



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

USE OF SECLUSION AND RESTRAINT

Effective Date: March 25, 2020

Policy: TX-16

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I. PURPOSE:

- A. To establish hospital policy and procedures governing the use of seclusion and restraint procedures which are to be used only when a patient is an imminent risk of significant violence or self-destructive behavior and no other less restrictive intervention is possible.
- B. To ensure seclusion and restraint procedures are used in accordance with state law and federal regulations.
- C. To ensure when seclusion or restraint procedures are used, staff respects the patient and treats individuals with dignity and protects the rights of all individuals involved.

II. POLICY:

- A. Montana State Hospital (MSH) is committed to a violence-free environment. We must continually reinforce to all people that violent acts and threats are not acceptable.
- B. MSH is committed to reducing the use of seclusion and restraint. We also recognize use of restraint and seclusion may only be used when there is an imminent risk of significant violence or self-destructive behavior.
- C. It is the policy of the MSH to provide care and treatment in a manner which is the least restrictive of patient movement and freedom. Seclusion and restraint are emergency procedures used only to prevent people from harming others or oneself.
- D. Seclusion and restraint are not treatment and may not be implemented as a behavioral consequence in response to a previously occurring behavior, or imposed as a means of coercion, discipline, convenience, or retaliation by staff.
- E. Seclusion and Restraint procedures may be used only when clinically justified in accordance with a Licensed Independent Practitioner order and used only when less restrictive interventions have been determined to be ineffective. The type of seclusion or restraint used must be the least restrictive procedure to effectively protect the patient, staff or others from harm. Seclusion and Restraint procedures must be ended at the earliest possible time.

- F. Orders for the use of seclusion or restraint are never written as a standing order or on an as needed basis (PRN).
- G. When seclusion/restraint procedures are implemented, the patient must be assessed face to face by a Licensed Independent Practitioner or trained RN or PA within the required time periods.
- H. Patients, and where appropriate, guardians and family/significant others are engaged in education strategies to prevent violence from occurring and to reduce the use of seclusion and restraint.
- I. The use of seclusion or restraint must be used in accordance with a written modification to the patient plan of care.

III. DEFINITIONS:

- A. **Seclusion:** Involuntary confinement of a patient alone in a room or an area from which the person is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive individuals.
- B. **Restraint:** The use of any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces free movement of the patient's arms, legs, body or head. Only those methods approved by MSH administration will be used to physically restrain a patient. See Attachment A for a list of restraints approved for use at MSH.
- C. **Chemical Restraint** is not approved for use at MSH. **Chemical Restraint** is when a drug is used as a restraint; a medication used to control behavior, or to restrict the patient's freedom of movement, and *is not a standard treatment or dosage for the patient's medical or psychiatric condition.*
- D. **Emergency Transport Restraints:** Wrist and ankle restraints or the transport blanket may be used for brief periods to safely transport a patient in an emergency situation. Examples of this use include use of wrist and/or ankle restraints to transport a patient on unauthorized leave safely back to their treatment unit, or use of the transport blanket to transport a violent or self-destructive patient to a safe location within a treatment unit. Use of emergency transport restraints require an order by a Licensed Independent Practitioner and face to face evaluation by a Licensed Independent Practitioner or trained RN or PA within one hour, along with documentation and review required just as with all other restraint procedures.
- E. **Clinical Assessment for Seclusion and Restraint:** An assessment in which a Licensed Independent Practitioner or trained RN or PA substantiates through documentation in the medical record the reason seclusion/restraint is necessary to

manage violent or self-destructive behavior which jeopardizes the immediate physical safety of the patient, staff member or others.

