Purpose

To describe the clinical management of a patient at initiation, continuation and removal of restraint or seclusion.

Policy

Indications for restraint are:

- **Non-Violent Track (formerly Medical Interference Track):** To support medical healing and protect patient from self-harm, or restrict patient’s movement to assist with the provision of care.

- **Violent Track:** To restrict a patient’s movement for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff members, or others.

Swedish Medical Center does not support the use of chemical restraint.
The treatment of a patient’s symptoms, like anxiety or agitation, is not considered a chemical restraint.

Restraint is never a PRN or standing order.

Restraint is not to be used for a patient with a BiPAP mask in place. The patient needs to be able to remove the mask in event of emesis. The use of a patient safety attendant (PSA) will be in place to monitor patients who require observation with the use of a BiPAP mask. As a safety alternative instead of restraint use for a patient with a BiPAP mask, the patient should be assessed for intubation.

Seclusion is only to be used in the Emergency Departments and Inpatient Behavioral Health Units.

All LIPs and staff providing direct care to patients are required to read and adhere to the Swedish Medical Center standard on the use of restraint or seclusion. Policy information relevant to LIP responsibilities is included in the Medical Staff Services Regulatory Compliance Guide and is required educational reading for biennial re-credentialing.

Staff is required to demonstrate competence in appropriate restraint application. Swedish maintains records of completion of training.

**LAW ENFORCEMENT RERAINT DeviceS:** Patients in law enforcement restraint devices are not covered by the Restraint or Seclusion Management Clinical Procedure. Per CMS Interpretive Guidelines §482.13(e) – *The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this rule. The use of such devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients.* The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital’s patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer’s prisoner).

When a forensic patient arrives at the hospital in the custody of a law enforcement officer, is physically restrained with law enforcement cuffs or other restrictive device, and the law enforcement officer indicates the patient is to remain in law enforcement restraint device:

- The patient remains in law enforcement restraint device.
- The law enforcement officer is expected to stay with the patient as long as the patient remains in law enforcement restraint device.
- No law enforcement restraint device order or renewal of order is needed as long as the law enforcement officer remains present with the patient. No face-to-face evaluation is required.
- If the patient is in the Emergency Department (ED), care is provided according to the *Emergency Department Care Guidelines.*
- If the patient is hospitalized as inpatient, care is provided according to relevant clinical protocols, procedures, and inpatient standards.
- While patient remains in law enforcement restraint device, the law enforcement officer is oriented to their responsibilities by SMC Security Services (See *Prisoner/Forensic Patient Clinical Procedure*).
- If the law enforcement officer decides to leave because the patient does not need guarding or because the law enforcement office must leave because they are urgently required elsewhere and discusses law enforcement restraint device, the patient is immediately evaluated for the need for continued restraint. If restraint is indicated, an order is initiated for Violent Restraint and this *Restraint or Seclusion Management* standard is followed.

**LIP Order Requirement**

Elements of this procedure require a licensed independent practitioner’s (LIP) order.
Responsible Persons

Any staff member, Licensed Independent Practitioner (LIP), Registered Nurse (RN), ED Tech, Licensed Practical Nurse, Nurse Technician, Mental Health Technician, Nurse Assistant-Certified (NAC), Security staff.

Prerequisite Information

1) LIPs and RNs approved to order restraints and/or complete the face to face assessment are listed as follows:

<table>
<thead>
<tr>
<th>TASK</th>
<th>MD / DO</th>
<th>ARNP</th>
<th>PA-C</th>
<th>RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORDER Non-Violent Restraint (formerly Medical Interference Restraint)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ORDER Violent Behavioral Restraint / Seclusion</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>FACE TO FACE ASSESSMENT for Non-Violent Restraint (formerly Medical Interference Restraint)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>FACE TO FACE ASSESSMENT for Violent Behavioral Restraint / Seclusion</td>
<td></td>
<td>X</td>
<td>X *</td>
<td>X *</td>
</tr>
</tbody>
</table>

* Completion of the Swedish approved training module is required for all ARNPs, PA-C, and RNs who place orders or conduct face to face assessments. Certificate of completion will be documented in the ARNP or PA’s Medical Staff file or the RN’s employee desk file.

2) The restraint or seclusion chosen is the least restrictive intervention that protects the patient’s or others’ safety and is to be discontinued at the earliest possible time. Restraint/seclusion is initiated only after evaluating the patient and determining that the use of alternatives to restraint or less restrictive measures poses a greater risk than that of using restraint/seclusion. See Alternatives to Restraint.

