DukeHealth

Policy/Procedure: DUHS Restraint/Seclusion Policy		
Document ID: 460	Revision Number: 2	Status: Published
Origination Date: 09/22/2015	Effective Date: 07/17/2023	

Applicability:

☐ Ambulatory Surgery Center Arringdon
☐ Davis Ambulatory Surgery Center (DASC)
☐ Duke Health Integrated Practice (DHIP)
☐ Duke Health Technology Services (DHTS)
☐ Duke HomeCare & Hospice (DHCH)
☐ Duke Primary Care (DPC)
☒ Duke Regional Hospital (DRH)
☒ Duke University Hospital (DUH) (both campuses)
  ☐ Durham Campus Only
  ☐ Duke Raleigh Campus Only
☐ Patient Revenue Management Organization (PRMO)
☐ Population Health Management Office (PHMO)

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Policy Statement: It is the goal of Duke University Health System (DUHS) to minimize the use of restraint and/or seclusion in all patient care settings throughout its facilities. DUHS is committed to preventing, reducing, and striving to eliminate the use of restraints and to preserving the individual's safety and dignity when restraints/seclusion are used. Restraint and/or seclusion are only used to protect the immediate physical safety of the patient, staff, or others. DUHS hospitals do not use restraint or seclusion, of any form, as a means of coercion, discipline, convenience, or retaliation.

Restraint and seclusion regulations apply to:

- All DUHS hospitals
- All DUHS hospital patients, regardless of age, who are restrained or secluded (including both inpatients and outpatients)
- All DUHS locations within the hospital (including but not limited to: medical/surgical units, critical care units, emergency department, psychiatric units)

The use of restraints will be limited to clinically appropriate and adequately justified situations. Restraint or seclusion are only used when less restrictive interventions, non-physical interventions, and alternative strategies are ineffective. When restraints are used, the least restrictive form of restraint or seclusion that physically protects the patient, staff, or others will be implemented. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the scheduled expiration of the order.

In all cases, the use of restraints or seclusion will be in accordance with written DUHS policy, applicable law/regulation, and a written modification of the patient's plan of care.

This policy does not apply to the use of handcuffs and other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons, which are not involved in the provision of health care. Please refer to DUHS Care of the Forensic Patient.

Additional information about disruptive patients can be found in the DUHS Disruptive Behavior-Patients, Family Members, or Visitors Policy

Purpose: The purpose of this policy is to provide direction for staff regarding the appropriate use of restraints and/or seclusion as a therapeutic restrictive intervention

Level:

☒ **Interdependent** - asterisked [*] items require an order from a health care practitioner licensed to prescribe medical therapy.
☐ **Independent** – no physician/practitioner order required.

Competencies/Skills: *Staff will be trained on the use of restraints and seclusion; competencies will be assessed at orientation, before participating in the use of restraints and initiation of seclusion, and on an annual basis thereafter. At a minimum, physicians and other licensed practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint and seclusion. Personnel records will reflect restraint and seclusion training and demonstration of competence.* **See:** DUHS Restraint Addendum C: Staff Competency and Education Regarding Restraints

Note: The LPN, in collaboration with the RN, may initiate, monitor, and discontinue restraints. In addition to providing continued support and collaboration, the RN must complete the Care Plan. Collaborating involves communicating and working cooperatively in implementing the health care plan with individuals whose services may have a direct or indirect effect upon the client's health care.

Definitions:

Advanced Practice Provider: Advanced Practice Provider or APP shall include professionals whose occupations involve them in direct patient contact and care, but who are not doctors of medicine or osteopathy. APP includes Certified Registered Nurse Anesthetists, Physician Assistants, Nurse Practitioners, Certified Nurse-Midwives, and Clinical Nurse Specialists.

Chemical Restraint: A drug or medication that is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement. A chemical restraint does not include medications used as a standard treatment for a patient's medical or psychiatric condition, as such are excluded from the standards for chemical restraint use.

Standard treatment is defined as a medication used to address a patient's medical or psychiatric condition and includes but is not limited to the following:

a) The medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer, for the indications it is manufactured and labeled to address, listed dosage parameters, etc.
b) The use of the medication follows national practice standards established or recognized by the appropriate medical community and/or professional medical association or organization.
c) The use of the medication to treat a specific patient's clinical condition is based on that patient's target symptoms, overall clinical situation, and on the Physician's or other LP's knowledge of that patient's expected and actual response to the medication.
d) An additional component of "standard treatment" for a medication is the expectation that the standard use of a psychotherapeutic medication to treat the patient's condition enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of medication. Psychotherapeutic medications are to enable, not disable. If a psychotherapeutic medication reduces the patient's ability to effectively or appropriately interact with the world around them, then the psychotherapeutic medication is not being used as a "standard treatment" for the patient's condition. Examples of standard treatment:
    - Clinical treatment of patients who are suffering from serious mental illness and who need appropriate therapeutic doses of psychotropic medication to improve their level of functioning
    - Appropriate doses of sleeping medication prescribed for patients with insomnia.
    - Anti-anxiety medication that is prescribed to calm a patient who is anxious.