- F. **Criteria/Clinical Justification for Seclusion or Restraint:** To prevent a patient from imminent risk of significant violence or self-destructive behavior to others or themselves when less restrictive interventions are inadequate to prevent the behavior.
 - G. **Emergency:** An emergency is a situation in which action is necessary to prevent an imminent risk of significant violence or self-destructive behavior to others, and/or to self.
 - H. **Licensed Independent Practitioner:** An active, provisional or part-time physician or APRN and/or CNS who attends to the care of the patients at MSH.
 - I. **Trained Staff:** Includes Licensed Independent Practitioner, RN, PA or other licensed nursing staff and direct care staff that have been trained in de-escalation techniques, safe management of seclusion and restraints, and review of systems including review of medications and labs.
- IV. **RESPONSIBILITIES:** Staff who have received facility approved training in de-escalation and safe management of seclusion and restraint may participate in secluding or physically restraining patients.
- A. **All MSH employees:** Supporting the commitment of MSH to reduce and or eliminate seclusion and restraint use and violence in general by utilizing less restrictive measures such as the de-escalation techniques listed in Attachment C.
 - B. **Staff Development:** Conducting regular training for all staff involved in the use of seclusion or restraints, alternatives, methods of de-escalation, and review of systems including review of medications and labs.
 - C. **The Weekly Event Review Committee** will perform an administrative review of selected seclusion and restraint procedures.
 - D. All staff shall make all efforts to preserve the privacy, safety, human dignity, and the physical and emotional comfort of the patient at all times.
 - E. Staff shall ensure the duration of the seclusion or restraint procedure is the shortest time possible to reasonably assure the safety and protection of the patient and the safety of others, regardless of the length of time identified in the order.
 - F. Staff shall provide the patient with a clear explanation of the reason(s) for seclusion or restraint, the monitoring procedure, the desired outcome, and the criteria the patient must meet in order for the procedure to be discontinued.

- G. Staff shall implement restraint procedures in a manner to minimize potential medical complications. Staff must be aware of the possibility of injury to the patient during the application and utilization of restraints.
- H. Sufficient numbers of trained staff shall be present to accomplish placement in seclusion and/or restraint in the safest manner possible.
- I. Staff must consider the potential impact of seclusion or restraints for those patients with a history of trauma such as physical or sexual abuse and be particularly sensitive to the needs of these patients.
- J. Staff shall provide patients in seclusion with constant, uninterrupted in-person observation for the first hour. After the first hour, in-person observation may be replaced by observation using audio and visual equipment at the direction of a trained nurse or a Licensed Independent Practitioner. When audio/video observation is used, the patient must be observed, and when appropriate, engaged in-person at least every 15 minutes.

In the event the uninterrupted in-person observation for the first hour is deemed detrimental to the patient, the Licensed Independent Practitioner/trained RN, with written justification, may modify this requirement to uninterrupted in-person observation using audio and visual equipment.

In the event of exceptional circumstances requiring the use of a prolonged seclusion, the requirement for constant audio/video observation may be modified upon written authorization of the Medical Director or Hospital Administrator. Modifications must be based on the patient's individual circumstances, taking into consideration such variables as the patient's condition, cognitive status, risks associated with the use of seclusion, and other relevant factors.

In all circumstances the patient in seclusion must be observed and engaged in-person at least every 15 minutes.

- K. Staff shall provide patients in restraint with constant one-to-one uninterrupted in-person observation.
- L. **Direct Care Staff**, in close consultation with and direction from the Licensed Independent Practitioner or Registered Nurse will:
 - 1. Promptly notify the Licensed Independent Practitioner and/or the RN when a patient is an imminent risk of significant violence or self-destructive behavior.
 - 2. Remove all potentially dangerous items from the patient and the room designated for seclusion/restraint before the patient is placed in seclusion/restraint.

