initiation of the intervention.

d. The *1-Hour Face to Face Evaluation* form and all items contained in the form will be documented in the patient’s record of care before the next assessment to renew orders is conducted, or before the end of the attending nurse’s scheduled work shift.

**5. Assessment for Renewal of Orders**

* 1. When the order for seclusion or restraints is about to expire, the nurse must contact the Doctor, report the results of a current re-assessment and receive orders to continue or end the S/R episode.

b. An Assessment to renew orders must be conducted at these intervals:

* + 1. Every four (4) hours for adults age 18 and above
    2. Every two (2) hours for children and adolescents ages 9 to 17
    3. Every one (1) hour for children age 8 and under
  1. The assessment to renew orders will include following concerns and be documented in the patient’s record of care on the *Assessment to Renew Orders* form:
     1. The type of orders requested.
     2. The patient’s current behaviors.
     3. The patient’s current medical condition.
     4. The circumstances under which S/R will be terminated and that the patient was verbally told the circumstances for meeting the exit criteria.
     5. Whether the patient has met the exit criteria.
     6. The rational that supports the continued use of seclusion or restraint due to the specific dangerous behaviors that the patient continues to display.
  2. A completed S/R *Order label* will be placed in the patient’s record of care each time the order is renewed. All required signatures pertaining to the order will be obtained within 24 hours.
  3. The *Assessment to Renew Orders* form and all items contained in the form will be documented in the patient’s record of care before the next assessment to renew orders is conducted, or before the end of the attending nurse’s scheduled work shift.

**6. The End of Episode** will be documented in the patient’s record of care on the appropriate form. Documentation will include the rationale for ending the episode, the date/time that each intervention ended, that the doctor was notified and orders were received and documented to end each intervention. Notice of the end of the episode will be sent to the Hospital Leadership Team.

**7. Observation and care of patients in seclusion or restraints**

* 1. The nurse will examine the patient for injury as soon as the situation becomes safe, usually during the 1-*Hour Face-to-Face* evaluation. The nurse or a Provider will treat any injuries that occurred during an episode.
  2. Vital signs will be monitored and documented on the *S/R Flowsheet* based on nurse assessment of need.
  3. Staff will directly observe the secluded patient the first fifteen (15) minutes and observations, along with the behavior of the patient, will be recorded on the *S/R Flowsheet*.
  4. Staff will continue to visually observe a secluded patient at least every fifteen (15) minutes and such observation, along with the behavior of the patient, will be recorded each time on the *S/R Flowsheet*. The patient should be observed more frequently as clinically indicated.
  5. Unless contraindicated by the patient’s condition, such observations shall include efforts to interact personally with the patient.
  6. A nurse will be notified immediately if the patient displays dangerous self-harm behaviors, and immediate efforts will be made by staff to protect the patient from any harm. Actions will be documented on the *S/R Flowsheet*.
  7. A patient in physical restraint will be released from such restraint within fifteen (15) minutes, or sooner, after the initiation of physical restraint, except when precluded for safety reasons.
  8. Ongoing provisions shall be made for nursing care, hygiene and diet. The patient will be offered:
     1. Foods, fluids, and toileting will be offered and an assessment of skin circulation will be conducted every two (2) hours, unless the patient is sleeping. These provisions and the patient’s response will be documented on the *S/R Flowsheet*.
     2. Range of motion exercise, if patient is in mechanical restraint, will be offered every two (2) hours, unless sleeping or agitated. These provisions and the patient’s response will be documented on the *S/R Flowsheet*.
  9. The patient is to be released as soon as possible when exhibiting calm, non-threatening behavior, and is able to agree to maintaining the exit criteria. Document process of release on the *S/R Flowsheet* and on the *End of Episode* form in the patient record of care.
  10. Staff will debrief the patient shortly after discontinuing the use of seclusion or restraint. The patient’s response to debriefing will be documented in the patient’s record of care under the appropriate *Daily Progress Note*.
  11. Emergency medications administered during S/R episodes will be documented in the *Emergency/Involuntary Medication Logbook*, noting if the patient took them voluntarily or involuntarily. Medications administered will be documented according to the policy “Medication Management & Administration”*.*
  12. Multiple S/R episodes with the same patient will require updates to the patient’s *Treatment Plan.*

