



North Shore-LIJ Health System is now Northwell Health

System Patient Care Services

POLICY TITLE Restraints	PATIENT CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY #: PCS.1614	CATEGORY SECTION:
System Approval Date: 1/25/17	Effective Date:
Site Implementation Date: 1/25/17	Last Reviewed/Approved:
Prepared by: Northwell Health Policy and Procedure Committee; Northwell Health Quality Management	Notations: This policy does not apply to the forensic use of restraints.

GENERAL STATEMENT OF PURPOSE

It is the intention of Northwell Health to be a restraint, seclusion, and coercion free environment. The Health System takes an organizational approach to manage aggression, reduce the use of restraints and seclusion, including chemical restraints, and enhance positive behavior management.

POLICY

Restraining patients is determined by the comprehensive individual patient assessment which is performed by a physician/licensed independent practitioner. The Attachments to the policy outline the process to manage aggression, reduce the use of restraints and seclusion, including chemical restraints, and enhance positive behavior management of the patient.

SCOPE

This policy applies to all Northwell Health employees, as well as medical staff, volunteers, students, trainees, physician office staff, contractors, trustees and other persons performing work for or at Northwell Health; faculty and students of the Hofstra Northwell School of Medicine conducting research on behalf of the School of Medicine on or at any Northwell Health facility; and the faculty and students of the Hofstra Northwell School of Graduate Nursing and Physician Assistant Studies.

DEFINITIONS

Attending Physician: The MD/DO/MBBS and any other equivalent titles, who are ultimately responsible for the management and care of the patient.

Chemical Restraint: 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 patients condition. The use of a chemical restraint should not be considered a routine part of care.

Constant Observation: A situation in which a staff member is responsible for maintaining a continuous watch of a single patient, keeping the patient in view at all times.

Episode: A restraint episode is initiated when a patient is placed in restraints and ends when a patient is removed from restraints. When a restraint is discontinued for any period of time, this is considered the end of an episode and a new order is required to reapply. The exception is when staff removes the restraint to provide care to the patient. (For example, the restraint is removed when the patient is bathed or during a procedure.)

Manual Hold: Holding a patient in a manner that restricts the patient's movement against the patient's will. Physically holding a patient to administer a psychotropic medication procedure is considered a restraint.

Non-Restraint/Mechanical Support/Protective Devices: Generally, if a patient can easily remove a device, the device would not be considered a restraint. Other examples include, IV boards / safety straps / belts or other devices used during surgical, medical, dental, or diagnostic procedures that are based on standard practice for the procedure, side rails on a stretcher used during transport or while a patient is waiting for a procedure, geri-chairs used as postural supports, self-releasing lap belts, reasonable safety restraints for children, medically indicated devices intended to stabilize a body part, e.g., back brace, splint, and helmets. Side rails used to protect the patient from falling out of bed when on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds are not restraints.

Non-Violent / Non Self- Destructive: Level One restraint standards are implemented for medical or surgical purposes and apply when the primary reason for use directly supports medical healing and to:

- Allow medical treatments to continue without interruption,
- Prevent pulling out necessary tubes or drains,
- Provide safety when the patient is unable to follow directions.

Provider: A provider is any practitioner permitted by both law and the hospital as having authority under his/her license to independently order restraints, seclusion or medications for patients. This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified healthcare personnel (i.e., Physician Assistants and Nurse Practitioners) to the extent recognized under State law or a State's regulatory mechanism. NOTE: A physician is the only individual who may write an order on OMH licensed psychiatric units.

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 including full side rails that prevent a patient from voluntarily getting out of bed are considered restraints.

Takedown: A team intervention under the direction of a Registered Nurse or Provider to safely gain control over an actively violent patient's limbs. The team composed of competent staff members, works in a coordinated manner to lower the patient to the ground safely, maintaining a

face up position. If a patient is initially in a face down position the patient is turned immediately to avoid positional asphyxiation.

Violent / Self- Destructive: Level Two restraint standards are implemented to protect the individual against injury to self or others resulting from an emotional or behavioral disorder. These standards apply to any patient regardless of the setting who presents with extreme agitation and/or dangerous behavior. Such patients cannot be reasoned with, persuaded, contained, delayed, or denied. In these instances, control must be established in order to prevent a patient from seriously injuring himself/herself or others.

PROCEDURE/GUIDELINES

Please refer to Attachments A through E for the procedures utilized to manage aggression, reduce the use of restraint and seclusion, and enhance positive behavior management.