3. As directed, apply restraints safely and make adjustments as necessary in order to ensure that the patient is as physically comfortable as possible while restrained. No restraint or body positioning of the patient shall place excessive pressure on the chest or back of the patient or inhibit or impede the patient's ability to breathe. Patients are to be restrained in a manner to minimize potential medical complications.
4. Provide required level of observation for procedure and as directed by Licensed Independent Practitioner and RN.
5. Provide the patient in restraints range-of-motion exercise for at least 10 minutes at least every two hours, unless the patient's behavior renders this impossible or unsafe for either the patient or the staff or is contraindicated by condition of joint or limb.
6. Change the patient's linen, bedding, and clothing promptly as it becomes soiled.
7. Offer fluids at least hourly unless fluids are restricted by a Licensed Independent Practitioner's order. Meals and snacks will be offered at regular intervals.
8. Offer the patient use of toilet facilities or a bedpan/urinal at least hourly and whenever a patient requests a need.
9. Allow and/or assist the patient to bathe or shower at least daily when procedures are used for extended periods of time. When necessary, a bed bath may be given. The patient will be provided A.M. and H.S. care including oral care, washing of face, hands, and hair care, and other care and comfort measures as appropriate. Staff will prompt and assist the patient to wash hands before meals and after toileting.
10. Document the following in the patient's medical record according to the Nursing Services Flow Sheet:
 - a. The patient's behavior and physical condition at least every 15 minutes as long as the procedure continues. When the patient appears calm, 15-minute check documentation should be based on a face-to-face interaction with the patient;
 - b. Whenever a patient appears calm following an interaction, the direct care staff member should call for the trained nurse to further assess the patient for possible release;
 - c. All care offered and care provided to a patient during the procedure including hygiene, diet, fluid intake, bowel/bladder functions, physical observations, range-of-motion, and vital signs;
 - d. Any exceptions to care and reason/rationale;
 - e. Observations regarding positioning, skin integrity, circulation, and gait.

11. Promptly inform RN about any changes in a patient's behavior or physical condition including when the patient appears calm.
12. Participate in the event review process.
13. Complete an incident report whenever the transport blanket is utilized, hands on procedures are utilized, and/or any adverse outcome occurs (falls, injuries, or allegations of abuse) as a result of the procedure. Forward to the Nursing Supervisor for review.

M. Registered Nurses will:

1. Assess the patient and situation to determine imminent risk of significant violence or self-destructive behavior requiring the emergency use of seclusion or restraint. This assessment will include the antecedents/behaviors leading to the need for the procedure, the alternatives used to avoid the procedure and medical concerns related to the use of the procedure.
2. Notify the Licensed Independent Practitioner of the patient's behavior, alternative approaches used to avoid restraint/seclusion and level of procedure implemented on an emergency basis. Inform Licensed Independent Practitioner of known pertinent medical health issues. Document this information on the Seclusion/Restraint Order and Progress Note form.
3. Obtain verbal or written order from the Licensed Independent Practitioner for the procedure prior to implementation or as soon as possible after an emergency implementation of seclusion or restraint and document the order on the Seclusion/Restraint Procedure Order/Progress Note form. The order will include the method of seclusion/restraint to be utilized, clinical rationale for use of procedure and behavioral criteria the patient must meet for release/removal from seclusion/restraint.
 - Seclusion or restraint orders are valid for a maximum of four hours. If procedures are continued, orders must be renewed by the Licensed Independent Practitioner every four (4) hours up to 24 hours. (NOTE: Orders for seclusion/restraint procedures for children and adolescents ages 9-17 are valid for two (2) hours only.)
 - Face to face evaluation of a patient in restraints or seclusion by a Licensed Independent Practitioner must occur every (24) twenty-four hours.
4. A Licensed Independent Practitioner during scheduled working hours, a Physician Assistant, or a trained RN in other circumstances will conduct a face-to-face evaluation of the patient within one (1) hour after initiation of the procedure and document as indicated below. Document on the Seclusion and Restraint

Intervention Order/Progress Note each time a face-to-face assessment is completed. Documentation will include:

