

**MOUNT CARMEL  
POLICY/PROCEDURE**

**SUBJECT: RESTRAINTS / SECLUSION: USE OF**

DEPARTMENT OVERSIGHT AND MAINTENANCE: Administrative

POLICY: Mount Carmel Health System seeks to limit the use of restraints to clinically appropriate and adequately justified situations. If there is an appropriate, clinically justified need to use restraint, then the least restrictive method will be used for the shortest period of time necessary. The goal will be to maintain the patient's rights, safety, well-being and dignity and to discontinue restraints as soon as possible. Mount Carmel Health System does not permit the use of restraints or seclusion for purposes of coercion, discipline, convenience or retaliation by staff.

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RESPONSIBLE PERSONS: All hospital personnel

**A. DEFINITIONS:**

**RESTRAINT:**

Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to freely move his or her arms, legs, body or head. A restraint does not include devices that protect the patient from falling out of bed (e.g., mattress monitor) or permit the patient to participate in activities without the risk of physical harm. NOTE: The use of 4 side rails or 2 full side rails would not be considered a restraint in the following circumstances:

- 1) immediate post-operative or post-procedural period
- 2) transporting a patient from one area to another by bed, gurney, or cart
- 3) in the event a rotation bed was being used as a part of the patient's therapy,
- 4) to protect a patient who is on seizure precautions
- 5) if the physical condition of a patient would prevent him/her from exiting the bed voluntarily anyway.

The use of 4 side rails or 2 full side rails with the intent of preventing a patient who is mobile from getting out of bed is a restraint.

**SECLUSION (ENVIRONMENTAL RESTRICTION):**

Seclusion is the involuntary confinement of a person 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. Seclusion is not just confining the patient alone in a room or area where the patient is physically prevented from leaving.

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If a patient is restricted to room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient threatens to leave the room, the room is considered locked, whether the door is actually locked or not. In this situation the patient is being secluded.

### **NON-VIOLENT OR NON-SELF DESTRUCTIVE BEHAVIOR:**

Patient may be attempting to dislodge tubes, lines due to confusion, disorientation.

### **VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR:**

Patient is aggressive, combative and has the potential to harm self, other patients or staff.

### **MEDICAL PROTECTIVE DEVICE:**

Appliances used to meet the assessed safety needs of a patient. When using medical protective devices, the MCHS policy on restraints does not apply. Ex: helmets, unsecured mitts. The use of a tabletop chair or seat belt that the patient is unable to release, may or may not be considered a restraint based on the individualized assessment of the patient and the intended use of the item. See adaptive support devices below.

### **ADAPTIVE SUPPORT DEVICE:**

Orthopedic appliances or other devices used to support the patient's posture or assist him/her in obtaining and maintaining normal body alignment and /or function. When using adaptive support devices, the MCHS policy on restraints does not apply. Ex: wheelchairs; braces; splints; casts; abduction pillow; hand rolls; heel-elbow protectives, etc.

### **ALTERNATIVES TO RESTRAINTS:**

Any mechanism that does not restrict a patient's movement or mobility, but may be effective in maintaining patient safety and well being. Use of alternatives is based on individual patient assessment.

Alternatives to restraints may include:

- Placing the patient by the nurses station
- Providing pleasurable distractions such as TV, music, conversation, reading to the patient, or engaging the patient in simple activities such as walking
- Any constructive hand motor activity (if not contraindicated)
- Sitter
- Bed alarms
- Low beds or mats on the floor if not contraindicated
- Toileting schedule
- Massage
- Quiet environment

### **MEDICAL IMMOBILIZATION:**

Mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures, such as immobilization of a body part during surgery or other procedure, for example, IV arm board, papoose board, etc. When using medical immobilization mechanisms, the MCHS policy on restraints does not apply.

