I. Purpose

To establish policies and procedures that will govern:
1. The use of seclusion and restraints;
2. The nursing care of patients who are in seclusion and/or restraints.

II. Policy

Nursing shall collaborate with the patient to develop strategies that may minimize the potential for a behavioral emergency and/or the need for seclusion or restraint. Seclusion or restraint shall be used only when less restrictive measures have proven ineffective and the behavioral emergency poses risk of harm to the patient, staff, or others. When seclusion or restraint is utilized, the patient’s rights, dignity and well-being shall be protected and preserved.

III. Definitions:

A. **Attending Physician**- The psychiatrist responsible for the psychiatric and medical/surgical non-psychiatric care and treatment of the patient.

B. **Constant Observation**- The continuous one on one observation of a patient by a staff person who is not performing any other duties or activities and has no other assignments; is assigned to the patient on a one-on-one basis; and is within arms length of the patient, unless there is a documented medical or psychiatric contraindication for this level of proximity. The patient must be within the staff
members’ vision in toilet or shower stall areas while respecting patient privacy to the extent possible.

C. **Continuous Monitoring**- The continuous in-person observation of a patient by an assigned staff person who is at arms length distance from the patient, within vision at a distance sufficient to intervene or through the seclusion room door. The physician shall determine whether this monitoring is accomplished by constant observation or visual constant observation.

D. **Emergency**- An instance in which there is an imminent risk of an individual harming himself or others, including staff; when nonphysical interventions are not viable; and safety issues require an immediate physical response.

E. **Restraint**- Three types of restraint are defined below.
   1. **Mechanical Restraint**- the use of approved mechanical devices that:
      a. involuntarily restrict the freedom of movement or voluntary functioning of a limb or a portion of a person’s body as a means of controlling his physical activities, and
      b. does not allow the patient the option to remove the device
   2. **Pharmacologic Restraint**- A medication that is given involuntarily to control extreme behavior during an emergency when such medication is not the standard treatment for the patient's medical or psychiatric condition. A medication must meet the following criteria to be classified as a pharmacologic restraint;
      a. it must be administered involuntarily
      b. it must be ordered for the purpose of behavior management, and
      c. the medication ordered is not the standard treatment for the patient’s medical or psychiatric condition
   3. **Physical Restraint**- (also referred to as “manual hold”) use of approved physical interventions or “hands on” holds to prevent a patient from moving his body to engage in a behavior that places him or others at risk of physical harm. Physical restraint does not include the use of “hands on” approaches, which occur for extremely brief periods of time, never exceed more than a few seconds duration and are use to:
      a. intervene in or redirect a potentially dangerous encounter in which the patient may voluntarily move away from the situation or hands on approach;
      b. quickly de-escalate a dangerous situation that could cause harm to the patient or others;
      c. interrupt dangerous behavior in order to interact with the patient to establish lesser restrictive alternatives.

F. **Seclusion**- the involuntary placement of a patient in a locked room or in a room or area where he is physically prevented from leaving.

G. **Treatment Plan**- The written document that reflects the integrated focus of treatment designed to promote the patient’s rapid stabilization, rehabilitation and return to the community. Derived from the assessments, and utilizing patient
strengths, the plan is the mechanism through which care and treatment needs are identified and goals and interventions planned to address each need. It is evaluated as the patient changes in response to care and treatment.

H. **Visual Constant** - The continuous one-on-one monitoring of a patient by a staff person who is not performing any other duties or activities and has no other assignments; is assigned to the patient on a one-on-one basis; and who maintains the patient within his eyesight. When a patient is secluded, this shall be performed by visualizing the patient through the seclusion room window. When the patient is restrained, the staff person must be within sufficient physical proximity for intervention while affording personal space.

I. **Staff approved/authorized by the facility to initiate mechanical restraints or seclusion** - This includes all Physicians and RNs who have completed the hospital approved Seclusion and Restraint training.

IV. **General Information**

A. Patients shall be treated with respect and dignity and in a safe, humane, culturally sensitive and developmentally appropriate manner. Treatment shall respect patient choice, participation in treatment, preference of restrictive measures, and measures to be used to provide external management while self-management strategies are being developed.