Hard Limb Restraints: Restraints made to provide a more secure fit using non-locking material (i.e. velcro).

Licensed Practitioner or LP: An LP is a licensed provider who is permitted by law *and* by the organization to provide care, treatment, and services. A licensed practitioner operates within the scope of their license, consistent with individually granted clinical privileges and hospital policy. For the purpose of this policy, a licensed provider includes physicians (doctor of medicine and doctor of

osteopathy), podiatrists, chiropractors, and Advanced Practice Providers who qualified under their delineated privileges and scope of practice to order restraint and seclusion.

Non-Violent Restraints: Restraints are used to maintain therapies or deliver treatments associated with non-destructive behavior, medical healing, and/or diminish the patient's risk of suffering physical harm.

Physical Escort: Physical escort includes a "light" grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, the physical escort would not be considered a restraint. However, if the patient cannot easily remove or escape the grasp, it would be considered a restraint.

Physical Hold: Holding a patient in a manner that restricts the patient's movement against the patient's will is considered a restraint. This includes holds that some members of the medical community may term "therapeutic holds". 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 does not count as a physical restraint for purposes of the regulations when the physical examination or test is done with the patient's consent. However, patients have the right to refuse treatment. This includes the right to refuse physical examinations or tests. For the purposes of this regulation, a staff member picking up, redirecting, or holding an infant, toddler, or pre-school-aged child to comfort the patient is not considered a restraint.

Physician: Means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by the state of North Carolina. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.

Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely. This restraint definition applies to all uses of restraint in all hospital care settings. Restraint includes the use of a "net bed" or an "enclosed bed" that prevents the patient from freely exiting the bed (exception: placement of a toddler in an "enclosed" or "domed" crib). 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 the bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). Only manufactured restraints are to be used (bedsheets and pillowcases may not be used as a restraint).

The devices and methods listed below **would not be considered restraints**:

- Use of an **IV arm board** to stabilize an IV line is generally not considered a restraint. However, if the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access their body, the use of the arm board would be considered a restraint.

- **Mechanical support** used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility (examples: leg braces supporting the ability to walk, neck, head, or back braces supporting the patient's ability to sit upright).
- Medically necessary **positioning or securing device** used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures is not considered a restraint.
- **Recovery from anesthesia** that occurs when the patient is in the critical care or post-anesthesia care unit is considered part of the surgical procedure; therefore, medically necessary restraint used in this setting would not be a restraint.
- **Age or developmentally appropriate protective safety interventions** (such as stroller safety belts, swing safety belts, high chair lap belts, and crib covers) that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool-aged child would not be considered a restraint or seclusion

Side Rails: A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and, therefore, would not be considered a restraint.

However, where side rails are not used as a method to prevent the patient from falling out of bed, but instead, used to restrict the patient's freedom to exit the bed, the use of side rails would be considered a restraint.

When the clinician raises all four side rails in order to restrain a patient, this is considered a restraint.

Conversely, if a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails for the patient would not be considered restraint because the side rails have no impact on the patient's freedom of movement. Side rails are not considered a restraint during the following situations:

- When a patient is placed on seizure precautions and all side rails are raised.
- Placement in a crib with raised rails is an age-appropriate safety practice for every infant or toddler.
- Patient is on a stretcher (a narrow, elevated, and highly mobile cart used to transport patients and to evaluate and treat patients).

See: DUHS Restraints Addendum A: Types of Physical Restraints

Seclusion: 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. Timeout is not considered seclusion.

Simultaneous restraint and seclusion: use is only permitted if the patient is continually monitored.
Continually monitored means monitored:

- Face-to-Face by an assigned, trained staff member; or
- By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

Soft Limb Restraints: Restraints made from soft, cloth-like material.

Timeout: 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. The patient can leave the designated area when the patient chooses.

Violent Restraints: Restraints used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.

Procedure:

I. Restraints and Seclusion

This policy covers all types of restraints including physical restraints, chemical restraints, and seclusion.