CLINICAL REFERENCES /PROFESSIONAL SOCIETY GUIDELINES

N/A

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES

1. 2014. *Preventing and Managing Crisis Situations* Albany, NY: New York State Office of Mental Health.
2. The Joint Commission 2016 Hospital Accreditation Standards PC.03.05.01 through PC.03.05.19
3. NYS DOH Hospital Minimum Standards – Section 405.7 (b)(5) Patient’s Rights.
4. NYS OMH Article 33 – 33.04 Restraint of Patients
5. CMS Conditions of Participation 482.13 (e) through 482.13 (g)
6. NYS Office of Mental Health. Title 14. Part 524, 526

ATTACHMENTS

- [Attachment A](#): Management of Aggression, Reduce the Use of Restraints and Seclusion, Including Chemical Restraints/Enhancement of Positive Behavior Management
- [Attachment B](#): Restraint Utilization Decision Tree
- [Attachment C](#): Procedure For Care Of The Patient Requiring Non -Violent Non -Self Destructive Secured Restraints And Violent/ Self- Destructive Restraints
- [Attachment D](#): Additional Requirements For Behavioral Health Units
- [Attachment E](#): Chemical Restraint

FORMS

N/A

<u>APPROVAL:</u>	
System Clinical P&P Committee	1/25/17❖
System PICG/Clinical Operations Committee	1/25/17❖

Standardized Versioning History:

*=Clinical Policy Committee Approval; ** =PICG/Clinical Operations Committee Approval

❖Expedited Approval Granted by:

Alex Hellinger, Co-Chair – System Clinical P&P Committee

Morris Rabinowicz, Co-Chair, - System PICG/Clinical Operations Committee

Management of Aggression, Reduce the Use of Restraints and Seclusion, Including Chemical Restraints/Enhancement of Positive Behavior Management

Restraining patients is determined by the comprehensive individual patient assessment which is performed by a physician/licensed independent practitioner.

1. Restraint use must be limited to appropriate clinical situations and shall be discontinued as soon as possible.
2. Restraints are utilized for behavior management only in emergency situations in which there is an imminent risk of an individual harming himself / herself or others, including staff; when nonphysical interventions are not viable; and safety issues require an immediate physical response.
3. Restraints used for medical/surgical purposes are utilized to support healing and provide safety.
4. Staffing levels and assignments are set to minimize circumstances that give rise to restraint use and to maximize safety when restraint is used.
5. Restraints are never used as punishment, coercion, for the convenience of staff, or as a substitute for a treatment program.
6. Serious physical and/or psychological harm to the patient may be caused when utilizing restraints. The negative impact on the patient and risk of the procedure must be assessed, as well as any special needs associated with vulnerable patient populations, such as, but not limited to, emergency, pediatric, and cognitively or physically limited patients.
7. When applying restraints, the least restrictive intervention is utilized only if all other alternative strategies have been attempted or considered. The risks and benefits are always considered.
8. Alternative strategies may include but are not limited to: verbal intervention, diversional activities, increased staff contact, frequent ambulating, re-evaluating the medication regimen, use of different behavioral interventions, behavior plans, individual crisis prevention/safety plans, and obtaining additional consultations.
9. Only those staff deemed competent to monitor and apply restraints may do so according to the manufacturer's directions. Data is collected for performance improvement activities.
10. Chemical restraint should be used only as follows:
 - a. The evaluating physician/licensed independent practitioner determines that it is the least restrictive intervention and is necessary to prevent violent or self-destructive behavior.

ORGANIZATIONAL APPROACH AND RESPONSIBILITIES

Aspects of an organizational approach include:

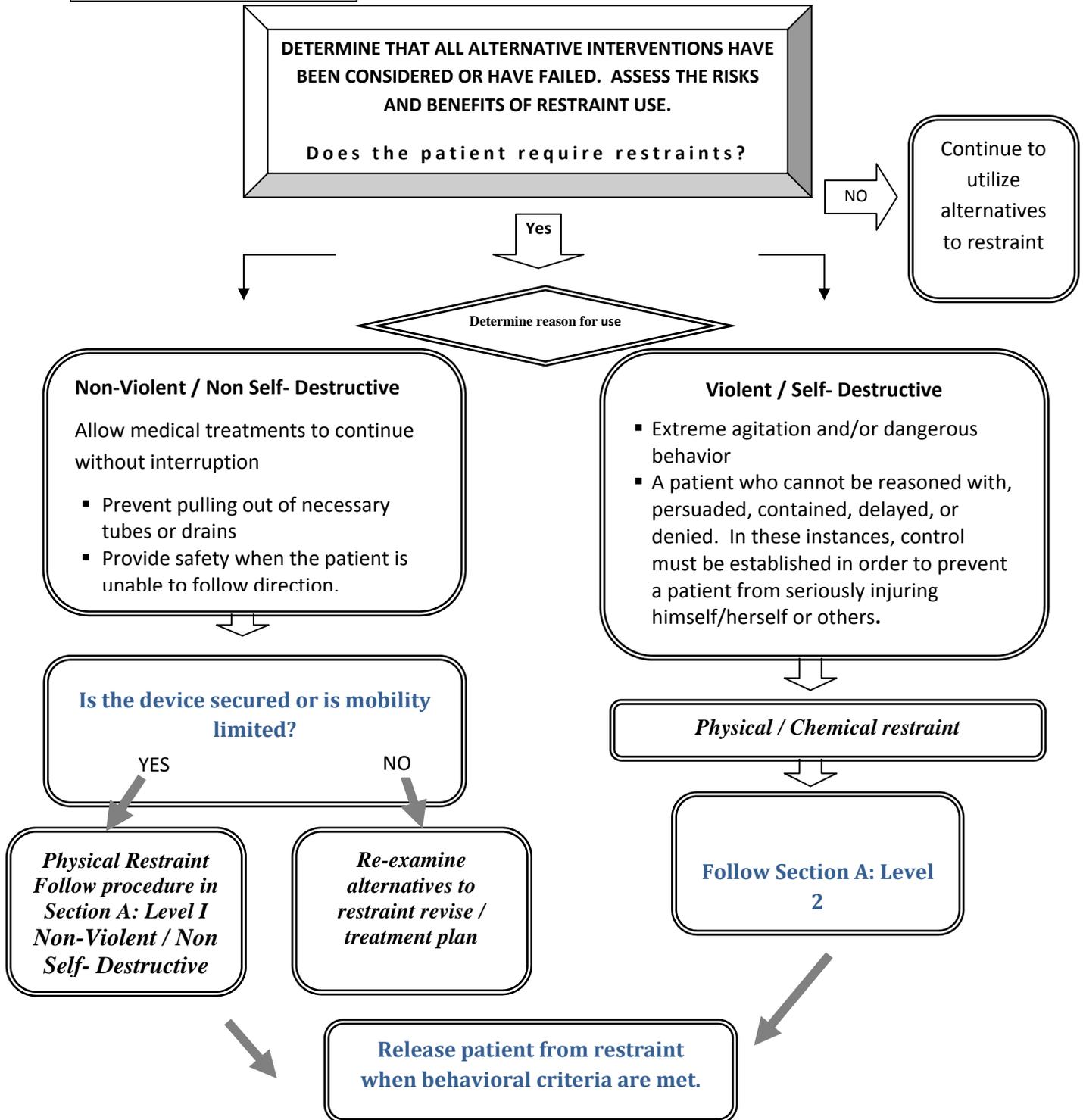
- Monitoring the physical environment for safety
- Staff competency profiles and training

- Clinical approaches
- Organizational risk assessment and monitoring through ongoing data collection and incident reviews
- Policies and procedures
- Workplace culture and critical incident stress management

Hospital leadership is responsible for:

- creating a culture that supports a patient's right to be free from restraint or seclusion and balancing it with staff safety
- establishing requirements for creating a physical, social, and cultural environment limiting the use of restraints
- ensuring the protection of patient's health and safety and the preservation of his/her dignity, rights, autonomy, and well-being.

Restraint Utilization Decision Tree



**PROCEDURE FOR CARE OF THE PATIENT REQUIRING NON -VIOLENT NON -SELF
DESTRUCTIVE SECURED RESTRAINTS AND VIOLENT/ SELF- DESTRUCTIVE
RESTRAINTS**

For Chemical Restraint follow Violent / Self Destructive Level Two and also see Section C.

	Non-Violent / Non Self- Destructive Management Level One	Violent / Self- Destructive Level Two
<p>1. DETERMINE THAT ALL ALTERNATIVE INTERVENTIONS HAVE BEEN CONSIDERED OR HAVE FAILED. ASSESS THE RISKS AND BENEFITS OF RESTRAINT USE.</p> <p>Assess the behavior and determine the procedure of care needed.</p>	<p>If the secured restraint is being utilized to:</p> <ul style="list-style-type: none"> • Allow medical treatments to continue without interruption • Prevent pulling out of necessary tubes or drains • Provide safety when the patient is unable to follow direction. <p>Use the procedure in this column for least restrictive restraints.</p>	<p>If the restraint is being utilized to:</p> <ul style="list-style-type: none"> • Prevent imminent danger to self or others • To administer court-ordered medication • To administer stat-IM psychotropic medication due to active dangerous behavior to self or others • Chemically restrain a patient <p>(Use the procedure in this column for most restrictive restraints regardless of the setting.)</p>
<p>2. ASSESSMENT</p>	<p>Assess the patient for current physical and psychological risk factors as well as special needs. Evaluation will include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient’s history, drugs and medications, most recent lab results, environmental factors (which may have precipitated the episode), etc. Consider medical conditions such as medication interactions, electrolyte imbalances, sleep apnea, hiatal hernia, hypoxia, sepsis, seizure disorders, physical disabilities, and/or a history of sexual or physical abuse.</p>	
<p>3. OBTAIN AN ORDER The use of physical restraints requires written authorization of the physician/provider or his or her licensed independent practitioner designee who has conducted a face to face physical assessment of the patient prior to writing the order. PRN orders are not allowed.</p> <p>The order for restraint will include:</p>	<p>A provider or his or her licensed independent practitioner designee may write orders as per the by-laws of the institution.</p> <p>The order for a non-violent/non self-destructive restraint may not exceed 24 hours.</p>	<p>A provider or his or her licensed independent practitioner designee may write orders for restraint as per the by-laws of the institution.</p> <p>A new order is required for each episode.</p>