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**CHEMICAL RESTRAINTS:**

A drug used as a restraint to control behavior or to restrict the patient's freedom of movement AND is not standard treatment or dosage for the patient's medical or psychiatric condition. If a psychotherapeutic medication reduces the ability to effectively or appropriately interact with the world around them, then the medication is not being used as a standard treatment for the patient's psychiatric condition. The standard use of a psychotherapeutic medication to treat a patient's condition enables the patient to more effectively or appropriately function in the world than would be possible without the use of the medication.

**LICENSED INDEPENDENT PRACTITIONER:**

Physicians, Residents, Advanced Practice Nurses. All are granted special licensing privileges by the State to order medical treatment as outlined by their scope of practice. **NOTE:** Physician Assistants are not considered LIPs. However, per state law and Medical Staff Bylaws they may write orders for restraints. An Advanced Practice Nurse and physician Assistant may write orders within the scope of the collaborative agreement with his/her supervising physician.

**QUALIFIED REGISTERED NURSE:**

A registered nurse who has received training and demonstrates knowledge in the specific needs of a patient population as it applies to the following:

1. Identifying staff and patient behaviors as well as environmental factors that may trigger circumstances that require the use of restraints
2. Identifying the risk of restraint use in vulnerable patient populations such as emergency, pediatric, cognitively or physically limited patients.
3. The use of non-physical intervention skills
4. Choosing the least restrictive interventions based on an assessment of the patient's behavioral and medical status
5. Identifying specific behavioral changes that indicate restraint or seclusion is no longer necessary.
6. Monitoring the physical and psychological well-being of the patient in restraints
7. Safe application of restraints

Based on this training, the RN is authorized to initiate restraint or seclusion, and/or perform evaluations or re-evaluations of patients in restraint or seclusion and to assess their readiness for discontinuation or establish the need to secure a new order.

**B. GENERAL GUIDELINES RELATED TO RESTRAINT USE**

1. Patients will be maintained in the least restrictive, yet safe environment.
2. The decision to increase environmental restrictiveness must be based on the assessed protective and safety needs of the patient and/or others.
3. Alternatives to restraints shall be attempted initially.
4. Once alternatives to restraints have been considered, attempted or failed, and the patient's safety and/or well being is still at risk, the use of a restraint may be necessary.

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5. Determining the type of restraint to use involves the application of two criteria:
  - a. "Least Restrictive" refers to the smallest amount of mobility being lost by the patient;
  - b. Safety is provided to the patient, staff and others.

Example #1: A wrap-around-belt may be considered "less restrictive" than a chest restraint or vest because it allows the patient increased movement of the upper torso. However, for a patient slumped over in a wheelchair, it would not be safe because it inhibits maximum respiratory, gastrointestinal, and renal function, and the chest restraint might be more appropriate.

Example #2: A chest restraint is usually considered to be "less restrictive" than limb restraints because it still allows the patient to move their arms and maintain some independence. However, for a disoriented or confused patient with a ventilator, it would not prevent the patient from pulling out his/her ET tube and soft wrist restraints might be safer.
6. The use of alternatives to restraints, the use of a restraint, and the necessary behaviors a patient must exhibit before discontinuing the use of a restraint device must be explained to the patient, and when appropriate, the family. If the use of restraints becomes necessary, it will be explained that our goal is to discontinue them as soon as the patient exhibits expected behaviors. This interaction must be documented.
7. When a pediatric patient must be restrained, an explanation of the purpose and duration of the restraint must take place with the patient and/or family. Consideration must be given to the child's cognitive and developmental abilities. Patient and family involvement in care must be documented.
8. If the patient/family or responsible person refuses the application of restraints or the use of alternatives that are designed to maintain the patient's own safety, notify the physician for further interventions. Document the notification and any interventions.
9. Restraints must be applied according to manufacturers' instructions.
10. A patient would be eligible for early removal of restraints if:
  - a. He/she no longer displays behaviors that would put them at risk to harm themselves or others.
  - b. Does not exhibit behavior that disrupts medical interventions
  - c. Does not prevent the maintenance of a safe environment for the patient or others
11. Based upon RN or physician assessment, a restraint may be released early. However, if the same behavior becomes evident again, a new order must be obtained. Document the reasons for reapplication of the restraint in the medical record.
  - a. Release of restraints with family present would not require a new written order from the physician to reapply restraints, as long as the family is in constant attendance in the room
  - b. A staff member must remove the restraint
  - c. A staff member must reapply the restraint at the time the family leaves the room
  - d. If the patient is left unattended and unrestrained, the restraint is considered discontinued and a new order is required to reapply the restraint.
12. Documentation for a patient in a restraint device will include but is not limited to:
  - a. Clinical justification for the use of restraints. The actual behavior justifying the use of a restraint must be documented.