3) Any device in any combination that restrains four (4) limbs requires a Violent Restraint Track order to support the increased monitoring and patient safety needs.

4) 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 in any form imposed as a means of coercion, discipline, convenience, or retaliation by staff.

5) A history of falls, dangerous behavior, a family’s request, or the possibility that the patient’s behavior may place him or her at risk is not sufficient reason to justify the use of restraint or seclusion.

6) The use of non-intended devices (sheets, gauze, tape, bandages) as a restraint is prohibited.

7) Swedish Medical Center provides staff training to ensure safe implementation of restraint or seclusion. Training is targeted to the specific needs of the patient population and is provided during orientation and on a yearly basis. Fire safety training for staff emphasizes the need to remove patients from seclusion or restraint devices as soon as possible to expedite the evacuation process.

8) Be alert for predictors of violence and respond early. See addendum, Early Predictors and Interventions to Reduce Potential for Violence.

9) The Epic System List titled ‘Restraint Status’ is the Swedish Restraint Log for nurse leaders. It tracks all patients with an active Restraint Order.

10) In an emergency situation, the RN may initiate restraint/seclusion.

11) Trial release of restraint or seclusion is not permitted. Restraint or seclusion may be temporarily released in the presence of a staff member for the purpose of providing care. If the patient is released from all restraint or seclusion and left unattended by staff, the restraint or seclusion is considered terminated. Once a patient is removed from all restraint or seclusion, any subsequent need for restraint or seclusion requires a new order.
<table>
<thead>
<tr>
<th>Responsible Person</th>
<th>Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any staff member</td>
<td><strong>CODE GRAY: VIOLENT RESTRAINT TRACK</strong></td>
</tr>
<tr>
<td></td>
<td>1. Call a <em>Code Gray</em> if patient’s behavior escalates towards violent harm to self, staff, or others.</td>
</tr>
<tr>
<td></td>
<td>2. After calling for a Code Gray, if more staff is needed to assist with patient care, patient hold, and restraint application, staff dials 3000 and requests the call center to re-page overhead the need for additional staff to respond to Code Gray (location).</td>
</tr>
<tr>
<td></td>
<td>3. If patient is transferred directly to an inpatient unit, call 3000 and announce a Code Gray-Transfer to alert Security to immediately deploy to location and assist in the safe transfer of the patient from existing restraint to Swedish restraint.</td>
</tr>
<tr>
<td></td>
<td>4. If patient will be discharged to another facility and is still in four-point restraint, call 3000 and announce Code Gray-Transfer. If the patient is not currently in restraint, but will be placed in restraint on gurney, call 3000 and announce a Code Gray.</td>
</tr>
<tr>
<td>Any staff member</td>
<td><strong>VIOLENT RESTRAINT TRACK: ADDITIONAL DIRECTION</strong></td>
</tr>
<tr>
<td></td>
<td>1. A security search is performed to ensure patient does not have any potentially harmful items in his/her possession when restraint/seclusion is ordered for violent behavior. Patient’s belongings are to be stored outside of the patient’s room.</td>
</tr>
<tr>
<td></td>
<td>2. Provide only disposable meal trays with paper tray, dishes and plastic utensils, no knives for patient exhibiting violent/suicidal behavior. No hot liquids are allowed. Immediately remove all items and dispose outside of the room after use.</td>
</tr>
<tr>
<td></td>
<td>3. Consider placing patient in a purple gown if there is concern that patient might leave unit.</td>
</tr>
<tr>
<td></td>
<td>4. Emergent Mental Health Hold: See <em>Definitions</em>.</td>
</tr>
<tr>
<td></td>
<td>5. Involuntary Treatment Act (ITA) Detention: See <em>Definitions</em>.</td>
</tr>
<tr>
<td>RN</td>
<td><strong>INITIATION OF RESTRAINT OR SECLUSION</strong></td>
</tr>
<tr>
<td></td>
<td>Seclusion is only allowed in Emergency Departments and Behavioral Health Units</td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> Simultaneous restraint and seclusion is infrequent. Please see Simultaneous Restraint and Seclusion or Seclusion in Locked Room</td>
</tr>
<tr>
<td></td>
<td>1. In an emergency situation, the RN may initiate restraint/seclusion.</td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> Ballard campus inpatient units only- Following the initiation of violent restraint or seclusion, the primary RN will call for the Rapid Response Team (RRT) to clinically assess the patient and complete the face to face assessment.</td>
</tr>
<tr>
<td></td>
<td>2. Notify the LIP and obtain an order prior to or immediately after restraint application. A telephone order is permitted if the LIP is not present at the time of restraint/seclusion.</td>
</tr>
<tr>
<td></td>
<td>3. Describe the specific behaviors that must be demonstrated by the patient in order to discontinue the use of seclusion. Explain these behaviors in a manner that the patient/family can understand and reinforce the plan as needed.</td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> Caution must be taken to prevent strangulation, impede circulation or cause other injury with restraint application.</td>
</tr>
<tr>
<td></td>
<td>4. Consult with the nurse manager, charge RN or nursing administrative supervisor to determine the level of staff observation required and any need for unit staffing level changes. Assign patient safety attendant (PSA) to provide direct observation and maintain safety of the patient and environment.</td>
</tr>
</tbody>
</table>
5. Ensure the restraint key is immediately available, if locked restraint used:
   - Charge RN
   - Patient RN
   - PSA for emergency release only
   - Taped to the unit patient reader board at nursing station or designated area