	Non-Violent / Non Self- Destructive Management Level One	Violent / Self- Destructive Level Two
<ul style="list-style-type: none"> • Type of restraint • Starting and ending times • Indications and reasons for use • Behavioral criteria for release <p>Notify the Attending Physician (MD/DO) of the restraint order if prescribed by another physician/provider.</p> <p>It is important to consult with the attending physician, “as soon as possible”, because information regarding the patient's history may have a significant impact on selection of restraint intervention.</p>	<p>“As soon as possible” is defined as two (2) hours from when restraints are applied for non-violent/non self-destructive management.</p>	<p>The order may not exceed:</p> <ul style="list-style-type: none"> • Adults: 4 hours • Children/Adolescent <ul style="list-style-type: none"> • Ages 9–17: 1 hour • Ages under 9: 30 minutes. • 30 minutes for manual hold <p>The Physician or Provider has the discretion to write the order for a shorter period of time.</p> <p>The facility’s clinical medical director or Director of Psychiatry or his/her designee must be notified and consulted if the restraint exceeds 2 hours for adults, 1 hour for ages 9-17 or 30 minutes for under age 9.</p> <p>“As soon as possible” is defined as one (1) hour from when restraints are applied for violent/self-destructive behavior.</p> <p>(A physician is the only individual who may write an order on OMH licensed psychiatric units.)</p>
<p>4. IN AN EMERGENCY SITUATION, when the patient is engaging in activity that presents an immediate danger to the patient or others and a physician/LIP or his or her licensed independent practitioner designee is not available on the unit, a qualified registered nurse (RN) present may direct that the patient be restrained.</p> <ul style="list-style-type: none"> • The provider/physician shall immediately be notified • Pending the arrival of the provider/physician the patient will be kept under constant supervision as warranted by his condition • The RN will document: <ul style="list-style-type: none"> • the name and time the 	<p>The physician or provider will perform a face to face evaluation of the patient and write an order for the restraint within one hour.</p> <p>The purpose of the assessment is to evaluate 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.</p> <p>Additionally, the patient must be assessed for all elements from # 2 Assessment noted earlier in the</p>	<p>The patient will have a face to face assessment within THIRTY MINUTES by the physician.</p> <p>The purpose of the assessment is to evaluate 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.</p> <p>Additionally, the patient must be assessed for all elements from # 2 Assessment noted earlier in the</p>

	Non-Violent / Non Self- Destructive Management Level One	Violent / Self- Destructive Level Two
<p>provider/physician was notified</p> <ul style="list-style-type: none"> • alternative measures that were considered or attempted • rationale for the restraint used • steps taken to ensure that the patient's needs, comfort, and safety were appropriately considered. 	<p>policy.</p>	<p>policy.</p> <ul style="list-style-type: none"> ▪ If a patient who is restrained for aggressiveness or violence quickly recovers and is released before the physician/provider or his or her licensed independent practitioner designee arrives to perform the assessment, the physician/provider or his or her licensed independent practitioner designee must still perform a face-to-face assessment and write an order for the period of time that the patient was restrained. The fact that the patient's behavior warranted the use of a restraint indicates a serious medical or psychological need for prompt assessment of the incident/situation that led to the intervention, as well as the medical and psychological condition of the patient at the time of the assessment. ▪ If the physician does not arrive within 30 minutes, the RN will document this delay. The physician will also document in the chart the reason for the delay in response time.
<p>5. UTILIZE THE LEAST RESTRICTIVE DEVICE</p>	<p>Restraint devices include but are not limited to:</p> <ul style="list-style-type: none"> • Waist/lap belt, that cannot be removed by the patient • Geri-chair with table • Soft limb restraints • Soft vest restraint 	<p>Restraint devices include but are not limited to:</p> <ul style="list-style-type: none"> ▪ Limb restraints • Soft vest restraint • Four-point restraints • Five point restraints(OMH units only)

	Non-Violent / Non Self- Destructive Management Level One	Violent / Self- Destructive Level Two
	<ul style="list-style-type: none"> • Secured mittens or mittens that limit mobility, even if unsecured. • Full side-rails 	<ul style="list-style-type: none"> • Manual Restraint (physical holds) • Chemical restraint (See Attachment D for additional information)

