



## MONTANA STATE HOSPITAL POLICY AND PROCEDURE

### USE OF SECLUSION AND RESTRAINT

**Effective Date:** November 15, 2013

**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 that, 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 that 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 that 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 Physician/Licensed Independent Practitioner (LIP) 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 Physician/LIP 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: A drug used as a restraint is 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 Physician/LIP and face to face evaluation by a Physician/LIP 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 Physician/LIP 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 that 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. Trained staff: Includes Physician/LIP, RN, PA or other licensed nursing staff and direct care staff that has 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 are responsible for 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 shall conduct 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 Patient Safety Review Committee will perform an administrative review of selected seclusion and restraint procedures.
- D. Seclusion or restraint shall be utilized only in cases of emergency and imminent risk of significant violence or self-destructive behavior, when other less restrictive methods have been determined to be ineffective to protect the patient, a staff member, or others from harm. Alternative approaches must be considered prior to the use of seclusion/restraint.
- E. Staff shall make all efforts to preserve the privacy, safety, human dignity, and the physical and emotional comfort of the patient at all times.
- F. Staff shall ensure that 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.
- G. 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.
- H. 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.
- I. Sufficient numbers of trained staff shall be present to accomplish placement in seclusion and/or restraint in the safest manner possible.

- J. 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.
- K. 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 an LIP. This direction and exception must be documented. If/when audio/visual monitoring is authorized it must be delivered in close proximity to the patient. 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 that the uninterrupted in-person observation for the first hour is deemed detrimental to the patient, the LIP/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 Superintendent. 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.**

- L. Staff shall provide patients in restraint with constant one-to-one uninterrupted in-person observation.
- M. Direct Care Staff, in close consultation with and direction from the Physician/LIP or Registered Nurse will:
  - 1. Promptly notify the Physician/LIP 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 Physician/LIP and RN.

5. Monitor vital signs at least every two 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.
6. 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.
7. Change the patient's linen, bedding, and clothing promptly as it becomes soiled.
8. Offer fluids at least hourly unless fluids are restricted by a physician's order. Meals and snacks will be offered at regular intervals.
9. Offer the patient use of toilet facilities or a bedpan/urinal at least hourly and whenever a patient requests a need.
10. Allow and/or assist the patients 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 patients 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.
11. 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.
12. Promptly inform RN about any changes in a patient's behavior or physical condition including when the patient appears calm.
13. Participate in event review process.
14. 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.

N. 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 Physician/LIP of the patient's behavior, alternative approaches used to avoid restraint/seclusion and level of procedure implemented on an emergency basis. Inform Physician/LIP 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 Physician/LIP 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 Physician/LIP 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 Physician/LIP must occur every (24) twenty four hours.
4. A Physician/LIP 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 Physician/LIP as soon as possible upon completion of assessment.
6. Notify the patient's attending Physician/LIP by phone message and nursing report as soon as possible regarding the seclusion/restraint procedure.
7. Notify the Physician/LIP when renewal orders are needed.
8. 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 2 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;
9. Obtain additional physician'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).
10. Supervise and assist staff in the safe implementation of seclusion and restraint procedures.
11. Direct the reduction of the level of restraint and the termination of the procedure when the criteria for release as set by the Physician/LIP is met and the patient is no longer an imminent risk of significant violence or self-destructive behavior.
12. 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.
13. Following a patient's release from Seclusion or Restraint, the Nurse/LIP 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.

14. 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 Physician as authorized by the Medical Director or Hospital Superintendent. 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.

O. Physician Assistants (PA) will:

1. A Physician/LIP 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 Physician/LIP as soon as possible upon completion of assessment.

3. Notify Registered Nurse of the outcome of the face to face evaluation.

P. Physicians/Licensed Independent Practitioners (LIP):

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 Physician/LIP 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 that clearly state:

- 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 Physician/LIP 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 physician/LIP must see and assess the patient.
5. Participate in the review process as indicated.
6. The attending Physician/LIP 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.
  4. Inform the Hospital Superintendent of all procedures that last more than 24 hours.
- Q. Quality Improvement Director is responsible for tracking use of these procedures throughout the hospital and disseminating data about use of restraint and seclusion to all staff members.

