Policy Name:	Restraints for Nonviolent, Non-Self-Destructive Patient Situations: Medical Use of Restraints
Policy Number:	None
Department:	Patient Care Policy Committee
Functional Area:	Patient Care
Contributing Department	Behavior Health
Approved by:	Patient Care Policy Committee, CNO/CCO
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Manual	Care Giving
Section	Fundamental Procedures

I. Mission, Vision and Values

This organization aims to ensure its Mission, vision, and values are reflected in all organizational-wide policies, procedures, and guidelines. This policy reflects our values human dignity and service by respecting a patient's right to be free from restraint and seclusion while maintaining a safe environment for patients, staff, and visitors.

II. 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 or 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." CMS §482.13(e).

Bon Secours Mercy Health strives to provide an environment that is restraint free and to protect the patient's health and safety and preserve his/her dignity, rights, and well-being. Limited use of restraints is an interdisciplinary process that is supported by administrative leadership, medical staff, nursing staff, and other disciplines. Patients will be maintained in the least restrictive environment conducive to their safety and general well-being. The process to prevent/reduce the use of restraints is encompassed along the care continuum to continuously improve our practice.

III. Purpose

A. Bon Secours Mercy Health strives to provide an environment that is restraint and seclusion free and to protect the patient's health and safety and preserve his/her dignity, rights, and well-being. Limited use of restraints is an interdisciplinary process that is supported by administrative leadership, medical staff, nursing staff, and other disciplines.

B. Patients will be maintained in the least restrictive environment conducive to their safety and general well-being.

C. The process to prevent/reduce the use of restraints and seclusion are encompassed along the care continuum to continuously improve our practice.

IV. Scope

Patient Care Services – All Patients

V. Procedure

A. ASSESSMENT

Restraints may be used in response to limit mobility or, temporarily immobilize a patient related to a medical condition or post-surgical or dental procedure. Any use of restraint is based on the assessed needs of the patient by a physician / provider, or Registered Nurse and assures that the patient and his or her rights, dignity, and well-being are preserved. Assessment considers the risks associated with vulnerable patient populations, such as emergency and cognitively- or physically limited individuals or other situations where restraint may be contraindicated.

B. CLINICAL JUSTIFICATION

1. The use of restraints is limited to clinically appropriate and adequately justified situations in which the individual's actions pose an imminent risk of injury to self and/or serious disruption of treatment (medical necessity). Clinical Justification for Non-Violent restraints may include:
    a) Pulling at lines, dressing or equipment
    b) Involuntary movement to cause harm

C. ALTERNATIVES – Least Restrictive

1. The organization's culture promotes a physical and social environment that minimizes the use of restraint through preventive or alternative strategies. The use of restraint occurs when other less-restrictive interventions have been attempted but found ineffective for providing a safe and therapeutic environment for the patient, staff, and others.
2. Alternative actions include, but are not limited to:
    a) 1:1 patient care
    b) Repositioning
    c) Reevaluate equipment
    d) Disguise equipment
    e) Reorientation
    f) Verbal redirection
    g) Diversional Activities
    h) Review Medication (Side Effects)
    i) Pain Management
    j) Alarm

D. RESTRAINT ORDER (to manage non-violent or non-self-destructive behavior)

1. An order from a physician or authorized practitioner is required for all instances of restraint.
    a) Orders must be time limited and may extend only to midnight of the day after the order is written (every calendar day).
    b) Each episode of restraint use must be associated with a new order.
    c) PRN orders ARE NOT permissible.
    d) Clinical justification for the restraint must be included in the order.
    e) Type of restraint to be used must be designated.
    f) Forensic Restraints applied by Law Enforcement are not applicable for a physician order.

E. INITIATION

1. In emergency situations, if a provider is not available to issue an order, physical restraint can be initiated by a registered nurse based on an appropriate assessment of the patient.

a) If the registered nurse initiates the restraint, an order must be obtained from the physician/provider as soon as possible, once patient is safe and stable.

b) If the provider is not immediately available, a telephone order is to be obtained.

2. If the attending physician did not order the restraint or seclusion, the attending physician must be notified as soon as possible.
3. Patient assessment by a physician/provider is required within 24 hours of the initial order and every calendar day thereafter.