	Non-Violent / Non Self- Destructive Management Level One	Violent / Self- Destructive Level Two
<p><i>6. APPLY THE RESTRAINT in a manner that respects the patient’s rights, confidentiality, dignity, privacy, and individuality. Only qualified staff may apply restraints as per manufacturer’s directions.</i></p> <ul style="list-style-type: none"> • Assemble trained staff to safely apply the restraint. • Explain the rationale for applying the restraint and describe any special needs or co-morbidities to the restraining team. • Identify the patient. • Assist the patient to a permissible position of comfort and attempt to gain the patient’s cooperation. Offer support and reassurance. Communicate and assure the patient that he/she is not alone. • Explain the procedure and the necessity for the procedure to the patient, and family or significant other, as well as the behavioral criteria for release, as appropriate. Allow the patient and/or family to participate in the care of the patient as appropriate. • Remove shoes and loosen or remove clothing as necessary. Check pockets for any contraband, as appropriate. • Restrain the patient in supine position unless medically contraindicated. For patients restrained in a bed, assure head of bed elevated to at least 30 degrees. • Validate that restraints were properly and safely applied. • Assign a staff member to remain with the patient in the event of a fire alarm or similar disaster. • Maintain a clean, safe, and comfortable environment. • Provide for modesty at all times. • Split side rails must have padding between the rails to prevent patient injury 		
<p>7. MONITOR</p> <p>Registered Nurses are responsible for assessment and monitoring activities.</p> <p>Unlicensed assistive personnel may assist in the monitoring activities.</p> <p>Only staff who are trained and competent in the care of a patient in restraint may perform monitoring activities.</p> <p>A means of communication such as a tap bell or call button must be available at all times.</p> <p>For patients that use hands to communicate for ex. sign language,</p>	<p>At the initiation of restraint and at least every thirty minutes thereafter, monitor the patient for safety and comfort.</p> <p>This evaluation includes, as appropriate to the type of restraint employed:</p> <ul style="list-style-type: none"> • signs of any injury associated with the application of restraint; • nutrition/hydration; • circulation and range of motion in the extremities; • hygiene and elimination; • physical and psychological status and comfort; and • readiness for discontinuation of restraint. <p>Vital signs are taken as ordered.</p>	<p>Monitoring is accomplished by continuous in person observation by an assigned staff member who is competent and trained.</p> <p>At the initiation of physical or chemical restraint and at least every fifteen minutes thereafter, monitor the patient for safety and comfort.</p> <p>This evaluation includes, as appropriate to the type of restraint employed:</p> <ul style="list-style-type: none"> • signs of any injury associated with the application of restraint; • nutrition/hydration; • circulation and range of motion

	Non-Violent / Non Self- Destructive Management Level One	Violent / Self- Destructive Level Two
remove restraints so patient can communicate with staff or provide alternate method of communication.	<p>Restraints are released at least every 2 hours, unless the patient is asleep. Range of motion, skin assessment and assessment for release will be assessed by the Registered Nurse at this time.</p>	<p>in the extremities;</p> <ul style="list-style-type: none"> • hygiene and elimination; • physical and psychological status and comfort; and • readiness for discontinuation of restraint. <p>Vital signs are taken at minimum every two hours.</p> <p>Intervention selection and determination of necessary frequency of assessment and monitoring can be individualized taking into consideration variables such as the patient’s condition, cognitive status and other relevant factors such as medication used for chemical restraint.</p> <p>Restraints are released at least every two hours, unless the patient is asleep. Range of motion, skin assessment and assessment for release will be assessed by the Registered Nurse at this time.</p> <p>An assessment of the patient’s condition shall be made at least once every 30 minutes (or at more frequent intervals if directed by the physician), by a registered professional nurse, nurse practitioner, or physician assistant responsible for the care of the patient.</p> <p>Staff will provide assistance to patients in meeting behavior criteria</p>

	Non-Violent / Non Self- Destructive Management Level One	Violent / Self- Destructive Level Two
		for discontinuation of restraint.
<p>8. DOCUMENTATION: Each episode of use is recorded. Documentation includes information about:</p> <ul style="list-style-type: none"> • Any in-person medical and behavioral evaluation for physical or chemical restraint or seclusion used to manage violent or self- destructive behavior • A description of the patient’s behavior and the intervention used • Any alternatives or other less restrictive interventions attempted • Informing the individual of behavioral expectations to avoid the use of restraint or seclusion • The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention • Individual patient assessments and reassessments • The intervals for monitoring • Revisions to the plan of care • The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion • Injuries to the patient • Death associated with the use of restraint or seclusion • The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion • Orders for restraint or seclusion • Notification of the use of restraint or seclusion to the attending physician • Consultations • Informing the individual of behavioral criteria for discontinuation of restraint • Assistance provided to the individual to help him or her meet the behavior criteria for discontinuation of restraint • Notification of the individual’s family, when appropriate; • Each in-person evaluation and re-evaluation of the individual <p>Documentation is accomplished in a manner (such as a restraint log) that allows for the collection and analysis of data for performance improvement activities.</p> <p>OMH licensed psychiatric units require that a log be maintained for evaluation at each survey. Log to include name, medical record number, beginning and end of each episode, restraint or seclusion and type.</p>		
<p>9. EARLY RELEASE / DISCONTINUATION: Restraints should be discontinued as soon as is safely possible. A physician, provider, or qualified RN may release the patient from restraints before the order’s expiration time if the patient’s condition improves and</p>	<ul style="list-style-type: none"> • A new order must be obtained for each episode of restraint. 	<ul style="list-style-type: none"> • A new order must be obtained for each episode of restraint. <p>The physician is notified when restraint is ended before the order expires.</p>

