Major Hospital A Major Health Partner	Use of Restraint and Seclusion NS-14
Does this policy meet a regulatory standard? Yes _X___ No ____	Formulated by: Restraint Team Approved by: Nurse Executive Council Effective Date: 7/1998

PURPOSE:

To establish standardized decision-making criteria and practical procedures for the use and discontinuation of restraints to protect the patient's health and safety and safety of others, as well as to preserve the patient's dignity, rights, and well-being.

SCOPE:

Applies to all staff members who provide patient care, who may assist with the application of restraints and who monitor patients in restraints or seclusion.

DEFINTIONS:

Restraint: Any manual method, physical or mechanical device, material, or equipment immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

Siderails: are used to restrict the patient's freedom to exit the bed. The use of side rails is inherently risky, particularly if the patient is elderly or disoriented. Disoriented patients may view raised side rails as a barrier to climb over, slide between raised rails, or scoot to the end of the bed to exit the bed. Exiting the bed by the above routes places the patient at risk for entrapment, entanglement or fall from a greater height. The risk presented by the side rail use should be weighed against the risk presented by the patient's behavior through individualized assessment.

Chemical: A drug or medication when it is used as a restriction to manage or control a patient's behavior or restrict freedom of movement or normal access to one's body and is not standard treatment or dosage for the patient's condition.

If the overall effect of a drug/medication or combination of drugs/medications, is to reduce the patient's ability to effectively or appropriately interact with the world around them, the drug/medication is not being used as a standard treatment or dosage for the patient's condition.

Physical hold: Physically holding a patient in a manner that restricts the patient's movement against his/her will is considered a restraint, including therapeutic holds; for example, when holding a patient to administer an IM injection of a medication used as a chemical restraint.

**Excluding instances when physical hold is necessary for the purpose of conducting a physical exam and/or when a patient requests to be held for injection or procedure*.

Seclusion: is the involuntary confinement of a patient alone in a room or area from which the patients are 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, staff member, or others.

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

Simultaneous use of seclusion and physical restraints are not used at MHP

Violent or Self-Destructive Restraint: Restraint is used to manage behaviors which are unanticipated, severely aggressive or destructive behavior placing the patient or others at an imminent risk of harm and non-physical intervention has not been effective. Includes soft limb, locking limb, chemical, physical hold, and seclusion types of restraint.

Non-Violent or Non-Self-Destructive Restraint: Restraint is used to manage behaviors which interfere with medical/surgical healing. Such as when a patient attempts to remove a line, tube, drain, or another medical device.

Episode: The time the restraint is initiated (applied) until the time all restraints are discontinued. It is the period from START to Discontinue; there may be multiple orders within an episode.

Time Out: An intervention in which the patient consents to be alone in a designated area for An agreed upon timeframe from which the patient is not physically prevented from leaving.

Alternative Measures: Interventions taken to modify the environment, enhance interpersonal interactions, or provide treatment in efforts to minimize or eliminate the behaviors/problems which places the patient at risk.

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Policy:

All patients have the right to be free from physical or mental abuse and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint and use of seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

A comprehensive assessment of the patient must determine that the risks of using restraint or seclusion are outweighed by the risk of not using restraint or seclusion. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff, and others from harm.

The use of restraint must be:

1. In accordance with a written modification to the patient's plan of care.
2. Implemented in accordance with safe and appropriate restraint techniques as determined by hospital policy in accordance with state law.
3. Alternatives to restraint are always considered before restraints are used. Due to the risks and consequences of use, staff will use the least restrictive, safest and most effective method(s) to protect the patient, staff, and others from harm.
4. Non-physical techniques are the preferred intervention in the management of behaviors, and restraint/seclusion are only used when non-physical interactions are ineffective or not viable.
5. The condition of the patient who is restrained or under seclusion must be monitored by a physician, other LIP or trained staff that has completed the training criteria listed in this policy.
6. All restraints or seclusion use are documented at specified time intervals based on type of restraint in EHR; documentation includes:
    - 6.1. Face to Face medical and behavioral evaluations (violent restraint use only)
    - 6.2. Order including:
        - 6.2.1. Specific location of restraint
        - 6.2.2. Type of restraint
        - 6.2.3. Description of patient behavior and intervention used
    - 6.3. Alternative or other less restrictive interventions used prior to initiation of restraint or seclusion.