R. Hospital Superintendent is responsible for

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 incidents that do occur and utilizing 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 Superintendent or designee will report to CMS each death that occurs while a patient is in restraint or seclusion; each death that occurs within 24 hours after the patient has been removed from restraint or seclusion or each death known to the hospital that occurs within one week after restraint has been removed or seclusion has ended, when it is reasonable to assume that 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. Physician/LIP 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/LIP 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 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 Nurse Manager and or Program Manager will ensure that a copy of every Seclusion and Restraint Intervention Order/Progress Note is forwarded to the Quality Improvement Director.
3. 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 Superintendent, Quality Improvement Committee, Medical Director, Director of Nursing Services, and to the medical staff.
4. The Hospital Superintendent or designee will report to CMS each death that occurs while a patient is in restraint or seclusion; each death that occurs within 24 hours after the patient has been removed from restraint or seclusion or each death known to the hospital that occurs within one week after restraint has been removed or seclusion has ended, when it is reasonable to assume that 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.

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 patients behaviors, events and environmental factors that 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 that indicate that 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, Physicians/LIPs will be trained to provide face to face evaluations and will be trained in the review of systems, medications, and labs.
- h. 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.

F. Equipment Maintenance

1. Assigned nursing personnel will examine all restraint devices upon each application and no less than monthly to ensure devices are working properly, are clean, and are in good repair. Documentation of the monthly review will be included on a chart that is to be kept on each treatment unit where devices are stored.

**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.

**VI. COLLABORATED WITH:** Director of Nursing Services, Medical Director, Hospital Superintendent, Quality Improvement Director

**VIII. RESCISSIONS:** #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. REVIEW AND REISSUE DATE:** November 2016

**XI. FOLLOW-UP RESPONSIBILITY:** Director of Quality Improvement

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- XII. ATTACHMENTS:** [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](#)

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
John W. Glueckert                      Date  
Administrator

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Thomas Gray, MD                      Date  
Medical Director

## LIST OF APPROVED RESTRAINTS

1. Physical Hold – Body holds that temporarily restrict a patient’s freedom of movement. All documentation and care procedures will be completed in the same manner used for other restraints.
2. Emergency Transport Restraints – Wrist and ankle restraints or the transport blanket may be used for brief periods to safely transport a patient exhibiting behaviors of imminent dangerousness. 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 patient to a safe location within a treatment unit. Use of emergency transport restraints requires an order by a physician/LIP with documentation and review required just as with all other use of restraint procedures.
3. Chair Restraint – Patients may be restrained to an appropriate chair designed for this purpose when a physician/LIP orders such an intervention. Restraints including belts, cuffs, soft ties, pelvic posey and anklets.

All restraints must be secured to the frame of the chair with buckles either padded or located away from the patient's body. Chair restraints may include waist only, waist/wrist, or full as specified in the physician/LIP order. Chair restraint is allowed only if the patient is provided appropriate privacy throughout the duration of the intervention.

4. Bed Restraint – Belts, nylon webbed belts, cuffs, soft ties, or combinations of soft ties may be used to restrain patients to a bed when necessary for the patient's self-protection, or the protection of others.

The level of restraint used may vary according to physician/LIP order and clinical judgment. At a minimum, the patient is to be restrained at the waist and one ankle. Additional limbs (other ankle and wrists) may also be restrained if necessary.

All restraints will be securely fastened to the frame of the bed. All buckles and other protrusions from restraint devices will be padded or located so that they do not rub against the patient's body.

The term Full Restraints refers to the placement of a patient on a bed with restraints applied to the waist, each ankle, and each wrist. Any modification increasing the level of full restraints necessary to ensure patient safety requires a physician/LIP order describing the type, placement of restraint, and justification for the modification.

The term Waist and Ankle Restraints refers to the placement of a patient on a bed with restraints applied to the waist and one or both ankles.