| RN | 6. Document in the *Restraint Flowsheet*:
|    |   - Alternatives to restraint/seclusion attempted or considered prior to the application of restraint/seclusion
|    |   - Patient’s behavior necessitating restraint/seclusion
|    |   - Time the LIP was notified of the need for restraint/seclusion order
|    |   - Device(s)/seclusion initiated
|    |   - Restraint/seclusion was properly and safely applied, and if any injury to the patient occurred
|    |   - Initial monitoring of safety and physical needs

9. Document additional behaviors, circumstances as needed or unexpected events related to restraint use in Shift Summary Note.
10. Complete an *eQMR* if patient, staff, or provider sustains an injury during the application of restraint.

| LIP and/ or appropriately trained RN | 7. **Restraint order is never a PRN or standing order.**
|                                  | 1. Place an order for restraint or seclusion prior to or immediately after restraint application / seclusion.
|                                  | 2. The order must specify:
|                                  |   - Behavior necessitating restraint/seclusion
|                                  |   - Restraint track – non-violent (formerly medical interference), violent, or seclusion
|                                  |   - Limb count for restraint
|                                  |   - Restraint length in hours
|                                  |   - Type of restraint device(s)/seclusion to be initiated
|                                  | 3. LIP, or appropriately trained designee, will conduct a face-to-face evaluation of the patient:
|                                  |   a. *Within one hour* of the initial application of restraint/seclusion for **Violent Behavior**. If a patient’s violent behavior resolves and the restraint/seclusion intervention is discontinued before the LIP, or appropriately trained designee, arrives to perform the one hour face-to-face evaluation, the LIP, or appropriately trained designee, is still required to see the patient face-to-face and conduct the evaluation within one hour after the initiation of this intervention.
|                                  |   b. *Within 24 hours* of the initial application of restraint for **Non-Violent Behavior** *(formerly Medical Interference)*.
|                                  | 4. Notify attending physician of the results of the face to face evaluation, the time at which face to face evaluation was completed and the need for order if the attending LIP did not order the restraint/seclusion or did not complete the initial face to face.
|                                  | 5. Document in a progress note (SmartText and .dot phrase is available):
|                                  |   - Evaluation of the patient’s immediate situation – condition or symptoms necessitating restraint or seclusion
|                                  |   - Evaluation of alternative measures tried
|                                  |   - Patient’s medical and behavioral history
|                                  |   - Need to continue or terminate the restraint/seclusion
|                                  |   - Notification of attending physician, if applicable
|                                  |   - Requests for consultations

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*Clinical Procedure: RESTRAINT OR SECLUSION MANAGEMENT*

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PATIENT MONITORING

1. Monitor and document in Restraint Flowsheet patient safety every 15 minutes for Violent Restraint Track and every 2 hours for Non-Violent (formerly Medical Interference) Restraint Track.
   - Circulation, motion and sensation, skin integrity
   - Psychological status
   - Observed behavior(s)

2. Monitor and document in Restraint Flowsheet patient physical needs (comfort, nutritional and hydration needs) every 2 hours:
   - Fluids offered while awake
   - Range of motion to extremities unless contraindicated; document contraindication reason (not applicable to seclusion)
   - Elimination needs when awake
   - Hygiene needs as needed

3. Monitor by observation, interaction, and direct examination of the patient. The observer must be able to see the patient fully at all times, i.e. extremities and head, to adequately assess general physical condition.