B. The treatment environment shall foster limited use of seclusion or restraint, using recovery oriented approaches and clinical processes that promote prevention through:
   1. Assessments that identify potential risk factors for dangerous behavior;
   2. Individualized treatment objectives and interventions that utilize patient strengths, patient-identified strategies to prevent and/or manage dangerous behavior;
   3. Collaboration and partnering with the patient to offer alternatives to behavior that could lead to harm to self or others; empowering the patient and providing the patient opportunities to learn to manage their own behavior rather than one that emphasizes staff control;
   4. Timely review and evaluation of factors that triggered and/or contributed to the use of seclusion or restraint;
   5. Consideration of how age, developmental level, cultural background, medical/physical condition, gender and history of physical or sexual abuse may influence behavioral emergencies, interventions utilized and impact effectiveness or response to seclusion and restraint;
   6. Recognition of how a staff member’s culture and perceptions and counter transference issues can influence his/her, response to patient behavior;
   7. Prioritizing use of non-physical interventions.

C. Seclusion or restraint shall never be used as punishment, coercion, retaliation, for staff convenience, as a substitute for treatment, or in a manner that causes undue physical discomfort or harm to the patient. The use of restraint or seclusion shall
not be based on a patient’s restraint or seclusion history or solely on a history of dangerous behavior.

D. Seclusion or restraint shall not be used in response to property destruction except when there is imminent danger to self or others.

E. Seclusion or restraint shall not be utilized as part of a behavioral treatment program.

F. The least restrictive method for the patient shall be utilized for the shortest period of time necessary to assure the safety of the individual and others. This includes using the minimum number of mechanical restraints, affording the patient maximum freedom of movement while assuring the physical safety of the patient and others.

G. The simultaneous use of seclusion and restraint is discouraged. Whenever both actions are implemented to provide safety to the patient and others, the attending physician and Unit Manager/Nursing Supervisor shall be notified immediately and together collaborate about alternatives. If one of the measures is not discontinued, the Medical Director and Director of Nursing shall be notified immediately.

H. Seclusion is contraindicated for patients with uncontrollable self-abuse or self-mutilation.

I. Physical or mechanical restraints may be contraindicated for individuals with known histories of sexual/physical abuse or certain medical conditions. This shall be based on discipline assessments and documented in the Treatment Plan. The MD order shall include any variation on restraint use due to special conditions.

J. Pain compliance techniques shall not be used.

K. Staff shall not:
   1. hold a patient’s jaw/chin closed or
   2. place something that could obstruct breathing over a patient’s nose or mouth.
   3. restrain a patient face down
   4. lie on, straddle or apply pressure to a patient’s chest/trunk

L. Written or verbal orders for initial and continuing use of restraint or seclusion shall be time limited. The orders shall be limited to four (4) hours. Standing or PRN seclusion or restraint orders shall not be used.

M. In an emergency situation that occurs while patient is in transport and away from the hospital, the accompanying staff member may physically, if it is safe to do so (adequate staff/assistance), or mechanically restrain the patient. The accompanying staff member shall immediately notify the charge RN or Nursing Supervisor. The RN shall immediately consult with a physician and review the situation, and obtain and write an order. Upon return to the Institute, the staff member shall give report to the RN or MD, review further details of the situation, and assure documentation in the record.

N. During drills, actual fires, or disasters, the staff member designated to be on constant observation or visual constant with any secluded or restrained patient shall remain with the patient until direction is given by an RN. EXCEPTION: The patient is in immediate danger, in which case the patient is to be immediately
removed from danger and the staff member assigned to be with the patient shall request assistance from other staff. In the event of an evacuation order, two staff members shall remain with the patient in the designated area until the safest relocation is determined.

O. Pharmacological restraint shall fully comply with the definitional and appropriateness criteria detailed in attachments.

P. The Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMH/MRSAS) has an approved behavioral interaction and crisis management system. The approved system provides a graded system of alternatives for managing people, utilizing the crisis model. All staff shall use the DMH/MRSAS approved system of graded alternatives for managing people. Only staff certified and competent to perform this system shall perform such activities as designated in this policy.

Q. The care and monitoring of patients in seclusion or restraint, as well as the application and removal of restraints, shall be performed only by individuals with current competency.