5. Waist/Wrist Ambulatory Restraints – Patients may be placed in waist/wrists ambulatory restraints.
6. Other Types of Restraint – Occasionally it is necessary to use other restraint procedures (e.g., placing a person's hands in mittens to reduce the risk of self-injury or use of pelvic posey). In such a case, a physician/LIP order is obtained in advance and must specifically designate the type of restraint to be used. All documentation and care procedures will be completed in the same manner used for other restraint procedures.
7. Prohibited Restraint Devices – *Handcuffs or other law enforcement types of restraint devices are prohibited.*



**MONTANA STATE HOSPITAL  
SECLUSION/RESTRAINT ORDER and PROGRESS NOTE FOR VIOLENT OR SELF-DESTRUCTIVE  
BEHAVIORS**

**Patient Name:** \_\_\_\_\_ **MSH #:** \_\_\_\_\_ **Unit:** \_\_\_\_\_

Antecedents/Behaviors leading to procedure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe Methods Used to Avoid Restraint and Seclusion: i.e. verbal reassurances/redirection, 1:1 interaction, stimuli reduction, diversional activities, ventilation of feelings, environment change, and medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Concerns:**  Obesity  Spinal Injury  Pregnancy  Recent Emesis  Hx of Seizures  
 Diabetes  Cardiac  Respiratory (URI, asthma)  Recent food/fluid intake  Hx of Trauma  
 Compromised skin integrity  Severe exertion associated with procedure  No injury noted  
 Injury at time of procedure (describe): \_\_\_\_\_  
 Others: \_\_\_\_\_

***1:1 FOR DIRECT OBSERVATION ASSIGNED***

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **RN Signature:** \_\_\_\_\_

<input type="checkbox"/> <b>PHYSICIAN/LIP ORDER (Valid up to 4 hours)</b>	<input type="checkbox"/> <b>ATTENDING LIP CONTACTED</b>
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**RATIONALE FOR SECLUSION AND/OR RESTRAINT**

**Initiated:** **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Original Order date:** \_\_\_\_\_ **Time:** \_\_\_\_\_  
 Imminent Danger to Self  Imminent Danger to Others  
 Other - Explanation: \_\_\_\_\_

**Patient to be placed in:**  Seclusion  Full bed restraints  Full Chair Restraints  Transport Blanket  
 Physical Restraint/Hold  
 Other (Explain): \_\_\_\_\_

**RELEASE CRITERIA (as specified by Physician/LIP):** \_\_\_\_\_  
\_\_\_\_\_

**VO/PO RN:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Physician/LIP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**INITIAL FACE TO FACE ASSESSMENT**

**THIS PAGE TO BE COMPLETED BY PHYSICIAN/LIP, A PHYSICIAN ASSISTANT, OR TRAINED REGISTERED NURSE WITH IN ONE HOUR OF THE ONSET OF THE PROCEDURE**

**Behavior leading to procedure:** \_\_\_\_\_

**Rationale for use of procedure:** \_\_\_\_\_

**Patient's immediate situation / Patient's reaction to the intervention:** \_\_\_\_\_

**Current behavior/mental status:** \_\_\_\_\_

**Physical Health Assessment**

**\*Vital Signs must be completed every 2 hour-if unable to obtain document**

Date Time	T	P	R	B/P	O2 SAT	Medication Reviewed c LIP	Labs Reviewed c LIP	Restraint Applied Properly	Initials

**Circle as appropriate:**

- |                         |                  |                       |
|-------------------------|------------------|-----------------------|
| <b>Circulation/skin</b> | <b>Hydration</b> | <b>Mobility</b>       |
| Intact                  | Fluids           | Ambulatory            |
| Skin Color WNL          | Refused          | Moves all extremities |
| Temp WNL                |                  |                       |
| Cap Refill <3sec        |                  |                       |

**Following explained to patient: [ ] Reason for Restraint/Seclusion [ ] Behavioral criteria for release**

**Interventions implemented to assist in meeting release criteria and active treatment provided:** \_\_\_\_\_

**Plan for continuing care to include continuing or terminating the procedure:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **MSH #:** \_\_\_\_\_ **Unit:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Physician/LIP or trained RN Signature:** \_\_\_\_\_

**RN ASSESSMENT Required at Least Every Hour**

**Current situation & behavior/mental status:** \_\_\_\_\_

\_\_\_\_\_

Behavior Descriptors: Tense, Excited, Unpredictable, Labile, Threatening, Verbal outburst, Hostile, Disorientated/Orientated, Calm, Resting

*\*Imminent risk of significant violence or self-destructive behavior requiring the emergency use of seclusion or restraint must be documented every hour.*