4. Monitor the patient for increased anxiety, agitation and/or physical activity that may indicate patient is escalating or attempting to harm self and immediately notify additional staff.

5. Delegated monitoring staff shall report immediately to the RN any change in condition, any physiological parameters that are outside of normal limits, or any change in the patient’s behavior.

6. Attempt to provide patient privacy from non-direct care personnel or visitor viewing.

CONTINUED USE OF RESTRAINT OR SECLUSION

1. Work with the patient to identify ways to regain control to ensure that the use of restraint/seclusion is discontinued at the earliest possible time.

2. Assess and document in the Restraint Flowsheet the continued need of restraint for Non-Violent (formerly Medical Interference) behavior:
   - Once per shift or a minimum of once every 12 hours.

3. Assess and document in the Restraint Flowsheet the continued need of restraint for Violent behavior within the time frames below:
   - Every 4 hours for patients age 18 or older
   - Every 2 hours for patients age 9 through 17
   - Every hour for patients under the age of 9

4. Notify LIP of need for new order within applicable timeframes if continued restraint use is necessary.

5. Evaluate Plan of Care effectiveness and revise as needed.

6. Document any unexpected events related to restraint use in the EMR. This information may be included in the Shift Summary Note.

7. Complete an eOVR if patient, staff, or provider sustains an injury during while patient is restraint/seclusion.

**Prolonged Restraint Use / Seclusion**

If patient remains in restraint for a prolonged period (see below), the Plan of Care is revised accordingly.
Clinical Procedure: RESTRAINT OR SECLUSION MANAGEMENT

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- 72 hours or longer for patients in Non-Violent (formerly Medical Interference) restraint
- 24 hours or longer for patients in Violent restraint/seclusion
- 4 hours for patients in simultaneous restraint and seclusion or locked seclusion

| RN | 1. Non-Violent Track (formerly Medical Interference Track): Each calendar day, complete a face to face evaluation & document. Each calendar day, enter new order if continued use of restraint required. |
| LIP | 1. Non-Violent Track (formerly Medical Interference Track): Each calendar day, complete a face to face evaluation & document. Each calendar day, enter new order if continued use of restraint required. |
| LIP | 2. Violent Track: Every 24 hours, complete a face to face evaluation & document. Enter new order per time frames below if continued use of restraint is required: |
| LIP | • Every 4 hours for patients age 18 or older |
| LIP | • Every 2 hours for patients age 9 through 17 |
| LIP | • Every hour for patients under the age of age 9 |
| LIP | 3. Document in a progress note (SmartText and .dot phrase are available): |
| LIP | • An evaluation of the patient’s immediate situation: condition or symptoms necessitating restraint or seclusion. |
| LIP | • Evaluation of alternative measures tried. |
| LIP | • The patient’s medical and behavioral history |
| LIP | • The need to continue or terminate the restraint/ seclusion |
| LIP | • Notification of the attending physician, if applicable |
| LIP | • Requests for any consultations |
| LIP | NOTE: If patient remains in restraint/seclusion for prolonged period, the Plan of Care is revised accordingly. |

DISCONTINUATION OF RESTRAINT/SECLUSION

1. Discontinue restraint/seclusion as soon as the patient’s behavior no longer places the patient at risk for accidental self-injury, intentional self-harm, interferes with necessary care, or poses a violent threat towards others. |
2. Progressive restraint release steps are to be followed for any patient in violent four-point restraint: |
   NOTE: If 5th or 6th restraint is also used, the 6th is removed FIRST in progressive release, followed by the 5th, before extremity restraints. |
   • 5th restraint: chest or waist restraint |
   • 6th restraint: spit hood |

Progressive Release for Patient in Double Locked Restraint

1. If patient also has fifth or sixth restraint, remove first and observe for 15 minutes. |
   If patient meets criteria for release stated above, proceed to step 2, below. |
   If patient meets criteria for release, release other limbs and observe for 15 minutes. |
   Manage Orders: IF patient behavior during progressive release reduces level of restraint, AND restraint is still necessary (e.g., four locked restraints to two restraints), THEN obtain new order for reduced level. |
   Restraints applied to patient must equal restraints ordered. Document actions taken and rationale.
3. Observe the patient for 15 minutes following release of restraint/seclusion.