NOTE: Any patient placed in 4-point restraints constitutes an unusual situation and must be reported immediately to the Administrative Director or Nursing Supervisor and within 4 hours to the facility Chief Nursing Officer or designee.

F. SAFE APPLICATION / MONITORING / DOCUMENTATION / REMOVAL

1. Safe Application

a) The RN may apply/administer the restraint may direct trained staff (includes but not limited to; LPN, TA/CNA/ PCA/ PCT, BHT, Protective Services under supervision of the RN) who have completed restraint education and competency, in the appropriate and safe application of restraint.

b) If facilities choose to include protective services in the application of restraints, protective service staff must be trained in the application of clinical restraints at the same level as nursing and support staff.

c) An explanation will be given to the patient and, as appropriate, family regarding the reason for the use of restraint and the requirements for discontinuation.

d) Restraints are contraindicated for patient patients on Bipap. The patient should be able to remove the mask in the event of vomiting.

e) It is noted that in the rare or limited situations that the use of restraints is required in the prone position additional observation is required due to the risk of asphyxiation."

f) Exceptions: Restraint is differentiated from mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures that are considered a regular and usual part of such procedures. Restraint or seclusion does not include:

i. Standard practices that include temporary immobilization or limitation of mobility related to medical or dental, diagnostic, or surgical procedures and the related post-procedure care processes (for example, surgical positioning, IV arm boards, radiotherapy procedures, physically holding children, protection of surgical and treatment sites in pediatric patients, electroconvulsive therapy, psychosurgery). Physical holding of a site when the patient consents and or requests stabilization assistance during a procedure or injection but is unable to hold still for safe deployment of the procedure is not considered restraint.

ii. Recovery from anesthesia when the patient is in PACU, or critical care is considered part of the surgical procedure; medically necessary restraint use would not need to meet the requirements of the regulation (i.e., raising side rails).

iii. Devices used for adaptive support (i.e., orthopedic appliance, braces, and wheelchair) used to maintain postural support of the patient or assist in obtaining/maintaining normative bodily functioning or medical protective devices (i.e., helmets, padded side rails for seizure patients).

iv. Seat belt use when transporting a patient in a wheelchair is considered a prudent safety intervention.

v. Hand mitts and self-releasing roll belts are not restraints if the patient has documented education and can easily and intentionally remove them.

vi. Forensic and correctional restrictions/devices used for security purposes are considered law enforcement restraint devices.

vii. Scheduled PRN medications used as part of the standard treatment regime.

g) Devices That Serve Multiple Purposes

i. Geri chair, recliners, or side rails are devices that may serve multiple purposes. When they have the intent of restricting a patient's movement and cannot be easily removed by the patient, these devices may constitute a restraint.

ii. Geri Chair Examples:

a. Restraint Example – If the chair has an overlap tray in a locked position, it may be considered a restraint if the intent is to effectively physically restricts a person's freedom of movement, physical activity, OR normal access to his or her body.

b. Non-Restraint Example - If the patient is in a Geri Chair for comfort or positioning and not for the purpose of restricting movement, it is not considered a restraint.

iii. Recliner Example:

a. Restraint Example – If the chair is reclined and in a locked position, it may be considered a restraint if the intent is to effectively physically restricts a person's freedom of movement, physical activity, OR normal access to his or her body.

b. Non-Restraint Example - If the patient is in a recliner for comfort or positioning and not for the purpose of restricting movement, it is not considered a restraint.

iv. Side Rails Example:

a. Restraint Example – 4 siderails (or 2 full length siderails) in the up position are considered a restraint.

b. Non-Restraint Example - Padded side rails for seizure precautions or side rails up for rotation/percussion/vibration

c. Raised siderails on stretchers or transport carts are permitted and are not considered a restraint

Note: Restraints should be avoided in patients who use sign language to communicate. If needed, restraints may release for communication with the patient.