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- b. Alternative measures tried, attempted and considered even if ineffective.
- c. A current LIP order depending upon the reason for the restraint ( e. g. non-violent behavior vs. violent behavior)
- d. The type of restraint used and evidence that the least restrictive restraint was chosen.
- e. The results of all monitoring, reassessments and related interventions related to the restraint use.
- f. Modification of the plan of care and achievement of goals.
- g. Patient and family involvement, instruction or notification.

**C. RESTRAINTS FOR NON-VIOLENT OR NON-SELF DESTRUCTIVE BEHAVIOR**

1. Restraints may be applied upon the assessment of a RN when no other restraint alternative methods are effective. The assessment should include the patient's physical and cognitive status and limitations. **A Licensed Independent Practitioner (LIP) order is required prior to or immediately (within minutes) following the application of all restraints.** The order must include the following:
  - a. The date and time the order was received
  - b. The type of restraint utilized
  - c. The reason for the restraint
  - d. Duration of restraintThe nurse should inform the ordering physician if the initiation of the restraint is based on a significant change in the patient's condition.
2. If the ordering physician is not the attending, the attending physician or his/her designee must be notified within 24 hours of the patient being placed in restraints.
3. PRN orders for restraints are not acceptable.
4. Telephone or verbal restraint orders must be countersigned dated and timed by the physician within 24 hours of receipt of order per medical staff bylaws.
5. A written order based on examination of the patient by a licensed independent practitioner, is entered into the patient's medical record within 24 hours of the initiation of restraint.
6. The renewal of the restraint order is issued no less often than once each calendar day and is based on the physician's or licensed independent practitioner's examination of the patient.
7. The patient's well-being must be observed and documented every two hours. Observation and monitoring should include:
  - a. The physical and emotional well-being of the patient, including nutrition, hydration, and toileting needs, range of motion, positioning, skin integrity, circulation status, respiratory status.
  - b. Maintaining the patient's rights, dignity, and safety
  - c. Consideration of alternatives or less restrictive methods to restraints
  - d. Review of criteria for restraint release which includes changes in the patient's behavior or clinical condition
  - e. Restraint care which identifies that restraints have been appropriately applied, removed while the patient was cared for and repositioned as needed, and appropriately reapplied.

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8. Documentation includes the following:
  - a. Relevant orders for use
  - b. Results of patient monitoring
  - c. Reassessment
  - d. Significant changes in the patient's condition

**D. RESTRAINTS OR SECLUSION FOR PATIENTS EXHIBITING VIOLENT OR SELF DESTRUCTIVE BEHAVIOR**

Restraint or seclusion for patients exhibiting violent or self-destructive behavior is limited to emergencies in which there is an imminent risk of a patient physically harming self or others and non-physical interventions would not be effective. The type of physical intervention selected considers information learned from the patient's initial assessment including the patient's age, physical status and cognitive and physical limitations. The use of restraint or seclusion is not based solely on a history of dangerous behavior or a patient's restraint or seclusion history.

**NOTE:** Restraint **and** Seclusion may not be used simultaneously unless the patient is continually monitored face-to-face by an assigned staff member or continuously monitored by staff using both video and audio equipment.

1. Restraints may be applied upon the assessment of a RN when no other restraint alternative methods are effective. The assessment should include the patient's physical and cognitive status and limitations. **A Licensed Independent Practitioner (LIP) order is required prior to or immediately (within minutes) following the application of all restraints.** The order must include the following:
  - a. The date and time the order was received
  - b. The type of restraint utilized
  - c. The reason for the restraint
  - d. Duration of Restraint

The nurse should inform the ordering physician if the initiation of the restraint is based on a significant change in the patient's condition.

