MercyCare Health Plans
MercyCare Insurance Company ~ MercyCare HMO, Inc.
Standard Operating Procedure

Title: Restraint Monitoring
SOP: MS-108.07
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Revision History

Date	Issue	Author	Description of Change
1/18/22	7	Joan C. Fisher, RN,CCM	Revised

Approved By — Department Director — 3/10/22 Date

I. Purpose

Establish minimum guidelines regarding restraints for network facilities and the monitoring of restraint usage.

II. Scope

All MercyCare Members

III. Reference Documents

A. CMS Manual System: CMS 482.13 (e) Standard: Restraining or Seclusion

IV. Definition

A. Physical Restraints: are 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, or head freely.

1. Restraint or seclusion may only be used if needed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
2. Forensic and corrections restrictions used for security purposes do not apply to this policy
3. Use of restraint/seclusion for violent/self-destructive behavior (behavior health management) can only be used in emergency situations if needed to ensure the patient's, staff member's, or others' physical safety and less restrictive interventions have been determined to be ineffective

B. Seclusion: Seclusion refers to the involuntary confinement of a person alone in a room where the person is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

C. Drug 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 for the patient's medical or psychiatric condition.

1. A standard treatment for a medication used to address a patient's condition would include all of the following:
   a. The medication is used within the pharmaceutical parameters approved by the FDA and the manufacturer.
   b. The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization.
   c. The use of medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's or other Licensed Independent Practitioner's (LIP – Physician Assistant, Clinical Psychologist, Nurse Practitioner) knowledge of that patient's expected and actual response to the medication

D. Types of Restraints

1. Soft safety restraints are the only devices to be used in most areas. These include waist, wrist, and ankle restraints.
2. When soft restraints have failed to restrain the patient, Velcro restraints are next attempted.
3. A helmet that the patient cannot easily remove meets the definition of physical restraint.
4. Geri Chairs are considered a restraint only when they are used to purposefully restrict movement. If the Geri chair is used to position the patient or facilitate the patient's ability to feed themselves, it is not considered a restraint.
5. Side rails:
   a. Lower side rails, when used to prevent a confused patient from climbing in or out of bed, is not an acceptable use of side rails.
   b. SIDE RAILS AS A PROTECTIVE DEVICE

1) Patients recovering from medical, diagnostic, or surgical procedures requiring sedation or anesthesia
2) Patient on a rolling cart or bed
3) Patients using the rails as an aid in turning and positioning
4) Patients with a particular diagnosis such as seizures.

V. Policy

A. All contracted network facilities shall be expected to be compliant with CMS 482.13 (e) Standard: Restraining or Seclusion. The decision to use a restraint or seclusion is not driven by diagnosis but by a comprehensive individual patient assessment which includes a physical assessment to identify medical problems that may be causing behavioral changes in the patient.

B. Contracted facility Staff who are involved with the application of a restraint or implementation of seclusion, providing care for a patient in a restraint or seclusion, or with assessing and monitoring the condition of a restrained/secluded patient receive initial and ongoing training in the proper and safe use of restraints/seclusion.

C. The least restrictive interventions should be used, when possible, prior to the use of more restrictive restraints. Examples of less restrictive interventions may include, but are not limited to:
• Bed exit alarm
• Offering reassurance/encouraging expression of feeling and concerns
• Comfort measures/pain relief
• Medication review
• Snacks/toileting/repositioning
• Orienting patient to setting
• Reducing stimuli by dimming lights, reducing noise, etc.
• Moving the patient to a room closer to the nurse's station
• Contacting a family member to sit at bedside
• Covering exposed lines or tubes (IV sites with kerlix, Peg tube with binder, etc)
• Discussing with the physician the removal of tubes, lines, dressing, etc. as soon as medically possible
• Providing diversional activities