2. Monitoring / Documentation

a) A patient's physical and emotional needs are considered while the individual is in restraint. The basic rights of human dignity and respect are maintained, and physical wellbeing is preserved through adequate exercise, nourishment, and personal care.

b) Monitor changes in the individual's clinical condition that may allow a less restrictive method or termination of physical restraints. Release patient if application criteria no longer exist.

c) Assessment of the patient during restraint use is the responsibility of the Registered Nurse or LPN under supervision of the RN. Trained or unlicensed staff may perform components of monitoring (i.e., checking vital signs and hydration; the patient's skin integrity and appropriate fit of restraint) and may also provide for general care needs (i.e., eating, hydration, toileting, range of motion).

d) Every 2 hours, perform the following:

i. Continued Justification

ii. Visual /Safety check

iii. Circulation / Skin Integrity
iv. Range of Motion
v. Fluids
vi. Food and Meal
vii. Elimination

e) Vital signs as indicated by patient status.

NOTE: Patient needs, and situational factors may require more frequent documentation.

3. Removal
   a) The decision to discontinue the intervention should be based on the determination that the medical need for restraint is no longer present or the patient's needs can be met with less restrictive methods.
   b) Staff cannot discontinue restraints and then re-start it under the same order because that would constitute a PRN order. A new order is required.
   c) A temporary release that occurs for the purpose of caring for a patient's needs—for example toileting, feeding, and range of motion are not considered a discontinuation of the intervention.
   d) Absence of the behavior that required restraints allows for the removal or termination of the restraint.

G. PLAN OF CARE / PATIENT EDUCATION – For inpatients departments only

"The use of restraint or seclusion must be in accordance with a written modification to the patient's plan of care." CMS 482.13 (e)(4)

1. The plan of care and/or treatment plan must be modified to include and address the use of restraints. The use of a restraint intervention should be reflected in the patient's plan of care or treatment plan based on an assessment and evaluation of the patient.
2. The plan of care or treatment plan (High-Risk Injury and/or Potential for Restraints Adult/Pediatric) should be reviewed and updated in the medical record within a minimum of 12 hours of application of the restraints.
3. The patient/family will be educated on the use of restraints, on an individual basis while their preferences and insights related to prevention and alternatives will be incorporated into the plan of care, whenever possible. All education is documented in the medical record.

H. PHARMACY REFERRAL/CONSULT

Referrals/Consult may be made to pharmacy for a drug profile review on patients placed in restraints or seclusion.

I. PERFORMANCE IMPROVEMENT

Performance improvement processes are used to appropriately evaluate and improve the use of restraints and seclusion. This includes identifying opportunities within the organization to reduce the use of restraint and seclusion.

J. REPORTING

1. Internal: Clinical leadership (manager, director, or vice-president) is notified of any instance in which the patient is in restraints for more than 24 hours.

2. External: Quality will facilitate/coordinate required reporting to external agencies in accordance with applicable laws and regulations, including deaths occurring while a patient is in restraints.
3. Quality Management will be responsible for oversight and reporting requirements at 42 CFR 482.13(g)
    a) Deaths must be reported to the Regional Office (RO) using electronic Form CMS-10455 available here: https://restraintdeathreport.gov1.qualtrics.com/jfe/form/SV_5pXmjIw2WAzto8J
    b) CMS requires reporting no later than the close of business on the next business day following knowledge of the patient's death of the following:
        i. Each death that occurs while a patient is in restraint or seclusion, ***excluding those in which only 2-point soft wrist restraints or only unsecured (AKA not tied down) mitt(s) were used, and the patient was not in seclusion at the time of death***.
        ii. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion, ***excluding those in which only 2-point soft wrist restraints or only unsecured (AKA not tied down) mitt(s) were used, and the patient was not in seclusion within 24 hours of their death***; and
        iii. Each death known to the hospital that occurs within one 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, regardless of the type(s) of restraint used on the patient during this time.

    Note: Death in Forensic restraints does not require CMS reporting

    c) The organization will also keep an internal hospital log or other system that includes but is not limited to, the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number and primary diagnosis for all deaths occurring in restraints or seclusion or within 24 hours of a death in restraints or seclusion.
    d) The following must also be documented in the patient's medical record for any patient whose death is associated with the use of restraint or seclusion:
        i. The date and time the death was reported to CMS for deaths required to be directly reported; and
        ii. The date and time the death was recorded in the hospital's/CAH's internal log.
    e) Death entries to the log and medical record must be made within 7 days of the death.

VI. DEFINITION OF TERMS

Chemical Restraint: A drug that is used as a restraint and is a medication used to control behavior or to restrict a patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

Emergency: A situation which necessitates action prior to obtaining a physician's order.