- a. Behavior leading to procedure;
 - b. Rationale for use of procedure;
 - c. Patient's immediate situation;
 - d. Patient's reaction to the intervention;
 - e. Current behavioral/mental status;
 - f. Assessment of physical status, medications and labs;
 - g. Reason for seclusion/restraint explained to patient;
 - h. Behavioral criteria for release explained to patient;
 - i. Interventions implemented to assist in meeting release criteria and active treatment provided;
 - j. Plan for continuing care including the need to continue or terminate the procedure.
5. Notify and consult with the Licensed Independent Practitioner as soon as possible upon completion of assessment.
 6. Notify the patient's attending Licensed Independent Practitioner by phone message or nursing report as soon as possible regarding the seclusion/restraint procedure.
 7. Notify the Licensed Independent Practitioner when renewal orders are needed.
 8. Monitor vital signs initially and at least every four hours or more often as directed. In the event the patient's behavior renders this impossible or unsafe for either the patient or the staff this will be documented in the medical record.
 9. An RN will assess the patient in seclusion/restraint at least every hour and document the following on the Seclusion/Restraint Order and Progress Note:
 - a. Current situation and behavior/mental status;
 - b. Patient's reaction to procedure;
 - c. Assessment of physical status;
 - d. Vital signs (at least every 4 hours);
 - e. ROM (every 2 hours when restrained);
 - f. Fluids offered;
 - g. Toileting offered;
 - h. Reason for restraint/seclusion explained;
 - i. Behavioral criteria for release explained;
 - j. Interventions implemented to assist in meeting release criteria and active treatment provided;
 - k. Plan to continue or discontinue procedure;

10. Obtain additional Licensed Independent Practitioner's orders should an increased level of intervention become necessary (e.g., any modification that increases the level of restraint, change in the placement of the patient from seclusion to restraint).
11. Supervise and assist staff in the safe implementation of seclusion and restraint procedures.
12. Direct the reduction of the level of restraint and the termination of the procedure when the criteria for release as set by the Licensed Independent Practitioner is met, and the patient is no longer an imminent risk of significant violence or self-destructive behavior.
13. The Nurse Manager and/or staff RN will review the event with all involved staff as soon as possible following the procedure to determine patient management strategies to avoid future incidents. The review will be documented on the Event Review Form.
14. Following a patient's release from Seclusion or Restraint, the Nurse/Licensed Independent Practitioner involved in releasing the patient, will initiate an update to the treatment plan aimed at decreasing the likelihood of further restraint or seclusion based on what the treatment team learned from the most recent event. The updated treatment plan will be documented as an addendum to the current treatment plan and placed in the patient's chart.
15. In the event of circumstances requiring prolonged seclusion, the requirement for at least hourly assessments by the RN may be modified upon written order of the Licensed Independent Practitioner as authorized by the Medical Director or Hospital Administrator. Modifications must be based on the patient's individual circumstances, taking into consideration such variables as the patient's condition, cognitive status, risks associated with the use of seclusion, and other relevant factors.

N. Physician Assistants (PA) will:

1. A Licensed Independent Practitioner during scheduled working hours; a Physician Assistant, or a trained RN in other circumstances will conduct a face-to-face evaluation of the patient within one (1) hour after initiation of the procedure and document as indicated below. Document on the Seclusion and Restraint Intervention Order/Progress Note each time a face-to-face assessment is completed. Documentation will include:
 - a. Behavior leading to procedure;
 - b. Rationale for use of procedure;
 - c. Patient's immediate situation;

- d. Patient's reaction to the intervention;
 - e. Current behavioral / mental status;
 - f. Assessment of physical status, medications and labs;
 - g. Reason for seclusion/restraint explained to patient;
 - h. Behavioral criteria for release explained to patient;
 - i. Interventions implemented to assist in meeting release criteria and active treatment provided;
 - j. Plan for continuing care including the need to continue or terminate the procedure.
2. Notify and consult with the Licensed Independent Practitioner as soon as possible upon completion of assessment.
 3. Notify Registered Nurse of the outcome of the face to face evaluation.