V. Procedures

A. All aspects of NVMHI Policy and Procedure P-14, Seclusion or Restraint, shall be followed.

B. Early Intervention

1. Whenever a patient begins to act in a manner that could indicate potential to escalate to dangerousness to self or others, nursing staff shall implement the interventions contained in the patient’s treatment plan or interventions appropriate to the patient’s demonstrated level of behavioral crisis.

2. Nursing staff shall consider patient preferences, utilizing interventions that have been previously effective for the patient as well as avoiding those that the patient has identified as making it worse or that have been ineffective unless the assessment factors have changed.

3. Nursing staff shall consider the least restrictive interventions if those described in the treatment plan are ineffective or not applicable to the current situation. These may include, but are not limited to:
   a. Verbal and non-verbal communication
   b. Reduced stimulation
   c. Walking or talking softly with the patient
   d. Allowing the patient physical space and distance
   e. Offering physical presence and availability to the patient
   f. Actively listening and communicating understanding of the patient’s perception
   g. Channeling feelings into activities
   h. Redirecting the patient to a quieter area
   i. Offering distracters and other diversionary activities
   j. Assisting and involving the patient in problem solving

4. RNs/LPNs shall use ordered medications that are consistent with the patient’s
treatment needs to support patient self-management.

5. Orders for a pharmacological restraint shall meet the definitional and/or the appropriateness criteria. Orders for pharmacological restraint that do not meet all criteria shall be questioned and the physician notified for clarification.

6. The RN shall assess the patient for behavioral and affective presentation, and triggers that may stimulate escalation.

7. The RN shall assess patient behavior to distinguish between behavior posing physical harm from behavior that irritates, annoys others or causes property destruction (without potential for physical harm).

8. The RN shall determine the appropriateness of implementing seclusion or restraint on an emergency basis in the following circumstances:
   a. If lesser restrictive interventions cannot be safely implemented;
   b. If lesser restrictive interventions are not feasible due to the immediacy of the threat, or
   c. If lesser restrictive interventions are not effective in decreasing the likelihood of harm to self or others.

C. Initiation of Seclusion or Restraint

1. If possible, a pre-seclusion or restraint conference shall be conducted in a non-patient area to plan individualized interventions. The planning discussion shall include:
   a. the dangerous behavior necessitating seclusion or restraint;
   b. infection control issues to be considered;
   c. plan for least restrictive nonphysical/physical techniques to be utilized;
   d. use of minimum number of staff to complete the procedure safely and efficiently, including gender mix and positioning to best support patients with a history of sexual/physical abuse or abuse history.
   e. criteria for release;
   f. identification of the most effective staff person to speak to/interact with the patient during intervention.
   g. Consideration of contraindications and impact of interventions to be used.

2. Staff shall approach the patient in a professional, positive, controlled manner to continue to assist the patient in regaining his own control. A calm voice tone shall be utilized and the patient’s understanding and ability to work with staff shall be assessed.

3. Staff members shall consider level of sensory input, stimulation and physical presence.

4. When seclusion or physical/mechanical restraints are initiated, staff shall assure the patient’s personal dignity, privacy, and confidentiality by providing a protected environment, occurring away from other patient’s if possible.

