NURSING SERVICE GUIDELINES
INPATIENT BEHAVIORAL HEALTH

Guideline: **Restraints/seclusion/physical hold – care of the patient who is requiring more restrictive methods such as seclusion and/or restraints**

Effective Date:
December 2024

Initial Effective Date:
July 2005

Policy Number Superseded:

Responsibility: All trained inpatient behavioral health staff

Purpose of Guideline:

To provide safety for the patient and others in the environment.
To assist the patient in regaining control over potentially harmful behaviors.
To protect the patient and others from harm.
To treat the patient as a worthwhile person with feelings, dignity and rights, regardless of unacceptable behavior.

Equipment:

Leather/TAT extremity restraints
Seclusion/time out room
Private lockable inpatient room
Seclusion/restraint/physical hold report sheet
Seclusion/restraint/physical hold orders
Seclusion/restraint/physical hold log

Procedure

PROCEDURE	POINTS OF EMPHASIS
(1) Exhaust less restrictive interventions (see guideline for Patient acting out).	Restraints/ seclusion (R/S) and/or physical holds should be avoided if possible. They are never used as

	punishment or for convenience of staff. Document failure of least restrictive interventions, or rationale for not attempting least restrictive methods.
(2) Discuss with patient alternative behaviors, then inform patient of nursing methods to be used for behavior that is harmful to self and/or others.	Check for contraindications or clinical considerations prior to application. Provide special attention to effectively communicate with deaf or hard-of-hearing patient. Utilize patient coping strategies determined on admission.
(3) Determine method to be used and establish a team captain.	The team captain is the person who communicates with the patient and decides on the course of action.
(4) Assessment. (a) Assess patient before obtaining/writing order for seclusion, restraints or physical hold (RN may assess if physician is unavailable and patient poses an immediate danger to self or others).	Order must include date, time, and duration of ordered therapy. Orders must be time-limited to 1 hour for children under 9, up to 2 hours for children and adolescents ages 9-17, and up to 4 hours for patients ages 18+ and cannot be written as a PRN order. May be renewed at above specified time periods for up to a total of 24 hours. Every 4 hours, a physician must complete a face-to-face re-evaluation. A physician must perform an initial evaluation within 1 hour of initial order.
(b) Assessment must include: (1) Vital signs. (2) Mental health status.	Vital signs should be documented each time the patient is placed in seclusion/restraints. If patient is

(3) Gross neurological assessment. (4) Patient's level of verbal control and response to stimuli therapy interventions.	uncooperative and vitals cannot be obtained, documentation should be noted in the medical record along with visual assessment of patients' condition. Document gross neurological assessment and mental health status on form/in the medical record.
(5) Obtain order as soon as possible.	
(6) Assign at least one staff member to monitor the patient. Provide reassurance to the other patients in the immediate area.	All patients in seclusion, restraints and/or physical hold must be monitored, with constant observation at all times.
(7) Notify campus security (383-2600) as determined by team captain.	If campus security is necessary, contact and inform them of the situation, including the number of needed officers.
(8) Restrictive methods. (a) Seclusion. (1) Escort patient to nearest locked room using crisis management techniques. (2) Search room for unsafe objects and remove. (3) Check patient for potentially harmful objects (pockets, socks). (4) Remove shoes, belts, jewelry. (5) Close door and lock. (b) Restraints. (1) Obtain appropriate restraints from storage.	Decreases potential for injury. Consistent techniques increase safety and effectiveness.