2. If the ordering physician is not the attending, the attending physician or his/her designee must be notified within 24 hours of the patient being placed in restraints.
3. PRN orders for restraints are not acceptable.
4. Telephone or verbal restraint orders must be countersigned dated and timed by the physician within 24 hours of receipt of order per medical staff bylaws.
5. Within 1 hour of the application of restraint or seclusion, a physician, a licensed independent practitioner, physician's assistant or qualified RN as defined in this policy, must perform a face-to-face evaluation of the patient and the need for seclusion or restraint. If the face-to-face is conducted by a trained LIP, physician's assistant or RN, they must consult the attending physician after the completion of the one hour evaluation. This must be documented in the patient's medical record. The documentation must include:
  - a. The patient's immediate situation – behavior being displayed
  - b. The patient's reaction to restraint and/or seclusion
  - c. The patient's medical and behavioral condition
  - d. The need to continue or terminate the restraint or seclusion.

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6. Physicians orders for restraints and seclusion are limited to:
  - a. 4 hours for patients 18 and older
  - b. 2 hours for children/adolescents ages 9-17
  - c. 1 hour for children under age 9
7. Before the order for restraint or seclusion expires, the patient is evaluated in person by one of the following:
  - a. The licensed independent practitioner primarily responsible for the patient's ongoing care, treatment or services
  - b. His or her licensed independent practitioner designee
  - c. Another licensed independent practitioner or
  - d. A qualified trained RN.
8. If the evaluation as carried out above determines that the use of restraint or seclusion should continue beyond the expiration of the time limited order, a new order is obtained from the physician primarily responsible for the patient's ongoing care or his or her licensed independent practitioner designee, or other physician or licensed independent practitioner.
9. If the patient's physician or his or her licensed independent practitioner designee is not the physician or LIP that gave the order then the patient's physician is notified of the patient's status if restraint or seclusion is to continue.
10. The physician or licensed independent practitioner conducts an **in-person re-evaluation** at least:
  - a. Every 8 hours for patients 18 years and older
  - b. Every 4 hours for patients 17 years and younger
11. A staff member who is trained and competent as described in Section G assesses the patient for well-being at the initiation of restraint or seclusion and every 15 minutes thereafter.
12. Patients in restraint **or** patients for the first hour of seclusion are monitored through continuous in-person observation by an assigned staff member who is competent and trained as described above.
13. After the first hour in seclusion without restraints, the patient may be continuously monitored using simultaneous video/audio equipment, if consistent with the patient's condition or wishes. If video/audio equipment is not available, the patient must be in 1:1 attendance.
14. If the patient is in physical hold, a second staff person is assigned to observe the patient.

**E. ADDITIONAL REQUIREMENTS FOR INPATIENT PSYCHIATRIC UNIT**

1. Clinical Leadership will be notified of any patient who remains in restraints/seclusion for more than 12 hours or experiences 2 or more separate episodes, and every 24 hours of continuous use of restraints/seclusion, thereafter.
2. As early as feasible in the restraint or seclusion process, the patient is made aware of the rationale for restraint or seclusion and the behavior criteria for its discontinuation.
3. Restraint or seclusion is discontinued as soon as the patient meets his or her behavior criteria.