6.4. Patient condition or symptoms that warrant the use of restraint or seclusion
6.5. Patient response to intervention(s) used, including rationale for continued use of the intervention.
6.6. Patient's knowledge of criteria to be met for restraint or seclusion discontinuation.
6.7. Care plan modification

Order requirements:

7. Must be in accordance with the order of a physician or other licensed independent practitioner (LIP) who is responsible for the care of the patient and authorized to order restraint by hospital policy in accordance with state law.
   7.1. Only MDs, D.O., NPs and RNs specially trained in restraint and seclusion may initiate and/or discontinue restraint or seclusion.
   7.2. Only RNs specially trained in restraint and seclusion may initiate the emergency application of restraint or seclusion prior to obtaining an order from a physician or other LIP. The order must be obtained either during or within the immediate 15 mins following initiation.
   7.3. The physician or independent licensed practitioner who has the authority and privileges to order restraints as permitted by state law and hospital policy must be consulted within 15 mins if the attending physician did not order the restraint.
   7.4. The physician or independent licensed practitioner must see and evaluate the need for restraint or seclusion use within (1) hour after application; orders are required with initiation of restraint or seclusion use within (1) hour after application.
   7.5. If a patient is no longer in restraint at the end of verbal order, the physician or independent licensed practitioner must still see and evaluate the patient within one hour (Indiana Family and Social Services Administration, 2025).
   7.6. Physician order must include:
      7.6.1. Restraint type
      7.6.2. Restraint location
      7.6.3. Behavior Requiring restraint/seclusion
8. Orders for the use of restraint **must never be** written as a standing order or on an as needed basis (PRN).
9. **NON- VIOLENT** restraint order must be renewed for each calendar day, and the ordering practitioner does not have to be physically present to re-evaluate the need for continuing the restraint.

9.1. If a restraint location and/or type are changed at any time, a new order is required.

10. **VIOLENT** self-destructive restraint including seclusion and chemical:
    10.1. Orders are time limited. Maximum length of original order is age dependent & each order may be renewed with the following limits up to a total of 24 hours:
        10.1.1. 18 years older – 4 hours
        10.1.2. Age 9-17 years – 2 hours
        10.1.3. Age 0-8 years – 1 hour
11. After 24 hours, before writing a new order for the use of restraint for the management of violent or self-destructive behavior: a physician or other licensed independent practitioner who is responsible for the care of the patient must see and complete a face-to-face assessment.

Discontinuation of restraint/seclusion orders:

12. Restraint(s) must be discontinued at the earliest possible time, guided by ongoing clinical evaluation and patient safety considerations regardless of the length of time identified in the order.
    12.1. The decision to discontinue the intervention should be based on the determination that the patient's behavior is no longer a threat to self, staff members or others.
        12.1.1. Rationale for restraint removal includes mental status has returned to baseline, acting appropriately, no longer combative, condition has improved.
13. Registered Nurses are authorized to remove and discontinue (including placing a verbal order to remove) non-violent restraints when medical device being protected is no longer in use and/or has been discontinued, provided the patient no longer poses a risk or self-harm or interference with medical treatment allowing the restraint to be discontinued at the earliest possible time. The decision must be based on clinical judgement and documented in the medical record.
14. If the restraint is discontinued prior to the expiration of the order, **a new order** must be obtained prior to the re-initiation of the restraint.
15. If the restraint location is changed or an additional restraint is applied, a new order is required.

Violent restraint requirements:

16. When a physical restraint, chemical restraint or the use of seclusion is used for the management of violent or self- destructive behavior that jeopardizes the immediate physical safety of the patient, staff member, or others, the patient must be housed in CCU/ER and the charge nurse be notified.
17. Face to face evaluation
    - 17.1. The patient must be seen face-to-face within one (1) hour after the initiation of the intervention by a Physician or other licensed independent practitioner.
    - 17.2. If a Physician or other licensed independent practitioner is not present when restraints are applied, then a Physician assistant or RN, who has been trained in accordance with the requirements specified in this policy, may complete the 1 hour face-to-face.
    - 17.3. If the face-to-face evaluation is conducted by a trained physician assistant, or trained RN, it is required to consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient within 15 minutes after the completion of the one (1) hour face-to-face evaluation
18. The one-hour face-to-face evaluation is to complete a comprehensive review of the patient's condition and determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior. The one (1) hour face-to-face evaluation must include:
    - 18.1. The patient's immediate situation.
    - 18.2. The patient's response to the intervention.
    - 18.3. The patient's medical and behavioral condition.
        - 18.3.1. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, medication, and most recent diagnostic tests abnormal results to be reported to the physician.
        - 18.3.2. The need to continue or terminate restraint.
19. When physical restraint, chemical restraint or seclusion is used for violent or self-destructive behavior, there must be documentation in the patient's medical record of the following:
    - 19.1. One (1) hour face-to-face medical and behavioral evaluation.
    - 19.2. A description of the patient's behavior and the intervention used.
    - 19.3. Alternatives or other less restrictive interventions attempted as applicable.
    - 19.4. The patient's condition or symptom(s) that warranted the use of the restraint.