	Non-Violent / Non Self- Destructive Management Level One	Violent / Self- Destructive Level Two
behavioral criteria are met.		
10. FREQUENT/PROLONGED USE OF RESTRAINT:	<p>During frequent or prolonged restraint use other treatment approaches should be considered such as:</p> <ul style="list-style-type: none"> • Altering clinical treatment plan. • Changing patient’s medication or dose. • Using different behavioral interventions. • Obtaining additional consultations. 	<p>During frequent or prolonged restraint use other treatment approaches should be considered such as:</p> <ul style="list-style-type: none"> • Altering clinical treatment plan. • Changing patient’s medication or dose. • Using different behavioral interventions. • Obtaining additional consultations. <p>After every 12-hours of consecutive use or two or more nonconsecutive separate episodes in a 12 hour period, the treatment team must meet to evaluate the clinical situation.</p> <p>Documentation should include the names of the inter-disciplinary team members who met, the results of the evaluation, and the reason to keep the patient in restraints.</p> <p>After more than 24 hours duration, for patients on OMH licensed psychiatric units, the Special Review Committee of the Department of Psychiatry is convened in an emergency session to review the appropriateness of such prolonged restraint. The committee membership on this occasion comprises staff from elsewhere in the department. The results of nursing and physician, reviews, and the patient’s medical record may be requested for the committee’s</p>

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		review during this process.

11. REPORTING TO CMS

- A. When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed of soft, non-rigid, cloth-like material
1. The hospital records in a log within seven days:
 - i. Each death that occurs while a patient is in wrist restraints.
 - ii. Each death that occurs within 24 hours after the patient has been removed from wrist restraints
 2. The following is to be documented in the log;
 - i. Patient’s name
 - ii. Date of Birth
 - iii. Date of Death
 - iv. Name of attending physician or provider responsible for the care of the patient
 - v. Medical Record Number
 - vi. Primary diagnosis
 3. The hospital makes the information in the log available to CMS either electronically or in writing immediately upon request
 4. **Staff must document in the patient’s medical record the date and time the death was recorded into the log**
- B. **The hospital must report to CMS (other than wrist restraints as defined in 11A), OMH and the Justice Center as applicable any death that occurs while a patient is restrained or where it is reasonable to assume that a patient's death is a result of restraint.**
1. The hospital must report all deaths associated with the use of restraints or seclusion in the following categories:
 1. Each death that occurs while a patient is in restraint or seclusion.
 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 of 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, of death related to chest compression, restriction of breathing, or asphyxiation. When a death has been identified that fits any of the above criteria, the Department of Quality must be notified immediately to determine if additional regulatory reporting is required, i.e. DOH, NYPORTS.

Each death associated with the use of restraint or seclusion must be reported to CMS no later than the close of business the next business day following knowledge of the patient’s death.

Staff must document in the patient’s medical record the date and time the death was reported to CMS.

	Non-Violent / Non Self- Destructive Management Level One	Violent / Self- Destructive Level Two
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12. CLEAN RESTRAINTS: Restraints must be cleaned according to the manufacturer’s directions. If cleaning directions are not stated, all cloth restraints must be laundered through the hospital’s laundry service or discarded after use. Any restraint (such as leather restraints) that cannot be laundered must be wiped with a hospital approved EPA disinfectant after each patient use.

13. EDUCATION:

Northwell Health educates and assesses the competence of staff in minimizing the use of restraint, and before they participate in any use of restraint, in their safe use. This is done during orientation and reviewed annually.

A. Training requirements for all direct care staff

In order to minimize the use of restraint, all direct care staff, as well as any other staff involved in the use of restraint, receive ongoing training in and demonstrate an understanding:

1. of the underlying causes of threatening behaviors exhibited by the individuals they serve;
2. that sometimes an individual may exhibit an aggressive behavior that is related to a medical condition and not related to his or her emotional condition. For example, threatening behavior that may result from delirium in fevers, hypoglycemia;
3. of how their own behaviors can affect the behaviors of the individuals they serve;
4. of the use of de-escalation, mediation, self-protection and other techniques, such as time-out; and
5. recognizing signs of physical and psychological distress in individuals who are being held, restrained, or secluded.
6. Techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
7. Medications used for chemical restraint and their indications for use and side effects (professional staff)

B. Training requirements for staff who are authorized to physically apply restraint

Staff who are authorized to physically apply restraint receive the training and demonstrate the competence cited in A1 through A6 above, and also receive ongoing training in and demonstrate competence in the safe use of restraint, including the application and removal of manual and mechanical restraints appropriate to the population served.

This training includes choosing the least restrictive intervention based on an individualized assessment of the patient’s medical or behavioral status or condition.