5. Staff members not involved in working with the individual patient shall assist other patients away from the area of intervention. The staff shall remain with
them as needed for reassurance and support, and offer them the opportunity to
discuss concerns.
6. Staff members shall maintain assigned positions when approaching a patient
demonstrating emergent behavior. Side dialogue/cross dialogue strategies may
be utilized to promote team communication. Any changes in the approach
shall be clearly indicated by the RN to other team members.
7. A staff member certified in the Department-approved behavioral interaction
and crisis management techniques may imitate a physical restraint. The staff
member(s) shall use the least restrictive form of physical restraint needed to
ensure the safety of the individual patient and others. An RN or physician
shall be immediately notified when a physical restraint is initiated.
8. Once a physical restraint is initiated, a physician or RN shall:
   a. assess the patient within ten (10) minutes of the patient being
      physically restrained;
   b. identify the least restrictive intervention, considering alternatives and
      patient preferences;
   c. make a determination of the need for continued physical restraint,
      mechanical restraint or seclusion;
   d. check the patient’s record for contraindications to seclusion or
      restraint use;
   e. check for the correct application of physical restraint and indications
      of or reports of pain or injury;
   f. release the patient if alternatives are identified;
   g. initiate required mechanical restraint or seclusion and;
   h. inform the patient of the behaviors that he must demonstrate for
      release or for a reduction in restraint.
9. An RN shall be present when seclusion or mechanical restraint is initiated.
10. Prior to placing a patient in seclusion or restraints, the following shall be
    completed:
    a. The reason for the procedure shall be explained to the patient by the
       RN or physician. If seclusion or restraint must be initiated prior to
       this explanation, the reason for the procedure shall be explained to
       the patient as soon as the patient has regained sufficient control of
       his/her behavior to allow such an explanation to be given. The
       explanation shall be repeated as necessary to facilitate
       understanding;
    b. The specific behavioral criteria for release shall be explained to the
       patient by the RN or physician;
    c. As soon as the patient appears to be able to listen to and comprehend
       information, the patient shall be advised of his right for an impartial
       review of the use of seclusion or restraint by the Human Rights
       Advocate and the Local Human Rights Committee;
    d. The patient shall be checked for any objects that might be used to
       injure him or herself, such as shoes, matches, lighters, belts, jewelry,
glass, sharp or potentially breakable objects. These objects shall be removed and stored in a safe place for return to the patient when and if appropriate. Socks shall be checked for hidden objects and patient name identification removed;

e. Any money, jewelry, or other potentially valuable items which were in the patient’s pocket or on his person shall be placed in a valuables envelope and placed in a designated locked drawer in the Medication Room and returned to the patient when safe to do so.

f. The patient shall be reassured of his safety and instructed of the availability of staff

11. Upon exit from the seclusion room, the ante room door shall remain unlocked and the patient shall be on visual constant.

12. The patient may be requested to change clothing in staff’s presence or wear a hospital gown if ordered by the physician. The order shall be documented on the Physician Order Sheet.

13. Any time a physical intervention is required due to a patient’s dangerous behavior, a Registered Nurse shall assess the patient’s physical status and report any potential injury or patient complaint of injury to a physician

14. When an RN authorizes the continuation of physical restraint, or the initiation of seclusion or mechanical restraint, he/she shall immediately contact a physician to obtain a verbal or telephone order as soon as possible, but no longer than one hour after the initiation of restraint or seclusion.

a. The order shall include the following:
   i. specific behaviors requiring seclusion or restraint;
   ii. type of restraint selected;
   iii. the maximum duration of the order, not to exceed 4 hours from initiation of the seclusion or restraint;
   iv. specific measures for meeting special needs of patients, i.e., eyeglasses, hearing aids to remain with patient;
   v. level of monitoring, if different from procedures described in policy;
   vi. behavioral criteria for release;
   vii. signature of physician;
   viii. date and time of order;
   ix. notation that it is a verbal or telephone order and that the order was read back to the physician for the purpose or confirming accuracy.

b. Only a Registered Nurse shall accept a verbal or telephone order. The verbal or telephone order shall written down by the RN and then read back to the physician for verification and signed with the name of the physician giving the order noting “TORB” and the name of the RN receiving the order.
D. Assessment, Interventions, Care and Monitoring During Seclusion or Restraint

1. During the hours from 5:00pm to 8:00am weekdays and 8:00am to 8:00am on weekends and holidays, the Nursing Supervisor shall make the following notifications of the need for seclusion or restraint, and document the notification in the patient’s record:
   a. The patient’s emergency contact (or others as indicated) when authorized by the patient and desired by the family, or emergency contact;
   b. The authorized decision maker of the patient.
      At the time of the notification(s), the Nursing Supervisor shall try to ascertain from the family / LAR the existence of antecedents or triggers known to the individual, and additional alternative strategies to prevent or manage the emergency.

2. The Human Rights Advocate and Risk Manager shall be notified of seclusion or restraint episodes via the 24-Hour Report of Seclusion, Restraint, Observations, and Restrictions Report (NVMHI 350).

3. A pre-conference shall be held prior to each planned entry into the seclusion room to discuss patient current behavior, infection control issues to be considered, plan for least restrictive nonphysical/physical techniques to be utilized, use of minimum number of staff to make entry, criteria for release.