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4. The patient, staff and patient's family if appropriate will participate in a debriefing about each episode of restraint or seclusion. The debriefing occurs as soon as possible but no longer than 24 hours after the episode.
5. The purpose of the debriefing is to:
  - a. Identify what led to the incident and what could have been handled differently
  - b. Ascertain that the patient's physical well-being, psychological comfort and right to privacy were addressed
  - c. Counsel the patient for any trauma that may have resulted from the incident
  - d. When indicated, modify the patient's plan of care, treatment and services.
6. The use of restraint or seclusion is recorded in the medical record and the focus of all entries is on the patient.
7. The medical record contains the following documentation:
  - a. That the patient and/or family was told of the hospital's policy on restraints
  - b. Any pre-existing medical conditions or any physical disabilities that would place the patient at greater risk during restraint and seclusion
  - c. Any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint or seclusion
  - d. Each episode of use
  - e. The circumstances that led to restraint or seclusion. Consideration of failure of nonphysical interventions
  - f. The rationale for the type of physical intervention selected
  - g. Notification of the patient's family if appropriate
  - h. Written orders for use
  - i. Behavior criteria for discontinuing restraint or seclusion (Applies to psychiatric Unit)
  - j. Informing the patient of behavior criteria for discontinuing restraint or seclusion. (Applies to psychiatric unit)
  - k. Each verbal order received from a physician or LIP
  - l. Each in-person evaluation and re-evaluation of the patient
  - m. 15 minute assessments of the patient status
  - n. Assistance provided to the patient to help him or her meet the behavior criteria for discontinuing restraint or seclusion
  - o. Continuous monitoring
  - p. Debriefing of the patient with staff (Applies to psychiatric unit)
  - q. Any injuries or treatment for these injuries
  - r. Any deaths
8. Documentation is done in a manner that allows for data to be collected and analyzed for performance improvement activities.
  - a. Use of psychoactive medications as an alternative for or to enable discontinuation of restraint or seclusion
  - b. Participation of LIP's in measuring and assessing the use of restraint and seclusion for all patients in the hospital.

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**F. REPORTING DEATHS RELATED TO RESTRAINT OR SECLUSION**

1. Death related to restraint or seclusion will be reported to risk management who will report to the appropriate authority.
2. The organization must report to Center for Medicare and Medicaid Services (CMS) any patient death that occurs:
  - a. During restraint or seclusion
  - b. Within 24 hours after removal from restraint or seclusion
  - c. Within one week after restraint or seclusion where it is reasonable to assume that use of restraint or seclusion directly or indirectly contributed to a death.  
“Reasonable to assume” includes but not limited to deaths related to restrictions of movement, death related to chest compression, restriction of breathing or asphyxiation.
3. Reports must be made by phone to the CMS regional office by close of the next business day.
4. The date and time of the call must be recorded in the medical record.

**G. TRAINING** -Staff competency in restraint management will be maintained.

1. At minimum, physicians, other licensed independent practitioners and physician assistants authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding restraint and seclusion.  
Physicians, residents, physician assistants and Advanced Practice Nurses will receive orientation in the Restraint Policy and Procedure during their orientation to Mount Carmel Health System and annually thereafter.
2. Staff will be trained in the use of restraint and seclusion before participating in the care of a patient needing these interventions. Staff competence is assessed to determine the staff's safe use of restraint and seclusion.
3. Staff will have education, training, and demonstrated knowledge based on the specific needs of the patient population and the staff members role in the care of the patient in at least the following:
  - Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion.
  - The use of nonphysical intervention skills
  - Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition.
  - The safe application and removal of all types of restraints or seclusion used in the hospital. These aspects require return demonstrations.
  - Training in how to recognize and respond to signs of physical and psychological distress.
  - Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
  - Monitoring the physical and psychological well-being of the patient who is restrained or secluded.
  - The use of first aid and CPR