19.5. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.
19.6. Restraint type and status.

20. Patient monitoring and reassessment:
    20.1. Emergency department patient monitoring will be completed and documented every 15 mins (+/- 5 mins) by an RN, LPN, Medic or PCT trained in patient monitoring.
    20.2. Inpatient department patient monitoring will be completed and documented every 15 mins by RN and charge nurses will be notified.
    20.3. Monitoring and documentation include:
        20.3.1. Behavior.
        20.3.2. Signs of Injury.
        20.3.3. Response to restraints.
    20.4. A comprehensive patient assessment will be completed every 1 hour (+/- 15 mins) by RN trained in restraints and seclusion. Assessment includes patient:
        20.4.1. Safety and Comfort.
        20.4.2. Circulation.
        20.4.3. Hydration and nutritional needs.
        20.4.4. Cognitive status.
        20.4.5. Skin integrity.
        20.4.6. Elimination needs.
        20.4.7. Range of motion with systematic release of restraints.
        20.4.8. Vital signs (according to individualized plan of care).
        20.4.9. Readiness for release from restraint/seclusion.
        20.4.10. Patient knowledge of restraint discontinuation criteria.
    20.5. Chemical restraint patient assessment following administration of medication includes agitation/sedation scoring according to the Richmond Agitation – Sedation scale (RASS) every 15mins x4 and then repeated every 15mins until score is >/= 0.

21. Locking restraints: keys will be kept in the following secure locations:
    21.1. Emergency Department: The charge nurse will carry a key and ED secretary has a key.
    21.2. Inpatient Department: The charge nurse will carry a key, and a key will be kept at the monitor tech desk.

Non-Violent Restraint Requirements:

22. When the restraint is used to ensure the physical safety of a non-violent or non-self-destructive patient, it is used to limit mobility or temporarily immobilize a patient's extremity to protect required medical devices.
    - 22.1. The order must be renewed each calendar day, and the ordering practitioner does not have to be physically present to re-evaluate the need for continuing the restraint.
    - 22.2. Individual care plan documentation every 2 hours (+/- 15mins) must include:
        - 22.2.1. Description of the patient's behavior and the intervention used.
        - 22.2.2. Restraint type and status.
        - 22.2.3. Alternatives or other less restrictive interventions considered.
        - 22.2.4. The patient's condition or symptom(s) that warranted the use of the restraint.
        - 22.2.5. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.
        - 22.2.6. Comprehensive assessment including:
            - 22.2.6.1. Safety and Comfort
            - 22.2.6.2. Circulation
            - 22.2.6.3. Hydration & nutritional needs
            - 22.2.6.4. Cognitive status
            - 22.2.6.5. Elimination needs.
            - 22.2.6.6. Range of motion with systemic release of restraints.
            - 22.2.6.7. Vital signs according to individual care plans.
            - 22.2.6.8. Readiness for release from restraint.
            - 22.2.6.9. Patient knowledge of restraint discontinuation criteria.

Side Rails:

Rationale for four side rails as a restraint – Medicare guidelines: The use of side rails to prevent a patient from exiting a hospital bed may pose a risk to the patient's safety, particularly for the frail elderly frame. The disoriented patient may see the side rail as a barrier to be climbed over or may attempt to wiggle through split rails or to the end of the bed to exit the bed. As a result, these patients may have an increased risk for a fall or other injury by attempting to exit the bed with the side rails raised.

22.3. **Side rails are considered a restraint when**:

22.3.1. When used to prevent a patient from voluntarily getting out of bed.

22.3.2. When the only side rail (s) lowered are at the head of the bed, i.e. only lowering one or both upper side rails.

22.3.3. Clinician raises all four side rails to restrain a patient, as defined in this regulation such as immobilizing or reducing the ability of a patient to move his or her arms, legs, body or head freely to ensure immediate physical safety of the patient, then the side rails are considered a restraint.

22.4. Request for side rails is not enough basis for use of restraint intervention.

22.4.1. A family member or POA requests a restraint intervention, such as raising all four side rails, to keep the patient from getting out of bed.