(2) Obtain restraint key from same. (3) Remove bedding from bed in private, locked room. (4) Check patient and room for unsafe objects and remove from area. (5) Unlock restraints and feed cloth straps through slots in bed (do not lock straps). (6) Escort patient to bed and place on back. (7) Adjust and secure restraints to patient's extremities. (8) Educate patient on specific behavior criteria for release of R/S. (9) Close door. (10) Refer to admission assessment for family preferences on R/S notification. (c) Physical hold.	In order to prevent unnecessary injury, restraints are to be applied according to manufacturer's guidelines. A staff RN must be present when a patient is placed in restraints. All patients in restraints must be isolated from others for protection. Notify family if indicated on the admission assessment. A physical hold is defined as a restraint in which the staff are holding a patient that restricts movement and is against the patient's will. A physical hold is considered a restraint and requires a physician order and the same level of documentation.
(9) Reassure the patient that he/she will be isolated from others and closely monitored by the staff.	Demonstrates concern and provides physical and supportive care. Constant observation is required while the patient is in restraint/seclusion/physical hold.
(10) Document in medical record. (a) Events leading up to seclusion/restraints. (b) Time initiated.	Treatment plan must be updated if R/S is used. Clinical leadership is notified if R/S occurs for longer than 30 minutes, or if 2 or more separate

(c) Type and location of seclusion/restraint. (d) Vital signs. (e) Evaluation at least every 15 minutes including: (1) Circulation checks, motor and sensory function below the level of restraint. (2) Change in mental status, behavior, readiness for release. (3) Other associated interventions. (f) Every 2 hours: relieve from restraints including active or passive range of motion; check vital signs; offer bathroom privileges; check skin condition and reposition to prevent pressure cores; offer fluids and food. (g) Patient condition. (h) Removal of devices as they occur. (i) Patient's response. (j) Nurse evaluation.	episodes of any duration occur within 12 hours. Consider any change in patient condition that may warrant physician notification and thus may require immediate medical treatment. Assess issues such as: History of abuse or rape. Claustrophobia. Asthma. Pregnancy. Physical injuries, head or spinal injuries, history of fracture. History of surgery. Disabilities. Seizure disorder, Age, gender, developmental issues.
(11) Review or teach the patient appropriate ways to handle anger and other emotions. Encourage the patient to practice these methods (i.e., journal, punching pillow, angry time).	Refer to patient's individual crisis plan.
(12) Discontinue restraint/seclusion/ physical hold use as soon as possible. If patient is in restraints, release 1 limb at a time, alternate sides of the body. Example: release left arm, then right leg.	By releasing one limb at a time, the staff have a chance to observe whether patient is returning to state of calmness.

(13) Observe for decreases in respirations, heart rate and general movement, as signs of patient calming down.	Continue to encourage the patient to calm down.
(14) Crisis debriefing. (a) Prior to release from seclusion and/or restraints, ensure patient is calm. (b) Discuss consequences for behavior. (c) Once patient is calm and returned to baseline, debrief episode with the patient. (d) Debriefing with the staff needs to occur. (e) Debriefing with the patient and staff must occur within 24 hours of the seclusion/restraint episode.	Debriefing nNeeds to include review with the patient: ▪ What happened. ▪ What could have been done to avoid restraints/seclusion. ▪ Refer back to admission crisis plan. ▪ Develop future plans with patient to avoid further use of restraint/ seclusion. ▪ Debriefing with staff should include review of what happen, prevention strategies, completion of debriefing tool.
(15) Log occurrence in logbook for seclusion/restraints.	Be sure to fill out episode completely. Review order to ensure documentation compliance.

References

Muir-Cochrane, E., Oster, C. & Gerace, A. (2014). The use of restrictive measures in an acute inpatient child and adolescent mental health service. *Archives of Psychiatric Nursing, 23*(6), 389-391.

Andrassy, B. M. (2016). Feelings thermometer: An early intervention scale for seclusion/restraint reduction among children and adolescents in residential psychiatric care. *Journal of Child and Adolescent Psychiatric Nursing, 29*(3), 145-147.

Caldwell, B., Albert, C., Azeem, M. W., Beck, S., Cocoros, D., Cocoros, T., et al. (2014). Successful seclusion and restraint prevention efforts in child and adolescent programs. *Journal of Psychosocial Nursing and Mental Health Services, 52*(11), 30-38.

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