C. Training requirements for staff who are authorized to perform the monitoring

Staff who are authorized to perform monitoring of individuals who are in restraint receive the training and demonstrate the competence cited in A1 through A6 above, and also receive ongoing training and demonstrate competence in:

1. taking vital signs and interpreting their relevance to the physical safety of the individual in restraint;
2. recognizing nutritional/hydration needs;
3. checking circulation and range of motion in the extremities;
4. addressing hygiene and elimination;
5. addressing physical and psychological status and comfort;
6. assisting individuals in meeting behavioral criteria for the discontinuation of restraint;

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<ol style="list-style-type: none"> 7. recognizing readiness for the discontinuation of restraint; and 8. recognizing when to contact a medically trained licensed independent practitioner or emergency medical services in order to evaluate and/or treat the individual's physical status. 		
<p>D. Training requirements for RNs who are authorized to initiate restraint and/or perform assessments/reassessments</p>		
<p>The RN, who in the absence of a physician/provider or his or her licensed independent practitioner designee, is authorized to initiate restraint, and/or perform assessments/reassessments of individuals who are in restraint to assess their readiness for discontinuation or establish the need to secure a new order, receives the training and demonstrates competence cited in A, B and C above, and is also educated and demonstrates competence in:</p>		
<ol style="list-style-type: none"> 2. recognizing how age, developmental considerations, medical conditions and co-morbidities, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual reacts to physical contact; and 3. the use of behavioral criteria for the discontinuation of restraint and how to assist individuals in meeting these criteria 		
<p>E. Training in first aid, cardiopulmonary resuscitation, and emergency medical services</p>		
<ol style="list-style-type: none"> 1. All staff that apply restraint or seclusion, monitor, access or provide care for a patient in restraint or seclusion are required to receive education and training in first aid techniques as well as training and certification in CPR. 2. The organization has a plan for the provision of emergency medical services. 		
<p>F. The involvement of individuals who have experienced restraint</p>		
<ol style="list-style-type: none"> 1. The viewpoints of individuals who have experienced restraint are incorporated into staff training and education to help staff better understand all aspects of restraint use. 2. Whenever possible, such individuals who have experienced restraint contribute to the training and education curricula and/or participate in staff training and education. 		
<p>G. Physician Education</p>		
<ol style="list-style-type: none"> 1. Physicians and other providers authorized to order restraint or seclusion must have a working knowledge of the policy regarding the use of restraint and seclusion. Training requirements above this minimum will be based on the competency level of the physicians and providers and the needs of the patient population they serve. 		
<p>H. Trainer Requirements</p>		
<ol style="list-style-type: none"> 1. Individuals providing staff training must be qualified as evidenced by education, training and experience in techniques used to address patients' behaviors. 		

ADDITIONAL REQUIREMENTS FOR BEHAVIORAL HEALTH UNITS

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DEBRIEFING	<p>Debriefing is important in reducing the recurrent use of restraint. The individual and, if appropriate and agreed upon by the patient, the individual's family, participate with staff who were involved in the episode, and who are available, in a debriefing of each episode of restraint. The debriefing occurs as soon as possible and appropriate, but not longer than 24 hours after the episode. If the individual has given permission for the family to participate, the family will be asked about their preferences for being informed about restraint use and participating in debriefings.</p> <p>The debriefing is used to:</p> <ul style="list-style-type: none">• identify what led to the incident and what could have been handled differently;• ascertain that the individual's physical well-being, psychological comfort, and right to privacy were addressed;• counsel the individual involved with respect to psychological trauma that may have resulted from the incident; and• when indicated, modify the individual's treatment plan. <p>Information obtained from debriefings is documented and may be used in performance improvement activities.</p>
INITIAL ASSESSMENT PROCESS	<p>The individual and/or family are informed of the organization's philosophy regarding the use of restraint to the extent that such information is not clinically contraindicated.</p>

ADVANCE PREFERENCES/BEHAVIOR
MANAGEMENT

- The initial assessment of each individual should include obtaining information about the individual that could help minimize the use of restraint, as appropriate. The initial assessment should include an aggression risk screening, and discussion with the patient/caregivers of the patient's triggers for aggressive or self-injurious behavior and methods that the patient uses to regain control. Techniques, methods, or tools that would help the individual control his or her behavior should be discussed. These tools and techniques will be used to develop a patient-specific behavior/crisis prevention plan.

The role of the family, including their notification of a restraint episode, is discussed with the individual, and, as appropriate, with the individual's family. This is done in consideration of the individual's right to confidentiality.

CHEMICAL RESTRAINT

The use of chemical restraint should not be considered a routine part of care.

A chemical restraint is a drug or medication that is being administered to restrict the patient's freedom of movement or to manage patient behavior – when not associated with necessary medical tests/procedures or underlying medical or psychiatric symptoms/conditions. As such, chemical restraint is not a standard treatment and should be employed as infrequently as possible.