**NOTE:** Trial release of restraint/seclusion is not permitted. Restraint/seclusion may be temporarily released in the presence of a staff member for the purpose of providing care. If the patient is released from all restraint/seclusion and left unattended by staff, the restraint/seclusion is considered terminated and any subsequent need for restraint/seclusion requires a new order.

4. RN Document on the Restraint Flowsheet:
   - Patient behavior allowing for release from restraint/seclusion
   - Discontinuation of restraint device(s)/seclusion

5. RN Document “Goals Met” on the restraint/seclusion Plan of Care.
6. RN Click on the “Complete” link next to the restraint/seclusion order in “Active Orders.”
7. Obtain a new order if restraint/seclusion is required again after a patient has been completely removed from all restraint devices/seclusion.

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### RESTRAINT-RELATED DEATH REPORTING*

* Required by CMS, reported by Swedish Risk Management

1. Complete the [Caregiver Restraint/Seclusion Death Report Worksheet](#) if patient:
   - Died while in restraint or seclusion.
   - Died within 24 hours after removal from restraint/seclusion.
   - Died within one week after restraint/seclusion.

**NOTE:** Contact Risk Management or Accreditation with any questions on form completion.

2. Fax the completed worksheet to Risk Management per instructions on the form.

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### Definitions

**Devices and alternatives NOT considered restraints:**

- Orthopedically prescribed devices, such as an orthopedic splint
- Surgical dressing, bandages, IV arm board
- Protective helmet
- Other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests
- Positioning the patient during surgery or post-anesthesia care
- Any device used to protect the patient from harm which **can be removed** by the patient (e.g. Omni belt and torso support).
- Hand mitts may be used as an alternative to restraints. When using mitts:
  - Patient should have free movement of both arms. Mitts should not be tied down and mitts should not be used in combination with any restraint devices.
  - Patient should have free movement of fingers inside the mitts.
- Use of side rails to protect the patient from falling out of bed as long as patient can **independently exit the bed.**
• Use of side rails/guard rails to protect the patient from falling out of stretcher, crib, or gurney.
• Patients monitored in their room with a staff person (e.g. PSA) and prompted to stay in room (not physically kept from leaving) is considered an alternative to restraint. If a patient will not remain in the room, a Code Gray can be called for possible restraint orders or seclusion.
• Law enforcement restraint device.

**ED Precautionary Hold.** See *ED Precautionary Hold: Behavioral Crisis Triage*.

**Emergent Mental Health Hold.** When, as a result of a mental health disorder a patient presents an imminent likelihood of serious harm to self or others or is in danger due to grave disability that patient may be held in the Hospital/ED until an MSW (or other MHP) is able to assess and facilitate a safe disposition. If the patient’s condition warrants a referral to the Designated Crisis Responder (DCR) the patient will be held until the DCR can evaluate and make a determination about the disposition of the patient. See RCW 71.05.153 for more information.

**ITA (Involuntary Treatment Act) Detention.** The DCR has determined the lawful confinement of a person under the provisions of 71.05 RCW (or 71.34 for juveniles) for not more than seventy-two hours (judicial court days). Detained persons are frequently “boarded” on various floors in the Swedish system awaiting transfer to court and/or an Involuntary Psychiatric Treatment Facility.

**Law enforcement restraint device.** The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons.

**Licensed Independent Practitioner (LIP).** For the purpose of ordering restraint or seclusion, a LIP is any practitioner permitted by State law and hospital policy as having the authority to independently order restraints or seclusion for patients. A resident who is authorized by State law and the hospital’s residency program to practice as a physician can carry out functions reserved for a physician or LIP by the regulation.

**Locked Seclusion Room.** A room with a lockable door that is specially equipped with simultaneous video and audio monitoring equipment. If the door is locked, the patient must be monitored either in-person or with simultaneous use of the video and audio monitoring equipment.

**Prolonged Restraint Use/Seclusion:**

- 72 hours or longer for patients in Non-Violent (formerly Medical Interference) restraint
- 24 hours or longer for patients in Violent restraint
- 24 hours for patients in seclusion
- 4 hours for patients in simultaneous restraint and locked seclusion

**Restraint.** A restraint is considered to be any device, equipment, or method that immobilizes or reduces the ability of the patient to move limbs, body, or head freely. If the patient can freely remove the device, equipment, or method, it is not considered a restraint.

**Non-Violent Restraint (formerly Medical Interference Restraint).** A restraint used to support medical healing and protect patient from self-harm, or restrict patient’s movement to assist with the provision of medical care. Patient immobilization that is a routine component of a procedure (e.g. MRI, surgery etc.) is not considered restraint.