C. **<u>Restraints for Violent/Self-destructive Behavior:</u>**

1. Use of restraint/seclusion for violent/self-destructive behavior (behavior health management can only be used in emergency situations) if needed to ensure the patient's, staff member's, or others' physical safety and less restrictive interventions have been determined to be ineffective
2. Anytime a restraint is used in the care of a patient, it must be addressed in that patient's plan of care. The patient's assessed needs, less restrictive interventions and preventive interventions should also be included.
3. When restraints are used, all possible interventions are used to help protect and preserve the patient's rights, dignity, and well-being during use:
   • Restraints are applied only on the basis of the patient's assessed needs.
   • Least restrictive interventions have been unsuccessful and documented as such.
   • Only trained staff is involved in the application of restraints and patient care during use.
   • Smoking materials will be removed from patient access including access from family and friends.
4. The order for restraint must be obtained prior to application. The physician or his/her LIP designee will conduct a face-to-face evaluation of the patient within one hour. Physician orders must be time limited. Orders for restraint are time limited to:
   • 4 hours for adults 18 years and older
   • 2 hours for children and adolescents ages 9-17
   • 1 hour for children under age 9
   • The restraint or seclusion order may only be renewed in accordance with these limits for up to a total of 24 hours. Before writing a new order, a physician or LIP (Physician Assistant, Clinical Psychologist, Nurse Practitioner) must see and assess the patient.
5. While in restraints for violent/self-destructive behavior (behavior health management), monitoring will be accomplished through continuous face-to-face observation. Patient's behavior, physical and emotional needs are monitored at least every 15 minutes by appropriately trained staff, and assessed/reassessed by an RN every hour.

6. Documentation required in the medical record includes the following:
   a. The 1-hour face-to-face medical and behavioral evaluation
   b. A description of the patient's behavior and interventions used
   c. Alternatives or least restrictive interventions attempted (as applicable)
   d. The patient's condition or symptom(s) that warranted the use of restraint or seclusion
   e. The patient's response to the intervention(s), including the rationale for continued use of the intervention
   f. Ongoing assessment and monitoring on the restraint flow sheet

D. **Use of Restraints for Non Violent or Non Self Destructive Behavior**

1. A comprehensive assessment of the patient and the environment, in conjunction with individualized patient care planning, should be used to determine those interventions that will best ensure the patient's safety and well-being with the least risk.
2. A request from a patient or family member for the application of a restraint, which they would consider to be beneficial, is not a sufficient basis for the use of a restraint intervention. Such a request should prompt a patient and situational assessment to determine whether an invention is needed.
3. Use of physical restraints for the non-violent/non self-destructive patient (medical necessity) applies when the primary reason for use directly supports medical healing.
4. Least restrictive interventions should be used, when possible, prior to the use of restraints.
5. Anytime restraints are used in the care of a patient, the restraint use must be addressed in the plan of care. The patient's assessed needs, less restrictive interventions, and preventive interventions should also be included in this plan.
5. The order for restraint must be obtained prior to application unless it is emergent. In an emergency, the order must be obtained either during the emergency application or immediately after the restraint has been applied.
   a. An examination by a physician or licensed independent provider must be entered into the patient's medical record within 24 hours of initiation of restraint.
   b. Continued use of restraint beyond the first 24 hours is authorized by a physician or licensed independent provider, issuing a new order if restraint use continues to be clinically justified. A new order is issued once each calendar day, and is based upon an examination of the patient by the physician or licensed independent provider
6. When in restraint, the patient's physical and mental status is assessed by a registered nurse every two hours. Periodic visual checks are done to monitor the patient's needs.
7. Restraint Documentation: The following documentation must exist for each incidence of restraint:
   a. Clinical justification for use. This should include the specific reason for the restraint, and interventions tried prior to prevent the use of restraint.
   b. Physician's order for restraint must contain the following information:
   c. Date and Time
   d. Type of restraint
   e. Reason for restraint
   f. Time limit of restraint order
   g. Patient checks and care provided are documented in the EMR by the staff member who provided that check and/or care.

VI. MercyCare Procedure for monitoring facilities

A. Inpatient Cases suspected for possible restraint use as reported in utilization review received from facility shall have documented in the MercyCare Concurrent Review Notes. Any discrepancy of the following shall be reported to the Medical Director for review:

1. Clinical justification for use of restraint
2. MD Order obtained: yes or no
3. Date and Time restraint applied
4. Type of restraint
5. Time Limit of Restraint
6. Date Restraint Discontinued

B. Medical Director shall determine if this is a Potential Quality Issue and if policy MS 044 needs to be followed.

C. Facilities found non-compliant with reporting to MercyCare or non-compliant CMS Manual System: CMS 482.13 (e) Standard: Restraining or Seclusion shall be forwarded to the MercyCare Credentialing Committee.