22.4.2. It is not necessary to obtain a new order each time the patient is returned to bed after being out of bed (for example during physical therapy; in chair for meals; using bathroom)

22.4.3. A patient and situational assessment to determine whether such a restraint is confirmed and the practitioner must then determine the type of restraint intervention that will meet the patient's needs with the least risk and most benefits the patient. If restraint (as defined by the regulation) is used, then the requirements of the regulation must be met. (For example, when four side rails are raised to prevent a demented/altered mental status of a patient from freely exiting the bed)

22.5. **Side Rails are not a restraint when a patient is:**

22.5.1. On a stretcher (i.e. during transport, or on ED/SCC/ACC stretcher)

22.5.2. Recovering from anesthesia

22.5.3. Sedated (i.e. while on ventilator receiving medications for sedative use, following a procedure in which conscious sedation is used until medication effects subside)

22.5.4. When patient expresses fear of falling out of bed and wishes for side rails to be raised for feeling safety while in bed.

22.5.5. Patients express the need for side rails to be in an upright position to aid in turning and repositioning self in bed.

22.5.6. Experiencing involuntary movements (seizure activity) Seizure precautions. The use of four siderails with seizure pads is a part of seizure precautions and is not considered a restraint.

22.5.7. Specialty beds with low air loss mattresses require four side rails for safety.

22.5.8. Not physically able to get out of bed on his/her own and has no impact on freedom of movement (i.e. paraplegic, quadriplegic, bed bound patients)

22.5.9. Raising fewer than four side rails when the bed has segmented side rails and would not immobilize or reduce the ability of a patient to move freely (i.e. if the side rails are segmented and all but one segment is raised, and the patient can freely exit the bed).

Staff Training requirements:

23. The patient has the right to the safe application of restraints by trained staff. Physicians and other licensed independent practitioners will maintain a working knowledge of the hospital policy regarding restraints. This will be accomplished via the orientation and credentialing process.
24. Before performing any of the actions specified in this policy, staff, as part of orientation and annual credentialing/competency assessment, must be trained and able to demonstrate competency in the application of restraints, monitoring, assessment, and providing care for a patient in restraint.
    24.1. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required biannual recertification.
25. Appropriate staff will have education and demonstrated knowledge based on the specifics of the patient population in at least the following:
    25.1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion.
    25.2. The use of nonphysical intervention skills.
    25.3. Choosing the least restrictive intervention based on an individual assessment of the patient's medical/ behavioral status or condition.
26. At Major Hospital we believe the following algorithm is a move from a least restrictive to a more restrictive environment. However, the nurse does not need to follow the algorithm if the safety of the patient or staff warrants a more restrictive plan.

26.1. Ask the patient to volunteer what techniques help them to decrease stress and offer those techniques when available.

26.2. For those who cannot provide what techniques work best for them, staff will offer the least restrictive diversion techniques, such as reorientation, adjusting lighting in the room, diversional activities and positioning.

26.3. Ask patients if a time-out away from stressors will help, if so complete time-out.

26.4. Use de-escalation techniques & therapeutic use of self.

26.5. When staff or other patients may be at risk of injury of the patient in hallways, seclusion may be needed which allows the patient to freely roam about their room but prevents them from leaving the room by stationing security outside of room.

26.6. When the patient is physically threatening staff or self-harm, restraints may be used.

26.7. Safe Application and use of all types of physical restraints used in the hospital, including training on how to recognize and respond to signs of physical and psychological distress (i.e., positional asphyxia).

26.8. Monitoring the physical and psychological well-being of the restrained patient including but not limited to:

26.8.1. Respiratory and circulatory status

26.8.2. Skin integrity

26.8.3. Vital signs

26.9. Any special requirements specified by hospital policy are associated with the one-hour face-to-face evaluation.

26.10. Clinical identification of specific behavioral change(s) indicates that restraint/seclusion is no longer necessary.

Trainer Requirements:

27. Individuals providing staff training are qualified as evidenced by education, training, and experience in techniques used to address patient behavior.
28. Staff personnel records that care for a patient population where restraints and seclusion may be used, will include required documentation for the use of restraints and seclusion.

Deaths associated with use of restraint or seclusion requirements:

29. The following information is required to be reported to CMS (Medicare)

29.1. Each death that occurs while a patient is in restraint.

29.2. Each death that occurs within 24 hours after the patient has been removed from restraint.

29.3. Each death known to the hospital that occurs within one (1) week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

29.4. Each death referenced above must be reported to CMS no later than the close

29.5. of business the next business day following knowledge of the patient's death by using FORM-10455 electronically with link provided in the internal Death Restraint Log. Staff will document the date in the patient's medical record and time the death was reported to CMS.