4. Staff shall monitor the patient in seclusion or restraint as follows:
   a. Patients in any type of mechanical restraint outside of seclusion shall be on constant observation or visual constant. All aspects of the Nursing Procedure on Special Observations shall be followed. A second staff member will check on the staff member and patient every 15 minutes and document per Nursing Procedure on Special Observations.
   b. Patients in seclusion shall be on visual constant. All aspects of the Nursing Procedure on Special Observation shall be followed. A staff member shall be stationed outside the seclusion room door, observing the patient continuously through the window. A second staff member shall check the staff member and the patient every 15 minutes and document as directed in the Nursing Procedure on Special Observations.
   c. Patients having combined use of seclusion and restraint shall be on visual constant. A staff member shall be stationed outside the seclusion room door, observing the patient continuously through the window. A second staff member shall check the staff member and patient every 15 minutes and document as directed in the Nursing Procedure on Special Observation.
   d. Patient’s position, general level of activity, and expressed needs shall be observed.
   e. Staff shall observe patients for any signs of changes in level of consciousness, circulation and respiration as well as for any verbal or
non-verbal expressions of pain or discomfort. A RN shall be notified immediately to assess the patient in any of these situations.

f. Staff shall observe patients for verbal and physical behaviors in relation to the criteria for release and notify a RN immediately as the criteria are met.

5. Staff shall intervene with the patient in seclusion or restraint as follows:

a. Observe the condition of skin, and circulation and position of restrained limbs of a patient in any type of restraints.

b. Provide the patient the opportunity to exercise restrained limbs every 2 hours at a minimum or as the patient requires

c. Document vital signs at least hourly

d. Offer food at regularly scheduled dining hours and at the appropriate temperature.

e. Offer fluids every hour while awake.

f. Interact verbally with the patient in a manner consistent with the treatment plan and directed toward assessment, monitoring, and evaluating the patient condition and facilitating release. This should be accomplished in a manner consistent with the patient’s need for rest or stimulation. Staff shall discuss with the patient the behavioral criteria for release from seclusion or restraint, and strategies to meet these criteria.

g. Provide the patient access to toilet facilities according to his needs or a minimum of every two (2) hours.

h. Provide the patient the opportunity to bathe and perform mouth care at least once every 24 hours. Assistance shall be provided consistent with the patient’s condition

6. Every fifteen minutes, unless more frequently ordered by the physician or determined by RN assessment, the assigned RN shall perform and document an assessment of the physical and psychological status and response to seclusion or restraint. The assessment shall be performed through direct observation and interaction. If the patient is in seclusion, the RN assessment may be conducted through the seclusion room window provided all aspects of the assessment can be accurately determined.

7. At least hourly, the assigned RN shall conduct and document an in-person, face-to-face assessment of the patient’s physical and psychological status and response to seclusion/restraints.

8. The RN shall assess and respond to:

a. the patient’s need for exercise, hygiene, elimination, and nutrition/hydration

b. the patient’s need for circulation and range of motion of extremities

c. the need for vital sign assessment;

d. signs of injury or illness such as skin color, complaints of pain or discomfort, level of consciousness

e. the physical and psychological status and comfort needs of the patient
f. patient’s response to interventions to promote discontinuation of restraint or seclusion, which may include medications, verbal or behavioral strategies that may be useful to the clinical situation and patient participation in formulating strategies to promote release.

9. An immediate in person, face to face assessment shall be conducted by an RN whenever the following circumstances are present:
   a. there is a change in the patient’s level of consciousness or responsiveness (e.g., sleep, drowsiness), respiration, circulation.
   b. vital signs signal a change in physical status, or
   c. concerns are raised by staff monitoring the patient.

10. Special attention should be directed toward patients whose cultural or functional needs or history of sexual/physical abuse may require individualized support and intervention.

11. When assessing patient readiness for release from seclusion or physical or mechanical restraint, it is important to distinguish behavior that represents continuing dangerousness from behavior that may represent an untoward response to seclusion or restraint.

12. Staff shall involve the patient in formulating strategies to promote recovery of control and expedite release from seclusion or restraint.

13. Staff shall assure patient privacy, confidentiality, dignity, and security by assisting other patients away from the area of staff intervention.

14. Special attention shall be paid to patients with unstable medical conditions requiring close monitoring and to the patient’s vulnerability to continued or reduced sensory input.