II. Alternatives to Restraints

Alternative measures such as relocation of the patient closer to the nurse's station, frequently checking on the patient, and scheduled toileting will be attempted prior to the utilization of restraint or seclusion. If alternative measures are not possible, the least restrictive method of restraint will be used. Efforts will be made to discuss the use of alternative methods and the need to restrain with the patient, patient's family, or other representatives. **See:** DUHS Restraint Addendum B: Alternatives to Restraints

III. Patient/Family/Significant Other Education

a) To the extent possible, before restraints or seclusion are initiated, the restraint or use of seclusion must be explained to the patient and/or family/significant other in order to make the restraint/seclusion experience less traumatic.

b) The Registered Nurse (RN) or another provider will provide patient/family education with an explanation of restraint/seclusion utilization and the reason for restraints/seclusion. The LPN may participate in the teaching and counseling of patients as assigned by a registered nurse. This should be done, where appropriate, prior to the application of restraints/seclusion. The policy, application, and criteria for release should also be explained.

c) All patients have the right to refuse treatment. However, if the patient's violent or self-destructive behavior jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient does not have the right to refuse the use of restraints or seclusion.

IV. Procedure for the Ordering and Use of Restraint or Seclusion

The decision for violent or non-violent restraints or seclusion is based upon the clinical findings and the patient's behavior. Restraints and seclusion may only be implemented upon the written order of a physician or other authorized Licensed Practitioner responsible for the patient's care and in accordance with policy. In some situations, however, the need for restraint or seclusion intervention may occur so quickly that an order cannot be obtained prior to the application of restraint or seclusion. In these emergency application situations, the order must be obtained either during the emergency application of the restraint/seclusion or immediately (within a few minutes) after the restraint/seclusion has been applied. The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

A. INITIAL ASSESSMENT

a) The assessment should include a physical assessment to identify medical problems that may be causing behavioral changes in the patient's behavior.
b) Less restrictive interventions are implemented to protect the patient or others from harm. If deemed ineffective, an assessment is performed to determine the appropriateness of restraints.
c) Except in emergent situations, a physician or licensed practitioner (LP) completes a comprehensive patient assessment prior to ordering restraints or seclusion. Note: A physician or LP's scope of practice and privileges must permit ordering restraints.
d) The assessment and alternatives must be documented in the electronic health record.

B. INITIATION/ORDERING RESTRAINTS

(PRN ORDERS ARE PROHIBITED)

Orders for the use of restraints or seclusion must never be written as a standing order or on an as-needed basis (PRN).

If restraints are ordered for a patient and the nurse uses their clinical judgement to discontinue some of the restraints, a new order must be obtained to reflect the change in the number and/or location of restraints. This situation would be defined as a new episode of restraints.

If a patient was recently released from restraints and exhibits behavior that can only be handled through the reapplication of restraints, a new order would be required. Staff cannot discontinue a restraint intervention, and then re-start it under the same order. A "trial release" constitutes a PRN use of restraint, and, therefore, is not permitted by regulation.

Note: A temporary, directly supervised release, however, that occurs for the purpose of caring for the patient's needs (e.g., toileting, feeding, or range of motion exercises) is **not considered a discontinuation of the restraint 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.

Orders for restraints/seclusion for non-violent/non-self-destructive patients and violent/self-destructive patients should follow the respective procedures set forth below:

Non-Violent/Non-Self Destructive Behavior	Violent/Self-Destructive Behavior
Initiation: An attending physician, licensed practitioner, or nurse who has completed physical restraint competency requirements may determine the need and initiate the use of chemical restraints, physical restraint(s), or seclusion based on assessment findings, the efficacy of alternatives, and the urgency of the situation. Chemical restraints are to be used for Violent/Self-Destructive behavior only.	
Restraint Order	**Restraint/Seclusion Order**
Face-to-Face Assessment: The patient must be seen when the physician or LP renews an order or writes a new order authorizing the continued use of restraint. There must be documentation in the medical record that describes the patient's clinical needs and supports the continued use of restraint or seclusion.	**Face-to-Face Assessment:** The patient must be seen face-to-face within 1 hour after the initiation of the intervention. Face-to-face assessment by the physician/licensed practitioner is conducted with nursing input and includes: - The patient's immediate situation; - The patient's reaction to the intervention; - The patient's medical and behavioral condition; and - The need to continue or terminate the restraint or seclusion
Time-limited: the maximum time limit for a restraint order is 24 hours.	**Time-limited:** renewed in accordance with the following limits for up to a total of 24 hours. - **4 hours** for adults (**18** years of age or older) - **2 hours** for children and adolescents **9 to 17** years of age; or - **1 hour** for children under **9** years of age
Order renewal: If the restraint use continues to be clinically justified beyond the expiration of the original time-limited order, a new/modified order shall be obtained every 24 hours while the patient is in restraints.	**Order renewal:** If the patient remains in restraint or seclusion 24 hours after the original order, the physician/licensed practitioner must see the patient and assess the patient before issuing a new order.