**RN Physical Health Assessment**

**\*Vital Signs must be completed every hour-if unable to obtain document**

Date Time	T q 2 hr	P q 2 hr	R q 2 hr	B/P q 2 hr	O2SAT	Restraint Applied Properly	ROM q 2 hours	Initials

**Circle as appropriate:**

- |                         |                            |                    |
|-------------------------|----------------------------|--------------------|
| <b>Circulation/skin</b> | <b>Nutrition/Hydration</b> | <b>Elimination</b> |
| Intact                  | Meal                       | Urine              |
| Skin Color WNL          | Snack                      | Stool              |
| Temp WNL                | Fluids                     | Incontinent urine  |
| Cap Refill <3sec        | Refused                    | Incontinent stool  |

**Comments:** \_\_\_\_\_

**Following explained to patient:**  Reason for Restraint/Seclusion  Behavioral criteria for release

**Interventions implemented to assist in meeting release criteria and active treatment provided:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Plan (need to continue or discontinue procedure):** \_\_\_\_\_

**Current Level of Procedure:**  Seclusion  Full Bed Restraints  Full Chair Restraints

Other: \_\_\_\_\_

Discontinue Seclusion: Time \_\_\_\_\_

Discontinue Restraints: Time \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **MSH #:** \_\_\_\_\_ **Unit:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Physician/LIP or trained RN Signature:** \_\_\_\_\_

MONTANA STATE HOSPITAL  
SECLUSION/RESTRAINT ORDER FOR VIOLENT OR SELF-DESTRUCTIVE INDIVIDUALS

Patient Name: \_\_\_\_\_ MSH #: \_\_\_\_\_ Unit: \_\_\_\_\_

**New Physician's Order required q 4 hours up to 24 hours.**

**Physician must conduct a face-to-face evaluation of a patient who has been secluded or restrained every twenty four (24) hours (from the time of implementation) for as long as the procedure continues.**

**RATIONALE FOR SECLUSION AND/OR RESTRAINT**

**Initiated: Date: \_\_\_\_\_ Time: \_\_\_\_\_ Original Order date: \_\_\_\_\_ Time: \_\_\_\_\_**

Imminent Danger to Self       Imminent Danger to Others

Other - Explanation: \_\_\_\_\_

**Patient to be placed in:**  Seclusion  Full bed restraints  Full Chair Restraints  Transport Blanket

Physical Restraint/Hold

Other (Explain): \_\_\_\_\_

**RELEASE CRITERIA (as specified by Physician/LIP):** \_\_\_\_\_

**VO/PO RN:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Physician/LIP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

## LESS RESTRICTIVE MEASURES TO SECLUSION OR RESTRAINT INTERVENTIONS

- \* The main goal of de-escalation training is to teach how to effectively preempt potentially negative or even dangerous situation. Developing a good working relation with individuals served by the hospital is paramount when preempting or intervening with an individual who is escalating.
- \* The program presents a system of gradual and graded alternatives for deescalating and managing people, using interpersonal skills.
- \* Options include:
  - Allow the patient to feel all his/her feelings
  - staff's actions need to be motivated by need to protect and teach,
  - identifying anger as an emotion/anger is okay, and
  - understanding fear as an instinct/fear is okay
- \* Crisis cycle – 6 phases – 6 responses
  - Response 1: *Removal of or From Stimuli* – Stay calm, search for the person's trigger mechanisms, and be an active and not a judgmental listener.
  - Response 2: *Offer Appropriate Options* – Avoid either/or choices, communicate understanding, allow the person to exercise his/her personal freedom and rights, use diversion and/or distraction, channel feelings into a positive direction or creative activity such as music.
  - Response 3: *Least Amount of Interaction Necessary* – Stay calm, don't overreact, careful about tone of voice and choice of words.
  - Response 4: *Structured Cooling Off* – Removal of or from stimulus e.g. time out, go for a walk, time alone in quiet day hall, avoid either/or choices, diversion and/or distraction, humor, food, one to one, read a book, or write in a journal.
  - Response 5: *Active Listening* – Use good nonverbal and verbal skills, give reassurance, find out what problem is, communicate with team (more options).
  - Response 6: *Observation and Support* – Rest and quiet time, give reassurance, help person to understand feelings, allow person to save face, and maintain dignity.