MEMORANDUM

DATE: February 7, 2000

TO: All Medical Staff
    All Residents and Fellows

FROM: Hagop S. Mekhjian, MD
       Medical Director, University Hospitals

RE: New OSU Hospital Policy on the Use of Restraints and Seclusion

On Wednesday, January 12, 2000, the OSU Hospital Medical Staff Administrative Committee approved a new policy and procedure regarding the ordering and use of restraints and seclusion. The new policy will be effective as of March 1, 2000, but I wanted to communicate these changes to you immediately so that you can begin to implement them in your own practice. These changes were necessitated by new federal government regulations that are part of our hospital’s conditions of participation in the Medicare and Medicaid programs. A summary of the new policy and procedure is included below but please find attached the following items:

1) a selection of frequently asked questions (FAQ) regarding the new policy
2) a selection of sample chart notes describing an initial order for restraints
3) a copy of the full policy as approved by the MSAC

As we all get used to these new rules, the nursing staff will need as much cooperation as you can possibly give them. Thank you in advance for your efforts.
Summary of the New Restraint and Seclusion Policy

1) The following points still apply as they did under the old rules for Medical/Surgical Care indications:
   • Restraint orders must be renewed every 24 hours.
   • Verbal orders for restraints must be signed, dated, and timed within 24 hours.
   • No PRN orders for restraints are allowed.

2) Under the old rules, no restraint order was needed if a patient qualified for restraints under a medical staff approved protocol (e.g., intubated patients, severe brain injury patients, etc.). Under the new rules, initial restraint orders are now needed on **all** patients including those qualifying for medical staff approved protocols, but restraints in those qualifying patients may be continued for the maximum time allowed by definition in the protocol.

3) The definition of restraint has been expanded to include both physical restraints **AND medications** “used to restrict the movement . . . of the patient’s body as a means of controlling the patient’s physical activities in order to protect them or others from injury.” Drugs that are used as a standard treatment for the patient’s medical or psychiatric condition are not included in this definition. (See FAQ #4 attached).

4) Except in emergency situations, a physician’s order must be obtained before implementing restraints or seclusion. If an emergency situation exists, a physician’s order must be obtained within **30 minutes** after restraint or seclusion is implemented.

5) A written modification to the patient’s plan of care is required for every use of restraints or seclusion. **Please see the attached sample chart notes for such documentation.**

6) If a restraint or seclusion is **NOT** ordered by one of the patient’s treating physicians (e.g., a cross-covering intern), then one of the treating physicians must be notified as soon as possible. For the purpose of this policy, a treating physician is defined as any physician member of service team to which the patient is admitted. **Please see the attached FAQ sheet for further clarification of this item**.

7) Restraint and seclusion are never to be used simultaneously.

8) **Behavior Control:** There is a new demarcation for the use of restraints and seclusion for the use of Behavior Control (as opposed to Medical/Surgical Care). Behavior Control is defined as the use of restraint or seclusion when “the situation involves unanticipated, severely aggressive or destructive behavior that places the patient or others in imminent danger.”
   • If used for Behavior Control, the duration of restraints are as follows for specific groups of patients:
     • Patients under 9 years of age 1 hour
     • Patients age 9-17 2 hours
     • Patients over 17 years of age or older 4 hours
     • A physician must see and evaluate the patient within one hour of the initial order
Behavior Control restraints may be renewed for the periods of time above for a total of 24 hours. At that time, the physician must again see and evaluate the patient before continuing the Behavior Control restraint order.

**Frequently Asked Questions regarding the New Restraint/Seclusion Policy**

1) Q: Is the category of “Behavior Control” only for use in the Neuropsych Facility and/or the Emergency Department’s psychiatric holding area?

   A: No. The federal regulations are very clear that the standards are not meant to differentiate patients based on their location but rather on the indications/situation which requires restraint/seclusion. It is made clear in the regulations that the Behavior Control standard is to be used in emergency, crisis situations when the patient is uncontrollable and exhibiting violent, aggressive behavior.

2) Q: If a patient is confused and attempting to pull out an IV/NG tube or attempting to get out of bed when they are not allowed to bear weight after hip surgery, does that fall under the Behavior Control or Medical/Surgical Care standards?

   A: This clearly falls under the Medical/Surgical Care standards. Remember, the Behavior Control standards are to be used only in crisis/emergency situations where the patient is exhibiting violent behavior. These situations do not meet that standard. In either of these cases, the physician could order restraints on the patient after completing the following:
   - an assessment of the patient,
   - a review of the medical record, and
   - documenting a change in the patient’s plan of care to reflect the need additional need for restraints in order to help treat a medical/surgical condition.
   If the physician on call is not one of the patient’s treating physicians, then he/she should notify one of the treating physicians as soon as possible.

3) Q: If you are concerned that a patient “might” get up at night and wander the halls or “might” fall in their room at night without being restrained, can you still restrain them?

   A: This question requires more information. Since neither of these are violent, threatening behaviors, these patients would fall under the Medical/Surgical Care standards. In order to meet the standard for restraining a patient in these cases, there would have to be documentation of:
   - a history of wandering off or falling,
   - an assessment that patient has an unstable gait,
   - or the documentation that the patient has a medical/surgical condition that requires the protective intervention of placing the patient in restraints.

   **It is explicitly stated in the regulations that convenience of the staff in NOT an acceptable reason to restrain a patient.**

4) Q: Can you give some examples of what is and what is not the use of a drug as a restraint?

   A: Yes.