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RESTRAINT AND SECLUSION QUICK GLANCE TABLE**

	<b>Restraint use for the Non-violent patient</b>	<b>Restraint use for the Violent patient</b>	<b>Seclusion use for the Violent patient</b>
<b>Obtain time limited order</b> for restraint or seclusion from the attending physician or other LIP. (include time, date, type of restraint, reason for use, and signatures)	Prior to or immediately (within minutes) following application of restraint.	Prior to or immediately (within minutes) following application of restraint.	Immediately or as soon as possible after securing the situation
<b>Order good for up to:</b>	24 hrs	<ul style="list-style-type: none"> <li>▪ 4hrs. – adult (18 and up)</li> <li>▪ 2hrs. – adolescent (9-17)</li> <li>▪ 1hr. – child (less than 9)</li> </ul>	<ul style="list-style-type: none"> <li>▪ 4hrs. – adult (18 and up)</li> <li>▪ 2hrs. – adolescent (9-17)</li> <li>▪ 1hr. – child (less than 9)</li> </ul>
If the initial order was not obtained from the attending physician... <b>Notify the Attending Physician</b>	Within 24 hours	Within 1 hour	Within 1 hour
<b>Direct Monitoring Requirement:</b> (includes responsiveness to patient needs and maintenance of overall well being)	At least every 2 hours	Constant in person monitoring (includes attentiveness to range of motion, positioning and circulation checks)	Constant in person monitoring <u>for first hour or longer as needed by patient</u> and then by audio visual monitoring with every 15 min. in person checks.
<b>Direct Assessment Requirement:</b> (includes responsiveness to patient needs, maintenance of overall well being, and evaluation of discontinuation of seclusion or restraints)	At least every 2 hours	Every 15 min. assessments (includes attentiveness to range of motion, positioning and circulation checks)	Every 15 min. assessments
<b>Vital signs at least every:</b> (or document “inability to obtain”)	8 hrs. (or more frequently, as otherwise ordered or indicated.)	<ul style="list-style-type: none"> <li>▪ 4hrs. – adult (18 and up)</li> <li>▪ 2hrs. – adolescent (9-17)</li> <li>▪ 1hr. – child (less than 9)</li> </ul>	<ul style="list-style-type: none"> <li>▪ 4hrs. – adult (18 and up)</li> <li>▪ 2hrs. – adolescent (9-17)</li> <li>▪ 1hr. – child (less than 9)</li> </ul>
<b>Face to face physical assessment by the Attending physician, other LIP, or an RN who is trained and competent in seclusion and restraint use.</b> (includes gross physical and neuro assessment, overall well being of patient, and evaluation of continued need for seclusion and/or restraint)	At least every 8hrs.  <b>**See example following this table**</b>	Initially within 1 hour <u>and</u> thereafter at least every: <ul style="list-style-type: none"> <li>▪ 4hrs. – adult (18 and up)</li> <li>▪ 2hrs. – adolescent (9-17)</li> <li>▪ 1hr. – child (less than 9)</li> </ul>	Initially within 1 hour <u>and</u> thereafter at least every: <ul style="list-style-type: none"> <li>▪ 4hrs. – adult (18 and up)</li> <li>▪ 2hrs. – adolescent (9-17)</li> <li>▪ 1hr. – child (less than 9)</li> </ul>
▪ <b>ATTENDING PHYSICIAN</b> (or the designated covering LIP)	At least every calendar day.	Initially within the first 24 hours and at least every 24 hours thereafter.	Initially within the first 24 hours and at least every 24 hours thereafter.
▪ <b>OTHER LIP</b> at least every:  (does not have to be the attending)	N/A	<ul style="list-style-type: none"> <li>▪ 8hrs. – adult (18 and up)</li> <li>▪ 4hrs. – adolescent (9-17)</li> <li>▪ 2hrs. – child (less than 9)</li> </ul>	<ul style="list-style-type: none"> <li>▪ 8hrs. – adult (18 and up)</li> <li>▪ 4hrs. – adolescent (9-17)</li> <li>▪ 2hrs. – child (less than 9)</li> </ul>
▪ <b>Telephone order by RN</b> at least every: (The face to face nursing assessment of the patient is shared with the attending or other LIP at this time)	N/A	<ul style="list-style-type: none"> <li>▪ 8hrs. – adult (18 and up)</li> <li>▪ 4hrs. – adolescent (9-17)</li> <li>▪ 2hrs. – child (less than 9)</li> </ul>	<ul style="list-style-type: none"> <li>▪ 8hrs. – adult (18 and up)</li> <li>▪ 4hrs. – adolescent (9-17)</li> <li>▪ 2hrs. – child (less than 9)</li> </ul>
<b>Documentation to include:</b> ▪ <b>Physicians' orders</b> for use of seclusion or restraint at least every:	Every 24 hours	<ul style="list-style-type: none"> <li>4hrs. – adult (18 and up)</li> <li>2hrs. – adolescent (9-17)</li> <li>1hr. – child (less than 9)</li> </ul>	<ul style="list-style-type: none"> <li>4hrs. – adult (18 and up)</li> <li>2hrs. – adolescent (9-17)</li> <li>1hr. – child (less than 9)</li> </ul>