**8. Additional observation and care procedures specific to mechanical restraints**

* 1. Patients placed in mechanical restraints must be observed continuously throughout the procedure. A staff member is assigned to sit within arm’s reach of the patient to ensure safety. **At no time will a patient in mechanical restraints be left unattended.**
  2. When releasing mechanical restraints:
     1. Remove one arm or leg restraint and if patient’s behavior appropriate,
     2. Remove diagonally opposite arm or leg restraint and if patient’s behavior appropriate,
     3. Remove last two restraints
  3. If at any time one or more mechanical restraints compromise the patient’s life or health of the patient’s limb, the mechanical restraint will be immediately released. If unable to release the restraint, staff will obtain the leather-grade shears from the restraint storage bag and cut the offending mechanical restraint in a safe manner to avoid harming the patient.
  4. Documentation of observation and care of the patient will be done on the *S/R Flowsheet* as previously directed in this policy.
  5. A *Critical Incident Report* must be filed for all seclusion and mechanical restraint episodes as per the *Critical Incident* policy and procedure.
  6. Any staff injuries during a S/R episode will be documented on an Employee First Injury Report and submitted to the employee’s supervisor within 24-hour of the injury.

**9. Orders for seclusion or restraints in excess of twenty-four (24) hours**

* 1. Seclusion or restraints continued more than twenty-four (24) hours, and subsequent 24-hours, will require a face-to-face evaluation by a Doctor with new orders documented each time.
  2. There will be documentation in the medical record that provides a reasonable rationale supporting the decision to continue with seclusion or restraints.

**10. Administrative review for each 24-hour period of continuous seclusion or restraint.**

* 1. An administrative review will be initiated at the conclusion of each twenty-four (24) period of continuous seclusion or restraint by the Director of Nursing (DON) and/or Hospital Administrator and will be completed prior to the expiration of each twenty-four hour period.
  2. The administrative review will document the clinical justification for the continuous use of seclusion or restraint in the patient’s record of care. Justification shall include:
     1. Documentation that the doctor ordering the continuous use of seclusion or restraint in excess of twenty-four (24) hours has conducted a face-to-face evaluation.
     2. Documentation of the ongoing behaviors or findings that warrant the continued use of seclusion or restraint and other assessment information as appropriate.
     3. Documentation of a plan for ongoing efforts to actively address the behaviors that resulted in the use of seclusion or restraint.
     4. A determination of the clinical appropriateness of the continuation of seclusion or restraint.
     5. The reviewer will date, time and sign the review.

**11. Treatment plan**

* 1. Patients with repeated episodes of seclusion or restraint will have a written modification to their treatment plan.
  2. The modification will be developed by the treatment team with the goal of reducing/eliminating future episodes of seclusion or restraint with defined actions and assigned responsibilities to achieve the goal.
  3. Whenever possible, input from the patient and family will be integrated into the modification of their treatment plan.

**12. S/R Logs**

* 1. Each episode of seclusion or restraint will be documented in the patient’s medical record.
  2. The *S/R Logbook* data will be extracted from the electronic medical record and tracked through reports generated in the Tableau report system. Components of this log include:
     1. Patient ID number that links to name, date of birth, and date of admission
     2. Type of episode: seclusion, physical restraint, mechanical restraint
     3. Date and time seclusion or restraint episode started
     4. Date and time seclusion or restraint ended

c. Emergency medications required during a seclusion or restraint episode will be promptly documented according to policy. The medication will also be recorded in the *Emergency/Involuntary Medication Logbook* which will be kept on each unit, and maintained by the charge nurse.

**13. Debriefing**

* 1. Patient debriefing: All patients will be offered debriefing as soon as possible following each episode of seclusion, mechanical restraint, and/or physical restraint. Debriefing elements include:
     1. Staff will allow the patient to express their feelings about the episode.
     2. Staff will provide reassurance and emotional support to the patient.
     3. Staff will review with the patient any triggers and/or cues they were attempting to give to others when they began to feel “out of control”.
     4. Staff will inquire if the patient knows why staff determined that the episode was necessary.
     5. Staff will assist the patient to identify coping skills that can be used in the future to avoid another episode.
     6. Staff will discuss with the patient how to therapeutically re-integrate into the milieu and assist them with the transition.
  2. Staff debriefing:
     1. All staff who participated in an episode will have a staff debriefing as soon as possible after the episode.
     2. Staff will discuss events leading to the episode.
     3. Staff will discuss how staff handled the incident.
     4. Discuss ways to improve teamwork around future patient interventions.
     5. Discuss changes to the patient’s *Treatment Plan* and present recommendations at the patient’s next multiple-disciplinary treatment plan team meeting.

**14. Quality Review of S/R**

* 1. The Hospital V.P, Quality Manager, Director of Nursing and Hospital Administrator on Call will be notified by nursing before the end of the shift, either by email or voicemail that a seclusion or restraint episode has occurred.
  2. Hospital Quality will review each episode of S/R. Any concerns will be brought to the attention of the hospital administration.
  3. The QI Manager will maintain, or designate maintenance of, a tracking record of S/R episodes which will access the following information:
     1. Patient’s identifying number: provides name, age, gender, ethnicity of patient.
     2. Unit in which the episode occurred
     3. Date and time each episode started
     4. Date and time each episode ended
     5. The length of time for each episode
     6. Type of restraint/seclusion used.
     7. Whether emergency/involuntary medications were given
     8. Whether injuries were sustained by the patient or staff
     9. Completion of documentation.