O. Licensed Independent Practitioner:

1. Will give orders authorizing the use of seclusion and restraint procedures (including any modification). The initial order is valid for up to four (4) hours. Orders must be renewed every four (4) hours up to 24 hours as long as the procedure continues. After 24 hours, before writing a new order for the use of seclusion / restraint, a Licensed Independent Practitioner must complete a face to face assessment of the patient. (NOTE: Orders for seclusion/restraint procedures for children and adolescents ages 9-17 are valid for Two (2) hours only.)
2. Provide orders clearly stating:
 - a. Reason or justification for the procedure;
 - b. Specific type of procedure to be used;
 - c. Maximum time period allowed for the procedure;
 - d. Criteria for release;
 - e. Date and time.
3. A Licensed Independent Practitioner during normal working hours, a Physician Assistant, or a trained RN in other circumstances will conduct a face-to-face evaluation of the patient within one (1) hour after initiation of the procedure and document as indicated below. Document on the Seclusion and Restraint Intervention Order/Progress Note each time a face-to-face assessment is completed. Documentation will include:
 - a. Behavior leading to procedure;
 - b. Rationale for use of procedure;
 - c. Patient's immediate situation;
 - d. Patient's reaction to the intervention;
 - e. Current behavioral / mental status;

- f. Assessment of physical status, medications and labs;
- g. Reason for seclusion/restraint explained to patient;
- h. Behavioral criteria for release explained to patient;
- i. Interventions implemented to assist in meeting release criteria and active treatment provided;
- j. Plan for continuing care including the need to continue or terminate the procedure.

4. After 24 hours, before writing a new order for the use of restraint or seclusion, a Licensed Independent Practitioner must see and assess the patient.
5. Participate in the review process as indicated.
6. The attending Licensed Independent Practitioner will document a face-to-face evaluation of patients, who have been restrained or secluded, by the next business day.

P. Program Managers will:

1. Conduct and complete required Patient Event Review and QI Incident Peer Review.
2. Ensure the QI Incident Peer Review (pages one and two) is filed with the Quality Improvement Department for future reference and the Patient Event Review (pages three and four) is filed in the Medical Record under the Treatment Plan.
3. Ensure the review and revision of the patient's treatment plan as indicated.

Q. Quality Improvement Director: Tracking use of these procedures throughout the hospital and disseminating data about use of restraint and seclusion to all staff members.

R. Hospital Administrator:

1. Promoting activities that protect patient and staff safety and lead to a reduction in the use of seclusion and restraint procedures. This will be done through analysis of restraint and seclusion incidents and utilize information to improve staff skills and patient treatment.
2. Promoting therapeutic non-coercive approaches to treatment, including trauma informed care which recognizes the potential for seclusion and restraints to traumatize both patients and staff.
3. The Hospital Administrator or designee will report to CMS each death which occurs while a patient is in restraint or seclusion; each death which occurs within

24 hours after the patient has been removed from restraint or seclusion or each death known to the hospital which occurs within one week after restraint has been removed or seclusion has ended, when it is reasonable to assume the use of restraint or seclusion contributed directly or indirectly to a patient's death such as deaths related to restrictions of movement for prolonged periods of time, related to chest compression, restriction of breathing or asphyxiation. This report will be made to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death. Documentation of the date and time of this reporting will be entered into the Progress Notes of the patient's medical record.

V. PROCEDURE:

A. Seclusion/Restraint Procedure:

1. Staff responds immediately to an emergency behavioral crisis, taking needed action to keep the patient and others safe.
2. Seclusion or restraint will be utilized if necessary, in accordance with staff responsibilities outlined in section IV.

B. Procedure for Termination of Seclusion/Restraint:

1. RN has assessed that the patient no longer requires seclusion or restraint; or
2. Licensed Independent Practitioner has assessed and ordered the discontinuation of seclusion or restraint; or
3. Any staff member determines that the patient's health, safety, or welfare requires immediate release.
4. Following a patient's release from Seclusion or Restraint, the Nurse/Licensed Independent Practitioner involved in releasing the patient, will initiate an update to the treatment plan aimed at decreasing the likelihood of further restraint or seclusion based on what the treatment team learned from the most recent event. The updated treatment plan will be documented as an addendum to the current treatment plan and placed in the patient's chart.