15. Staff shall be alert to adequate lighting and ventilation in the seclusion room, comfortable temperatures, the presence of any safety hazards, and the cleanliness of the room.

16. Effective psychiatric nursing care shall be maintained including support, respect, and clarification of the patient’s perceptions and feedback in relation to the behavioral criteria for release from seclusion or restraint. Patient strengths that shall support the patient in regaining self-control shall be utilized to expedite rapid release from seclusion or restraint.

D. Re-Evaluation, Continuation and Release:

1. The duration of an episode of seclusion or restraint shall be dictated by the behavioral criteria specified in the order, not by the length of time of the order. Restraint or seclusion use is discontinued when the patient meets the behavioral criteria for release.

2. Unless otherwise ordered by the physician, patients in seclusion or restraint shall be released when sleeping.

3. When a patient exhibits the release criteria described in written order, an RN or physician shall be notified immediately. The RN or a physician shall evaluate the patient to determine if the release criteria have been met. If the determination is made that a patient is exhibiting the behaviors indicated in order but the patient is still not ready for release, the justification must be
documented in the clinical record and a new physician order obtained with new release criteria.

4. If a patient in seclusion or restraint for four (4) hours continues to exhibit behavior that poses danger to self or others, the physician or RN shall perform a face-to-face re-evaluation. Consideration must be given to interventions that would expedite release. A new physician’s order shall be written as well as documentation to reflect the results of the re-evaluation including continued need for seclusion and restraint, alternatives considered and rejected, and interventions implemented to promote release.

5. If the patient remains in seclusion or restraint for 8 hours, a physician shall perform a face-to-face re-evaluation.

6. Staff shall facilitate the patient’s re-entry into the treatment milieu following release from seclusion or restraint. This will include:
   a. assessment/re-assessment of need for special observation consistent with patient needs and physician order;
   b. transitional support such as quiet time or diversionary activities, according to the patient’s individual needs;
   c. opportunities to discuss the experience privately with staff who will listen and clarify patient perceptions;
   d. re-establishing contact with the patient, conveying care, concern and respect;
   e. return of patient belongings;
   f. replacement of name identification band on the patient’s wrist.

7. When the patient is released from seclusion or restraint, the nurse, physician, patient and others shall participate in a debriefing within 24 hours after each episode. The debriefing shall include the patient, the family if appropriate, and available staff who were involved in the episode. The debriefing involves:
   a. discussing the events and behaviors that led to the use of seclusion or restraint;
   b. discussing and clarifying any possible misperceptions the patient may have concerning the incident;
   c. discussing alternative interventions to reduce the potential for future seclusion and/or restraint;
   d. discussing what could have been handled differently;
   e. ascertaining the patient’s willingness to involve family or other caregivers in a debriefing to discuss and clarify their perceptions as well as identify additional alternatives or treatment plan modifications;
   f. determining that the patient’s rights, including right to privacy, and physical/psychological well being were addressed during the seclusion/restraint, and informing the patient of the opportunity to discuss issues with the Human Rights Advocate.
   g. reviewing how the patient’s behavior met the criteria for release;
h. modifying the patient’s treatment plan when indicated;
i. hearing and recording the patient’s perspective on the episode;
j. addressing any trauma that may have occurred as a result of the incident.

8. The attending or covering physician shall assure that the use of seclusion or restraint is reviewed by the Treatment Team no later than 5 p.m. on the next weekday and make additions or revisions to the treatment plan as needed.

F. Preparation/Application of Restraints

1. Preparation of Equipment:
   a. Equipment shall be gathered and placed adjacent to the area where the patient is to be restrained.
   b. All restraints and connecting belts must be checked for safe working order and cleanliness. Connecting belts must be checked to assure they are in a locked position.