Episode: Each time a provider's order is written.

Physical Restraint: "Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely." CMS 482.1(e) (1)

- Any method of physically restricting a person's freedom of movement physical activity or normal access to his or her body. This restraint definition applies to all uses of restraint in all hospital

care settings. Under this definition, commonly used hospital devices and other practices could meet the definition of a restraint, such as:

- Tucking a patient's sheets in so tightly that the patient cannot move.
- Use of a "net bed" or an "enclosed bed" that prevents the patient from freely exiting the bed.
- Use of "Freedom" splints that immobilize a patient's limb.
- Using side rails to prevent a patient from voluntarily getting out of bed; or
- Geri chairs or recliners
- A physical escort with grasp that the patient cannot escape.

NOTE: Generally, if a patient can easily remove a device, the device would not be considered a restraint. In this context, "easily remove" means that 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 (e.g., side rails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the patient's physical condition and ability to accomplish objective (e.g., transfer to a chair, get to the bathroom in time).

Seclusion: The involuntary confinement of a person alone in a room where the person is physically prevented from leaving.

Side rails

- If a patient is in a hospital bed with side rails raised, and the side rails restrict the patient's freedom to exit the bed, and the patient cannot easily remove or release the side rail, the side rail is a restraint.
- A patient may request siderails be raised. In this situation, this will not be considered restraint. The patient's request must be documented in the record. Rails will be lowered at the patient request. If a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails is not a restraint because it has no impact on patient's freedom of movement.
- If the patient is on a stretcher (a narrow, elevated, and highly mobile cart used to transport patients and to evaluate or treat patients), there is an increased risk of falling from a stretcher without raised side rails due to its narrow width, and mobility. In addition, because stretchers are elevated platforms, the risk of patient injury due to a fall is significant. Therefore, the use of raised side rails on stretchers is not considered restraint but a prudent safety intervention. Likewise, the use of a seat belt when transporting a patient in a wheelchair is not considered restraint.
- Padded side rails for seizure precautions are not considered a restraint.

VII. Attachments

Restraint Orders - Tip Sheet

VIII. Related Policies

Restraints or Seclusion for Violent, Self-Destructive Patient Situations

IX. REFERENCES:

- 12VAC35-115-110. Use of Seclusion, Restraint, and Time Out. Retrieved from July 17, 2024 (still current 2/10/2025) https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/section110/
- CMS §482.13 - Centers for Medicaid and Medicare Services, 42 CFR 482.13 – Condition of participation: Patient's rights. Retrieved February 10, 2025. https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-sec482-13.pdf

- https://elsevier.health/en-US/preview/ventilation-noninvasive-cpap-and-bipap published November 2024 (Retrieved 02/10/2025)
- Lippincott (2024, Feb. 20) *Prone Positioning* Retrieved February 10, 2025
- Moore, J.M., Dana IM, (2025). The acutely agitated or violent adult: Overview, assessment, and nonpharmacologic management. *Up to date* https://www.uptodate.com/contents/assessment-and-emergency-management-of-the-acutely-agitated-or-violent-adult
- Ohio Laws and Administration Rules – 5122-26-16 *Seclusion, restraint and time-out.* Retrieved 02/10/2025 at https://codes.ohio.gov/ohio-administrative-code/rule-5122-26-16, Effective October 20, 2023
- The Joint Commission, 2025 The Joint Commission Comprehensive Manual of Accreditation - Provision of Care Standard PC.03.05.03: The hospital uses restraints or seclusion safely.

X. Regulatory Notices

Nothing in this policy modifies the at-will status of any organizational associate or otherwise creates a contractual relationship between the organization and any associate.

The organization, in its sole discretion, reserves the right to amend, terminate or discontinue this policy at any time, with or without advance notice.

XI. Version Control

Version	Effective Date	Next Review Date	Description	Supersedes, if applicable	Prepared By
1	02/16/2021	02/16/2023	Original Document	Local Policies on same subject matter	Policy Team
10	01/15/2024	01/15/2026	Updated notification of attending physician	Version 9	Policy Team
11	02/10/2025	02/10/2027	Updated CMS Death Reporting with Mitts	Version 10	Policy Team

Keyword search; Restrained, restraining,