C. Documentation Procedure:

1. All staff will document in accordance with role and responsibility.

D. Reporting Procedures:

1. An incident report will be completed whenever the transport blanket or spit hood is utilized and/or any adverse outcome occurs from utilization of seclusion/restraints. The RN will forward the incident report to the Safety Officer.
2. The Quality Improvement Director will ensure a process to maintain a database, prepare and distribute reports regarding these occurrences at periodic intervals but not less than quarterly. This information is analyzed and reported on a quarterly basis to the Hospital Administrator, Quality Improvement Committee, Medical Director, Director of Nursing Services, and to the medical staff.

E. Training procedures:

1. Staff will be educated, and their competency tested regarding Use of Seclusion and Restraint Policy during initial orientation and annually. Staff will receive annual de-escalation training.
2. Staff will be educated in the following areas:
 - a. Techniques to identify staff and patient behaviors, events and environmental factors which may trigger restraint or seclusion use.
 - b. Use of nonphysical intervention skills.
 - c. Choosing the least restrictive intervention based on individualized assessment.
 - d. Safe application of restraint or seclusion, including how to recognize and respond to physical and psychological distress.
 - e. Clinical identification of behavioral changes which indicate restraint or seclusion is no longer necessary.
 - f. Monitoring and assessment of physical and psychological well-being of the patient (e.g., respiratory and circulatory status, skin integrity, vital signs, medications, and labs) in association with the one-hour face to face evaluation.
 - g. Trained RNs, Licensed Independent Practitioners will be trained to provide face to face evaluations and will be trained in the review of systems, medications, and labs and the use of first aid techniques and certification in the use of cardiopulmonary resuscitation including periodic recertification.
3. Documentation of this training will be maintained in the Staff Development Department.
4. Patients, and when appropriate, families will be educated regarding seclusion/restraint use.

- VI. REFERENCES:** Standards/Statutes: 53-21-146 M.C.A.; M.C.A. 53-21-147 Patient Rights; CMS 42 CFR Part 482 conditions of participation for hospitals, Subpart B – 482.13 Patient Rights and, (f) Seclusion and Restraint for behavior management.
- VII. COLLABORATED WITH:** Hospital Administrator, Medical Director, Director of Nursing, Quality Improvement Director, Staff Development Coordinator.
- VIII. RESCISSIONS:** TX-16 *Use of Seclusion and Restraint* dated November 15, 2013; TX-16, *Use of Seclusion and Restraint* dated August 16, 2013; TX-16, *Use of Seclusion and Restraint* dated September 27, 2012 TX-16, *Use of Seclusion and Restraint* dated September 16, 2011; TX-16, *Use of Seclusion and Restraint* dated December 1, 2007; TX-16, *Use of Seclusion and Restraint* dated August 1, 2006; TX-16, *Use of Seclusion and Restraint* dated March 20, 2006; TX-16, *Use of Seclusion and Restraint* dated November 17, 2004; TX-16, *Use of Seclusion and Restraint* dated June 18, 2001; HOPP 13-03R.070073 – *Use of Behavior Control, Seclusion, and Restraint* dated 1/31/96.
- IX. DISTRIBUTION:** All Montana State Hospital Policy Manuals.
- X. ANNUAL REVIEW AND AUTHORIZATION:** This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM. § 37-106-330.
- XI. FOLLOW-UP RESPONSIBILITY:** Director of Quality Improvement.
- XII. ATTACHMENTS:** For internal use only.
- A. List of Approved Restraints
 - B. Seclusion and Restraint Intervention Order/Progress Note
 - C. Less Restrictive Measures to Seclusion or Restraint Interventions Taught in Mandt Training

Signatures:

Kyle Fouts
Hospital Administrator

Thomas Gray, MD
Medical Director