<table>
<tr><th colspan="4">C. REQUIRED MONITORING/DOCUMENTATION</th></tr>
<tr><th colspan="2">Non-Violent/Non-Self Destructive Behavior</th><th colspan="2">Violent/Self-Destructive Behavior</th></tr>
<tr><th colspan="2">Nursing Documentation</th><th colspan="2">Nursing Documentation</th></tr>
<tr><td colspan="2">Patient/Family/Support Person Education: Document discussion and education for the need for restraints
Less restrictive alternatives: Implement and document less restrictive alternatives to restraints (see Appendix B) and their ineffectiveness
Restraint type
Initiation of care plan: Risk for Injury: Non-Violent restraints</td><td colspan="2">Patient/Family/Support Person Education: Document discussion and education for the need for restraints
Less restrictive alternatives: Implement and document less restrictive alternatives to restraints (see Appendix B) and their ineffectiveness
Restraint type
Initiation of care plan: Risk for Injury: Violent restraints</td></tr>
<tr><th colspan="2">Monitoring/Documentation of Restraints</th><th colspan="2">Monitoring/Documentation of Restraints</th></tr>
<tr><td colspan="2">Monitoring and documentation of restraints occur on initiation, every 2 hours, and at discontinuation of restraints (see below for details).</td><td colspan="2">Monitoring and documentation of restraints occur at initiation, every 15 minutes, every 2 hours, and on discontinuation of restraints (see below for details).</td></tr>
<tr><td colspan="2">*Asterisk below denotes documentation to be made by RN/LPN; other documentation listed below may be delegated by RN/LPN.</td><td colspan="2">*Asterisk below denotes documentation to be made by RN/LPN; other documentation listed below may be delegated by RN/LPN.</td></tr>
<tr><th>Frequency</th><th>Documentation</th><th>Frequency</th><th>Documentation</th></tr>
<tr><td>On Initiation</td><td>• *Less restrictive alternatives and patient response to interventions
• *Clinical justification for restraints/Description of episode
• *Patient/Family/Support Person education
• *Restraint type
• *Initiation of Nursing Care Plan</td><td>On Initiation</td><td>• *Less restrictive alternatives and patient response to interventions
• *Clinical justification for restraints and/or seclusion/ Description of the episode
• *Patient/Family/Support Person education
• *Restraint type
• *Initiation of Nursing Care Plan</td></tr>
<tr><td></td><td></td><td>Every 15 min</td><td>1:1 Visual Observation
• Pt observation
• Pt activity
• Pt behavior</td></tr>
<tr><td>Every 2 hours</td><td>• *Circulation (excludes net beds)
• Correct application verified
• Skin integrity
• Range-of-Motion exercised to restrained extremities</td><td>Every 2 hours</td><td>• *Circulation (excludes net beds)
• Correct application verified
• Skin integrity
• Range-of-Motion exercised to restrained extremities</td></tr>
</table>

	• Food/Meal and Fluid offered • Elimination offered		• Food/Meal and Fluid offered • Elimination offered
Discontinuation	*Clinical justification for discontinuation	Discontinuation	*Clinical justification for discontinuation

Nursing Plans of Care

All restraint application and removal shall be documented in the EHR by the Registered Nurse and shall include written modification to the patient's plan of care, including:

- Assessment
- Goal
- Intervention
- Responsible person for implementation
- Patient/family Informed of the reason why restraints are being utilized
- Identification of alternatives that were considered and/or used
- Results of the alternatives and why they were not effective

D. DISCONTINUATION OF RESTRAINTS

Restraints will be discontinued when:

- the patient's condition no longer justifies the use of restraint(s)/criteria are met for restraint removal allowing the RN/LPN to discontinue the restraint *or*
- the time-limited order expires

Documentation at Time of Discontinuation

When a patient no longer meets the criteria for restraints, the reason for discontinuation shall be documented in the patient's electronic health record.

Addendums Names:
Addendum A: DUHS Restraints Addendum A: Types of Physical Restraints
Addendum B: DUHS Restraint Addendum B: Alternatives to Restraints
Addendum C: DUHS Restraint Addendum C: Staff Competency and Education Regarding Restraints
Addendum D: DUHS Restraint Addendum D: Performance Improvement
Addendum E: DUHS Restraint Addendum E: Restraint Death Reporting Requirements

Associated Policies:
DUH Durham Campus Only: ED PEU Patient Requiring Restraints POLICY, Determining a Safety Plan for the DRH Behavioral Health Philosophy Regarding Seclusion and/or Restraint

REFERENCES:

Authoritative Source:
The Joint Commission
PC.03.05.01 through PC.03.05.19
Comprehensive accreditation manual for hospitals: The official handbook. Oakbrook Terrace, IL: The Joint Commission.
CMS
§482.13(e) Condition of Participation: Patient Rights
§482.13(f)
§482.13(g)
NCGS
NCGS §131E-117(6)
NCGS 122C-60
NCGS §122C-31(a), (d), (f)
10A NC ADC 26C.0303