Restraint and Seclusion

QUICK REFERENCE SHEET : PHYSICIANS, LIP's, PA's

HealthAlliance supports the patient's right to be free from restraints or seclusion of any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. Less intrusive and least restrictive measures must be considered before the initiation of any restraint. Despite all efforts, restraint may be necessary to protect the patient from injury to himself or others.

As per CMS guidelines, physicians/LIP's and all mid-level practitioners will have a working knowledge of the hospital policy regarding the use of restraints and seclusion.

1.1. Physicians/LIP's and PA's, upon appointment and upon reappointment, will be educated to the policy content via an on-line *Quick Reference/Overview* and a related quiz, distributed by the Medical Staff/Credentialing Office. Once completed, the quiz will be returned to that office.

1.2.

The following behavior scale will be used to assess patient behaviors when chemical or 4 point restraint or the use of seclusion are necessary

Richmond Agitation-Sedation Scale (RASS)

Score	Term	Description
+4	Combative	Overtly combative, violent, immediate danger to staff
+3	Very agitated	Pulls or removes tube(s) or catheters(s), aggressive
+2	Agitated	Frequent non-purposeful movement, fights ventilator
+1	Restless	Anxious but movements not aggressive, vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (
-2	Light sedation	Briefly awakens with eye contact to voice (<10 seconds)
-3	Moderate sedation	Movement or eye opening to voice (but no eye contact)
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation
-5	Unarousable	No response to voice or physical stimulation

See the grid below for guidelines for the use of restraints for violent and non-violent patients.

<table>
<tr><th><u>Actions</u> needed for the use of restraint or seclusion</th><th><u>Nonviolent Patient</u>
2 soft restraints, Geri Chair, Full Side Rails</th><th><u>Violent Patient</u>
4 Point Restraint or Chemical Restraint
(RASS +4)</th><th><u>Violent Patient</u>
Seclusion
(RASS +4)</th><th>Applicable Caregiver</th></tr>
<tr><td>Obtain order from the attending physician/LIP or PA</td><td rowspan="2">Order is preferably obtained prior to initiating a restraint but can be provided immediately following the application of 2 point restraints and other devices when urgent need necessitates application.

Telephone orders are acceptable, when necessary.

PRN orders are permissible for Geri-chairs and full side rails [only] for non-violent patients.</td><td>Order will preferably be provided after the practitioner assesses the patient and prior to initiating restraints these types of restraints.</td><td>Same requirements as noted in the column to the left for a violent patient.</td><td rowspan="2">MD/LIP, PA</td></tr>
<tr><td colspan="2">A Rapid Response will be called when the patients attending physician is not readily available and a patient is exhibiting violent or self destructive behavior.

When absolutely necessary, telephone orders are acceptable for physical or chemical restraints but must be authenticated within 30 minutes, never to exceed one hour.

PRN Orders are never accepted</td></tr>
<tr><td>Frequency of order renewal</td><td>Every 24 hours while devices are in use.

Geri-chair and full side-rail are a one-time order do not require renewal.</td><td colspan="2">All orders for <u>chemical restraints</u> are considered one-time orders. Successive orders qualify as a new one-time order.

Renewals for continued need for <u>4-point restraints or seclusion</u> must occur at the following times.

• Med Surg patients - 4 hrs for adult s(18 and up)
• Med/Surg patients- 2 hrs for adolescents (9-17)
• Med Surg patients- 1 hr-child (less than 9)

Total maximum time allowed for restraint = 24 hours. Restraints used for greater than 24 hours defines “prolonged restraint” and must be reported to the CMO (if used in the mental health units) and the Quality Management Committee for all other settings.</td><td>MD/LIP, PA</td></tr>
</table>

Actions needed for the use of restraint or seclusion	**Nonviolent Patient 2 soft restraints, Geri Chair, Side Rails**	**Violent Patient 4 Point Restraint or Chemical Restraint (RASS +4)**	**Violent Patient Seclusion (RASS +4)**	**Applicable Caregiver**
The patient's attending physician must be notified when the initial order was not obtained from that attending physician (i.e., a Hospitalist provided the restraint order during a Rapid Response, the patient was not admitted to their service)	As soon as possible	As soon as possible	Immediately, or as soon as possible when the patient is safe	RN or the practitioner who ordered chemical or 4 point restraints, or seclusion
		When a **PA** orders a chemical or 4 point restraint, or seclusion, she/he must consult the attending physician responsible for the care of the patient as soon as possible after the completion of the assessment. The attending is not required to come to the hospital but can determine the need to assess the patient based on symptoms, condition and history.		
Initial Face-to-face physical assessment must occur for all episodes of restraint for the violent patient. This will be documented on the *Post Restraint Progress Note* for all episodes of chemical restraint, 4 point restraint, and seclusion	Not required	Within 30 minutes, never to exceed one hour. The physician/LIP or PA who ordered restraint or seclusion via telephone order, must authenticate the order and assess the patient within 30 minutes, never to exceed 1 hour.		MD/LIP, PA Note: when a PA conducts the one hour face to face assessment, once completed, the attending must be notified.
Ongoing Face-to-face physical assessment.	Minimally, every 24 hours	Minimally, every 24 hours and as necessary, and before a new order is written.		MD/LIP, PA, or NP
Discontinuation Restraint may only be employed while the unsafe situation continues. Once the unsafe situation ends, the use of restraint (any type) or seclusion must end.	As soon as possible and when interventions requiring restraint have been discontinued	As soon as possible and when the patient's unsafe behavior ends.	4 hours (unless patient is sleeping). A new seclusion episode may only be reinitiated if the patient continues to remain a harm to self or others and a new order is obtained.	MD, PA, NP, or RN *Once discontinued, a new order for re-application is required. Otherwise, this would constitute a PRN order which is unacceptable.