15. **Staff Training**

* 1. All staff involved in placing patients in seclusion or restraint shall be trained regarding these policies and procedures annually and during the period of orientation to job responsibilities.
  2. All hospital staff will be certified in BLS/CPR before participating in any seclusion or restraint. Recertification is required to maintain current status.
  3. All staff involved with seclusion or restraint will be trained in safe physical restraint C.P.I. techniques annually and during the period of orientation to job responsibilities.
  4. All staff involved with seclusion or restraint observations will be trained in monitoring the physical and psychological well-being of the patient in seclusion and/or restraints. This includes but is not limited to respiratory and circulatory status, skin integrity, vital signs, frequency of offering food, water and personal hygiene.
  5. All nurses will be trained in conducting face-to-face evaluations, recognition of behavioral changes that indicate that restraint or seclusion is no longer necessary, and the associated documentation for seclusion and/or restraint episodes.
  6. All of the above trainings will be recorded and tracked.
  7. All trainers of the above training will be qualified as evidenced by education, training, and experience in the principles and techniques used to address patient behavior crisis situations.

16. **Deaths associated with seclusion or restraint**

* 1. The Administrator on Call will immediately be notified of any deaths that occur during hospitalization or within one week of discharge. The AOC will immediately send notice to the Hospital Leadership Team.
  2. Deaths associated with the use of seclusion or restraint must be reported to the Centers for Medicare and Medicaid Services (CMS) Regional Office, according to the following requirements:
     1. Each death that occurs while a patient is in seclusion or restraint
     2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
     3. Each death known to the hospital that occurs within 1 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. “Reasonable to assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.
  3. The Director of Nursing will document in the patient’s medical record the date and time the death was reported to CMS.
  4. The hospital must report all patient deaths reference above by telephone to the CMS Regional Office at (303) 844-2111 prior no later than close of business the next business day following knowledge of the patient’s death.
  5. Hospital Quality will assist and conduct any investigations, notifying other agencies as required.

**DEFINITIONS**

**Timeout:**  the movement of a patient for any period of time to a designated area from which the patient is not physically prevented from leaving and for the purpose of providing the patient an opportunity to regain self-control.

**Seclusion:** the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion does not include being on a locked unit with others.

**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; or 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. A restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involves the physical holding of a patient for the purpose of conducting routine physical examinations or tests.

**Mechanical Restraint:** physical device used to involuntarily restrict the movement of an individual or the movement or normal function of a portion of his or her body. Types of mechanical restraints include, but are not limited to: restraint sheets, camisoles, belts attached to cuffs, leather cuffs, and restraint chairs.

**Episode:** An S/R episode ends when the patient can maintain the terms of the exit criteria for greater than two (2) hours, or a Doctor orders the discontinuation of the episode. The *S/R 1-Hour Evaluation Form* need only be completed once for an episode. An episode may require multiple documented assessments of behavior to justify renewal of orders.

**Emergency Medication**: a one-time order (no prn) from a Provider for psychiatric medication administration to a patient for prevention of imminent threat of bodily harm, an assault on another person, or self-destructive behavior. The patient may take the medication voluntarily or it may be administered involuntarily. Repeat orders for emergency medications can be given for up to 72-hours at which time a concurring medical consult must be obtain and documented (see policy for Emergency Medications).

WSH does not utilize drug or medication restraints, which by definition reduce the patient’s ability to effectively or appropriately interact with the world around the patient and is not being used as a standard treatment or dosage for the patient’s condition.

**Involuntary Mediation: Psychiatric** medication that is not accepted willingly by the patient. Medication may be administered in an emergency situation by a nurse or Provider under a time limited order, or per court order.

**Doctor:** A professional person who is licensed to practice medicine in Colorado and credentialed to provide psychiatric and medical care at West Springs Hospital or Transitions at West Springs.

**Provider:** is a person who is 1) a Doctor licensed to practice in Colorado and credentialed to provide medical or psychiatric care at West Springs Hospital and Transitions at West Springs; 2) a person who is licensed to practice professional nursing, has obtained specialized education/training, is included on the Nurse Advance Practice Registry, and is credentialed to provide care at West Springs Hospital and Transitions at West Springs; 3) a person who is licensed in Colorado as a Physician Assistant, has obtained specialized education/training/certification, and is credentialed to provide care at West Springs Hospital or Transitions at West Springs.