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▪ <b>Relevant reassessments</b> of patient's condition and ongoing need for seclusion or restraint at least every:	Every 24 hours	4hrs. – adult (18 and up) 2hrs. – adolescent (9-17) 1hr. – child (less than 9)	4hrs. – adult (18 and up) 2hrs. – adolescent (9-17) 1hr. – child (less than 9)
▪ <b>Results of ongoing patient monitoring</b>	At least by the end of each assigned nurse's shift (this could be 4, 8, or 12 hrs. depending on shift length)	At least by the end of each assigned nurse's shift (this could be 4, 8, or 12 hrs. depending on shift length)	At least by the end of each assigned nurse's shift (this could be 4, 8, or 12 hrs. depending on shift length)
▪ <b>Any significant changes in patient condition</b>	As applicable	As applicable	As applicable

**24 Hour Order Renewal Example for “Non-Violent or Non- Aggressive Restraint Use”**

*(Orders are limited to 24 hours)*

**Initial Order:** Telephone or written order obtained prior to application or immediately (within minutes) following application of restraints. Order is obtained from any LIP based on RN/LIP assessment of patient restraint and safety needs.

**Every 2 hrs:** RN assesses patient for physical and emotional well-being and evaluates the possibility of discontinuing the restraint.

**Every Shift:** Vital signs every 8 hours AND  
RN documents "end of shift" results of patient monitoring, prior to leaving her assignment.

**Within 24 hrs:** RN notifies the attending physician of the restraint use (if unaware) AND  
The attending physician (or LIP designee) evaluates the patient in person for the ongoing need for the restraint, AND  
The attending physician (or LIP designee) renews the order if indicated.

**Every Calendar Day:** The attending physician (or LIP designee) evaluates the patient in person for the ongoing need for the restraint, AND  
The attending physician (or LIP designee) renews the order if indicated.

**24 Hour Order Renewal Example for “Violent or Aggressive Restraint/Seclusion Use”**

*(Orders are limited to 4, 2, or 1 hr. (depending on patient's age)*

**Initial Order:** Emergency telephone order obtained by RN from any LIP or written LIP order. Orders are based on patient's environmental restriction and safety needs .Order is obtained prior to application or immediately (within minutes) following application of restraint.

**Within 1 hr:** RN notifies the attending physician (or LIP designee) of the restraint use (if unaware), including assessment of patient's gross physical and emotional status and reviews the medication regimen with the physician AND  
RN documents: assessment of patient condition, reason for and response to the environmental restriction, less restrictive alternatives attempted first, patient and family education regarding the intervention, behaviors to be displayed prior to discontinuation of the environmental restriction, and the care being provided to the patient

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- Every 4 hours:** Vital signs documented (or documented as unable to obtain)
- Every Shift:** RN documents "end of shift" results of patient monitoring, prior to leaving her assignment.
- \*\*4 Hrs from start:** Attending physician (or other LIP) renews order based on own direct patient observation and assessment with documentation of same.
- 4 Hrs later:** RN obtains telephone renewal order from LIP or attending based on own direct patient observation and assessment with documentation of same
- \*\*4 Hrs later:** Attending physician (or other LIP) renews order based on own direct patient observation and assessment with documentation of same.
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- 4 Hrs later:** RN obtains telephone renewal order from LIP or attending based on own direct patient observation and assessment with documentation of same

*\*\*At least one of the starred order renewals MUST be completed by the ATTENDING physician and continue on an "every 24 hour cycle" after that.*