**Violent Restraint.** A restraint used to restrict a patient’s movement for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff members, or others.

**Chemical Restraint.** A drug or medication used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement that is not a standard treatment or dosage for the patient’s
condition. For example, giving a medication for treating extreme agitation to sedate a patient would be considered treatment for a condition and, therefore, not considered a chemical restraint. **Chemical restraint is not used at Swedish.**

**Seclusion.** Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. §482.13(e)(1)(ii). Seclusion offers a selective and limited environment designed to:

- Minimize external stimulation.
- Protect patients from the medical and equipment hazards in the emergency department.
- Prevent detained patients from eloping prior to the rule out of urgent medical conditions and/or psychiatric crisis.

Seclusion is initiated when a patient is told to remain alone in a care area or defined space and that the consequences of elopement would result in initiation of a Code Gray or utilizing a locked door in a dedicated seclusion room. Seclusion occurs in both locked and unlocked environments. Initiating a Code Gray or utilizing a locked door to a dedicated seclusion room constitutes **physically preventing the patient from leaving** the designated room or space.

The following actions **do not directly** constitute the use of seclusion:

- A patient being detained in the emergency department. Seclusion begins when the patient is confined to a defined space, alone and has been instructed to not leave the defined space (i.e., private treatment room, triage space, etc.).
- The assignment of a PSA to provide direct observation. Multiple patient populations may have a PSA assigned to assist with observation and maintenance of a safe environment.

Assigning the patient to a private room is not constituted as seclusion if the patient may willingly exit the room or defined space to ambulate or perform ADLs.

Seclusion is only used in the ED and Inpatient Behavioral Health units.

**Restraint key.** The key used to release patients from locking restraints. Key is kept in all four locations:

- With patient’s RN
- With Charge RN
- Taped to white communication board at nurses’ unit, where applicable.
- With the PSA for emergency release only

**Time out.** An intervention in which patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving.

**Forms**

- [Caregiver Restraint/Seclusion Death Report Worksheet](#)
- [Restraint or Seclusion Flow Sheet](#) (61078) (downtime only)

**Supplemental Information**

LIPs who order restraints receive an annual training document in the requirements of this policy and demonstrate a working knowledge of this policy through ongoing compliance.

Ongoing training will be provided to all RNs completing face-to-face assessments each calendar year.

Staff is required to demonstrate competence in appropriate restraint application. Swedish maintains records of completion of training. Training may include:
• Review of SMC’s policy on use of restraint and seclusion
• Techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of restraint or seclusion
• Alternatives to restraint or seclusion and nonphysical interventions
• How to choose the least restrictive intervention based on the patient’s medical or behavioral status
• How to apply restraint or seclusion safely
• How to assess, monitor and document the patient’s physical and psychological condition
• How to recognize and respond to signs of physical and psychological distress, including how to apply first aid, if needed
• Indications that restraint or seclusion is no longer necessary

Regulatory Requirement

CMS. Medicare Conditions of Participation for Hospitals. 482.13(e-g) – Patient Rights.

CMS: Conditions of Participation §482.13(e)(5)
CMS: Conditions of Participation §482.13(e)(12)

DOH MQAC Advisory (October 2015)

WAC-246-320-226 (3)(f)

WAC 246-840-300

DNV. PR.7, PR.8, and PR.9 – Patient Rights.

References

Swedish Medical Staff By-laws/Rules and Regulations

Addenda

Behavioral Health Patients in the ED: Levels of Observation
Care of the Patient in a Law Enforcement (LE) Device Algorithm
Caring for Agitated, Potentially Violent Involuntary Boarded Patients
Documenting Face-to-Face Evaluation for Restraint Order: Medical Interference, Violence, or Seclusion
Early Predictors and Interventions to Reduce Potential for Violence
Hand Mitts
Quick Guide to Restraint/Seclusion Documentation
Restraint Alternatives
Restraint Devices
Restraint Track and Device Algorithm
Restraint/Seclusion Process Workflow
Restraint Log Documentation
Seclusion Process Workflow
Simultaneous Restraint and Seclusion or Seclusion in Locked Room
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Accreditation Department
Edmonds Medical Executive Committee (April 2017)
First Hill Medical Executive Committee (April 2017)
Issaquah Medical Executive Committee (April 2017)
Workplace Violence Prevention Committee (June 2018)
Ballard Quality Council (2020)

Sponsor

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