Chemical restraints can have significant adverse effects and should be used only after:

1. The patient has been assessed for factors contributing to the patient's behavior.
2. Alternative treatment modalities have been tried and were ineffective.
3. There has been a thorough consideration of risk vs. benefit and administration of a medication as a chemical restraint is the thought to be the least restrictive and most effective approach to ensure patient and staff safety.

Examples of Chemical Restraints:

1. A patient waiting to be evaluated in an Emergency Room for an orthopedic injury becomes extremely agitated, threatening and assaultive to staff secondary to an unusually prolonged wait time. All attempts to verbally de-escalate the situation are unsuccessful. The patient is manually restrained and administered a sedating drug such as midazolam to rapidly manage the patient's behavior and ensure safety.
2. A patient with a history of illicit substance abuse and criminality is admitted to a medical floor to rule out an acute abdomen. After getting into an argument with a staff nurse about pain medication, he grabs her by the neck and pushes her against the wall. He refuses to let her go unless he receives the medication he has requested. An emergency is called and the patient is physically restrained but still shouting that he is "going to assault you." He is administered a sedating medication to calm him down and ensure other patient and staff safety.

Medications that are prescribed and administered to (a) enhance the ability to participate in medical evaluation and treatment, and/or (b) target agitated behaviors associated with an underlying diagnosis (e.g. post-operative or other forms of delirium, mania, psychotic disorders) are not chemical restraints.

Examples of Medication Administration that are NOT Chemical Restraint:

1. For medical evaluation and/or treatment: A drug or medication that is used to enable the patient to more effectively participate in medical evaluation and treatment is NOT a chemical restraint. An example includes "procedural sedation", i.e., a sedative medication being used prior to medically necessary procedures/tests (e.g., lumbar puncture) to facilitate patient comfort and/or the completion of the procedure/test.

2. For agitated behavior associated with an underlying diagnosis: A psychotropic medication used to treat a symptom or feature of an underlying neuropsychiatric or psychiatric disorder is NOT a chemical restraint. Examples include, but are not limited to, pharmacologically treating agitation/aggression associated with post-operative or other forms of delirium, mania, or psychotic disorders.

Medications administered that are not standard treatment for the patient’s medical or psychiatric condition are considered restraint when they are used to control behavior or to restrict the patient’s freedom of movement. Follow Section A, Level 2 Violent / Self-Destructive Guidelines.	
ALTERNATIVE INTERVENTIONS:	Determine that all alternative interventions have been considered or failed.
ASSESSMENT:	Assess the patient for current physical and psychological risk factors as well as special needs. Consider pre-existing medical conditions such as sleep apnea, COPD, cardiac arrhythmia, cardiac conduction abnormality, seizure disorders, and/or a history of sexual or physical abuse.
PHYSICIAN OR LIP ORDER:	<ul style="list-style-type: none"> - A restraint order must be entered in the record, indicating “Chemical restraint,” and include all the supporting documentation. - The medication order must state the reason for the medication, the dose, route, and frequency of monitoring. - The medication order can only be a stat order. A PRN order is not permitted. The indication must clearly state "chemical restraint." - A new order is required for each dose. - Vital signs (T, P, R, BP) are to be taken as per the physician’s order – at minimum every 2 hours. - Other monitoring such as neurological checks should be considered.
NOTIFICATION:	Notify the treating physician as soon as possible.
PLAN OF CARE:	Modify the plan of care to reflect the need for chemical restraints. More than 1 episode of a chemical restraint in a 12 hour time period requires review by the treatment team.
ONGOING MONITORING	Continually monitor and assess the patient for safety and comfort needs as per the physician’s order, but no less than every 15 minutes. Practitioners ordering chemical restraints must also order constant observation for a period of time that they determine (at least 1 hour), in order to observe the patient for any possible safety

	concerns, such as respiratory depression.
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Medications administered that are not standard treatment for the patient’s medical or psychiatric condition are considered restraint when they are used to control behavior or to restrict the patient’s freedom of movement. Follow Section A, Level 2 Violent / Self-Destructive Guidelines.

<p>DOCUMENTATION:</p>	<ul style="list-style-type: none"> - The circumstances that led to restraint use - Consideration or failure of non-physical interventions - The rationale for use of Chemical Restraint; - Notification of the individual’s family, when appropriate - Written orders for use - Behavioral criteria for avoiding further chemical restraint. - Modifications in the plan of care. Each in-person evaluation and re-evaluation of the patient - Assessments of the patient’s status - Assistance provided to the patient to help him or her meet the behavioral criteria for avoidance of further chemical restraint as part of debrief - Continuous monitoring, and - Any injuries that are sustained and treatment received for these injuries or death. <p>Documentation is accomplished in a manner (such as a restraint log) that allows for the collection and analysis of data for performance improvement activities.</p> <p>(OMH licensed psychiatric units require that a log be maintained for evaluation at each survey.)</p>
<p>EDUCATION:</p>	<p>Ongoing education and training will be provided as per Section A, # 13</p>