29.6. Deaths associated with the exclusive use of soft-2-point wrist restraints without seclusion are to be entered in an internal log which must be immediately available for CMS upon request. The name of the practitioner responsible for the care of the patient may be used in the log in lieu of the name of the attending physician if the patient was under the care of a non-physician practitioner and not a physician. Deaths to be entered in the internal log include:

29.6.1. Any death that occurs while a patient is only soft 2-point wrist restraints when no seclusion is allowed.

29.6.2. Any death that occurs within 24 hours after a patient has been removed from only soft 2-point wrist restraints.

29.6.3. Each entry must be made not later than seven days after the date of death of the patient.

29.6.4. Each entry must include:

29.6.4.1. Patient Name

29.6.4.2. Date of birth

28.6.4.3. Date of death

28.6.4.4. Name of attending physician or another licensed independent practitioner who is responsible for the care of the patient.

28.6.4.5. Medical record number

28.6.4.6. Primary Diagnosis(es)

28.6.4.7. Date and time death information recorded in internal death log.

Policy Exclusions:

30. This policy does not apply to:

30.1. If the patient can easily remove the device, the device would not be considered a restraint.

30.1.1. Easily remove means the manual method, device, material or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff. Such as patient can put side rails down, not climb over; buckles are intentionally unbuckled; ties or knots are intentionally untied by the patient.

30.2. A restraint does not include medical devices such as orthopedically prescribed devices, surgical dressings, IV arm boards, braces to assist with ambulation, medically necessary positioning devices, protective helmets, or other methods that involve physical holding for the purpose of conducting routine physical examinations or tests or to protect the patient from falling out of bed, or to permit the patient to participate in activities without risk of physical harm.

30.3. Devices and methods described here generally would not be considered restraints:

30.3.1. IV arm board to stabilize an IV line (unless the arm board is tied down, or the entire limb is immobilized such that the patient cannot access his/her body freely.

30.3.2. Mechanical support used to achieve proper body position, balance or alignment to allow greater freedom of mobility than would be possible without such use of support – such as head, neck, leg and back braces.

30.3.3. Medically necessary positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, diagnostic, or surgical procedures.

30.3.4. Recovery from anesthesia that occurs when the patient is in critical care or post- anesthesia care (PACU) is considered part of the surgical procedure therefore necessary restraint use in this setting is acceptable. However, if the restraints are maintained when the patient transfers to another unit or recovers from the effects of the anesthesia (whichever occurs first), a restraint order would be necessary, and all restraint requirements would apply.

30.4. See 21.6 above "When side rails are not restraints"

Law Enforcement Devices

31. Exempt devices include handcuffs or other restrictive devices applied by law enforcement officers (who are not working as employees of Major Hospital) for the purpose of public safety and detention. The application, monitoring, and removal of forensic devices are the responsibility of the enforcement officers. The hospital and its staff are responsible for providing safe and appropriate health and medical care to these individuals during their hospitalization.

Pediatric Population:

32. Placement of an infant or toddler in the crib with raised rails would not be considered a restraint.
33. Age or developmentally appropriate protective safety interventions, such as stroller safety belts, swing safety belts, highchair lap belts, raised crib rails and crib covers that safety conscious childcare providers outside a health care setting would utilize to protect an infant, toddler or preschool aged child would not be a restraint.

Quality Assurance and Performance Improvement

34. Hospital leadership
    - 34.1. Assesses, monitors, and reports on the use of restraint or seclusion through data collection to identify trends or gaps in care and utilize it to reduce the incidence of restraint use and incidents related to restraint use.
    - 34.2. Ensures the hospital complies with the requirements set forth by ACHC standards as well as those set forth by State law and hospital policy when the use of restraint or seclusion is necessary.

35. Reviewed & Revised

Reviewed	Revised
7/01	10/07
5/16	12/10
	12/13
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	8/15

	5/16
	11/16
	8/18
	1/19
	2/19
	6/20
	2/22
	8/23
	5/24
	7/14/2025
	12/3/2025

References &/or Standards listed here.

ACHC Chapter 15 Patient Rights and Discharge Planning, 15.02.00 Restraint and Seclusion 2025.

AS-79 Major Hospital Use of Weapons Policy
FSSA DMHA Seclusion and Restraint Rule (Indiana rules on use of restraint and seclusion)

Indiana Family and Social Services Administration. (2025). *Seclusion and restraint*. IN.gov. https://www.in.gov/fssa/dmha/forms-documents-and-tools/consumerhttps://www.in.gov/fssa/dmha/forms-documents-and-tools/consumer-issues/seclusion-and-restraintissues/seclusion-and-restraint

Federal Register: November 29, 2019, 84FR 51732, Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Part 482.13, Medicare and Medicaid Programs, Hospital Conditions of Participation: Patient's Right: Final Rule.

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