2. Application
   a. Plastic Restraints with Leather Belt
      i. Wrap the plastic restraints around the narrowest part of the wrist.
      ii. Slide the plain end of the strap under the metal locking clamp. (Place stockinet as needed under the restraints to prevent friction.)
      iii. Pull the restraint tight enough to prevent slipping over the hand but loose enough to slip 2 fingers between the restraint and the patient’s skin.
      iv. Lock the restraint by placing the clamp edge in the desired groove of the plastic end and then pressing downward until it lock snaps. (The leather connecting belt between the plastic restraints must be in the locked position.)
      v. With body belt in hand, slip the body belt through the leather connecting belt holding the wrist restraints. Slip buckle through the leather connecting belt multiple times as needed to attain comfortable yet safe fit.
      vi. Wrap belt around the patient’s waist. (A nurse may assess the need to pass through pants belts loops if present.) Make sure buckle remains in a comfortable position for the patient, i.e., not under the patient’s back or hand.
      vii. Tighten the belt as necessary
      viii. Place stem of belt buckle in hole appropriate for patient size and comfort.
      ix. Lock by simultaneously pressing in on metal spring and pushing down on metal locking mechanism located on the side of the belt until you hear the “click”.
      x. Wrap excess strap away from patient’s hands.

Note: For ankle restraints, follow a., i-iv only.
b. Application of Synthetic Leather Restraints
   i. Wrap the synthetic leather restraints around the narrowest part of the wrist.
   ii. Adjust the synthetic leather restraint and put the cuff stem into the hole. Pull the restraint tight enough to prevent slipping over the hand but loose enough to slip 2 fingers between the restraint and the patient’s skin.
   iii. Lock the restraint by pressing the lock down onto the stem. Make sure the lock “clicks” shut.
   iv. With body belt in hand, slip the body belt through the leather connecting belt holding the wrist/ankle restraints. Slip buckle through the leather connecting belt multiple times as needed to attain comfortable yet safe fit.
   v. Wrap belt around the patient’s waist. (A nurse may assess the need to pass through pants belts loops if present.) Make sure buckle remains in a comfortable position for the patient, i.e., not under the patient’s back or hand. Tighten the belt as necessary.
   vi. Place stem of belt buckle in hole appropriate for patient size and comfort.
      Lock by simultaneously pressing in on metal spring and pushing down on metal locking mechanism located on the side of the belt until you hear the “click”.
   vii. Wrap excess strap away from patient’s hands.
      (For ankle restraints, follow b., i-iii only.)

3. Aftercare of Equipment
   a. Cleaning
      i. Leather/Plastic Restraints and Belt must be cleaned after each use by the following method:
         aa. Scrub with cloth or sponge with soapy water using friction.
         bb. Wipe with anti-microbe wipe (sani-dex).
         cc. Allow to air dry.
      Note: Should restraints be needed again immediately after removal, cleanse with alcohol prep pads or 70% isopropyl alcohol on a cloth. This readily dries, thus permitting safe reuse of restraints.
      ii. Synthetic Leather Restraints:
         aa Submerge entire restraints in 70% isopropyl alcohol for 10 minutes.
         bb. Allow to dry completely before next use.
   b. After cleaning, all restraints and belts shall be checked for working order.
   c. Restraints are placed in a navy blue duffle bag and placed in the ante-room or chart room of each unit. Each bag shall contain the
2 open wrist restraints connected by locked connecting belt.
2 open ankle restraints connected by locked connecting belt.
1 body belt.

VI. Documentation:

A. Refer to Appendix A for specific Guidelines for Seclusion/Restraint ID Notes.
B. The assigned RN, or designee, shall initiate an ID Note for Special Observation (NVMHI 304[5]) to reflect monitoring of the patient’s behavior, position, activity level, and staff interventions at least every fifteen (15) minutes.
C. The Nursing Staff assigned by the Charge Nurse to document special observation shall:
   1. Observe the patient and nursing staff member assigned to CO or VC every 15 minutes. Observe the patient for behaviors, and any special and/or emergent needs. Observe the staff for assistance needed in patient care.
   2. Document the location and predominant behaviors in the context of the identified release criteria of the patient every 15 minutes using established codes.
   3. Document staff interventions and patient responses using established codes.
   4. Initial in the box for that 15 minute observation and enter signature corresponding to initials in the signature box.
   5. Enter brief narrative notes on the ID Note section when information cannot be coded.
   6. Follow all aspects of the Nursing Procedure on Special Observation.
D. The Charge RN shall complete the 24 Hour Report of Seclusion, Restraint, Observations, and Restrictions (NVMHI 350).

IV. References

NVMHI Policy and Procedure, P-14, Seclusion or Restraint.


Department of Mental Health, Mental Retardation, Substance Abuse Services (2001). Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation, and Substance Abuse Services. VA