   **Example 1**: A patient has Sundowner’s Syndrome. He gets out of bed in the evening and walks around the unit. The unit’s staff find his behavior bothersome, and ask the physician to order a high dose of Valium to “knock him out” and keep him in bed. The patient has no medical symptoms or conditions that indicate that he needs Valium. In this case, for this patient, the drug (Valium) is being used as a restraint. The
regulations clearly prohibit using a drug as a restraint for staff convenience, to coerce or discipline a patient, or as a method of retaliation.

Example 2: A patient is on an acute medical and surgical unit for a routine surgical procedure. She has no history of a psychiatric condition and is on no medications (aside from those she is being given before, during, and after surgery). One afternoon during her recovery period, the patient becomes increasingly agitated and aggressive. Attempts to divert and calm her are ineffective. The patient begins shouting that her roommate is spying on her, and physically attacks her roommate. In this case, the use of a drug as a restraint to calm and protect the patient and her roommate from harm is governed by the Behavior Control standard for seclusion and restraint. The patient needs to be seen and assessed by a physician within one hour of the initiation of the drug used as a restraint.

Example 3: A patient is in a detoxification program. He becomes violent and aggressive one afternoon. Staff administer a PRN medication ordered by his physician to address this outburst. In this case, the medication used for the patient is not considered a “drug used as a restraint.” The availability of a PRN medication to manage outbursts of aggressive, violent behavior is standard for the patient’s medical condition (i.e., drug or alcohol withdrawal). Therefore, his medication does not meet the definition of “drug used as a restraint” since it is “a standard treatment for [his] medical or psychiatric condition.” The use of this medication for the patient is not affected by either the Behavior Control or Medical/Surgical care standard since it is clearly indicated for treatment of the patient’s primary diagnosis.

5) Q: If I am a cross-cover intern or resident who orders restraints on a patient in the middle of the night, when should I call a “treating physician” member of the primary service caring for the patient?

A: It is clear from the regulations that the impetus of this requirement is the fact that one of the patient’s “treating physicians” may have a piece of important information about the patient’s condition that is not readily available to a cross-covering doctor. In an academic center, this is not likely since on-call residents are usually in-house and have access to all pertinent medical records. However, we must still follow this standard in the regulations.

As you can see from the sample progress notes, cross-covering interns and residents are going to be asked to use their professional judgement on when exactly to contact a member of the primary team. If the need to order restraints represents a significant change in the patient’s status or represents a significant departure from their previous clinical course, an attending or resident physician on the primary service should be called immediately no matter what time it is. If the patient is otherwise stable and the use of restraints does not represent a significant change in their clinical course compared to previous nights in the hospital, it could be prudent to delay contacting a member of the primary service until first thing in the morning (probably approximately 7:00am or on check-out to the primary team when they arrive). In either case, this decision on when, how, and who to contact needs to be documented in the chart note made by the cross-covering member of the housestaff. Please see the attached sample progress notes.

6) Q: What if a patient needs to have a restraint placed to properly complete a procedure or surgery?

A: If the restraint is used “usually and cusomarily” during a medical, surgical, diagnostic, or anesthetic procedure, then it should be included in informed consent that is received from the patient before the procedure occurs. In this case, it is NOT considered a restraint under this policy. For example, this would include the immobilization of a leg for arthroscopic knee surgery or the routine use of sedation to perform an endoscopy. However, it is important to remember that this should be covered and documented in your statement of informed consent in the medical record.
Sample Progress Notes for Initiation of Restraints

Remember, your goal with this note is to document the following:

1. the indications for restraints/seclusion
2. the change(s) in the patient’s plan of care regarding the use of restraints/seclusion
3. if you are not one of the patient’s treating physicians, the fact that you will communicate the initiation of either restraints or seclusion to one of the patient’s treating physicians as soon as possible.

DATE, TIME
Intern cross-cover note
I was called to see Mrs. Smith by her nurse. After an assessment of the patient and a review of the pertinent records in the chart, I feel that she will need soft wrist restraints for the remainder of the night in order to be sure that she will not pull her NG tube or remove her IV. Appropriate monitoring will be done by the floor nurses. Given that it is 3:00am, that she had similar problems over the past few nights, and that she is otherwise stable, I will alert the primary team at 7:00am later this morning.

Jane Intern, MD  pager #1234

DATE, TIME
Intern cross-cover note
I was called to see Mr. Jones by the charge nurse because his nurse was having a difficult time getting him to cooperate with staying in bed after his hip replacement. After an assessment of the patient, a review of the pertinent records in the chart, and a discussion with the nursing staff, I feel that he will need both restrained with a posey and also some sedation to allow him to rest comfortably through the night. Given that this is a significant change in his status from baseline, I will go ahead and contact his attending physician, Dr. Smith, at this time to make her aware.

John Intern, MD  pager #1235

DATE, TIME
Intern cross-cover note
I was called to see Mr. Jackson after he was found screaming in the hallway and threatening a PCA and waving his fists. I gave a verbal order for Haldol 10mg IM X 1. With the help of security and two PCA’s, Mr. Jackson was back in bed by the time I arrived on the floor approximately 5 minutes after being called. He had been appropriately restrained with bilateral soft wrist restraints. He had calmed down markedly after one dose of Haldol and was resting comfortably. I was able to assess the patient at that time and review the pertinent medical records in the chart. He will be restrained per the Behavior Control protocol. Given that this is a significant change from his baseline, I will contact his attending physician, Dr. Jones, immediately.

Jack Intern, MD  pager #1236