Seclusion/Restraint is one of the most risky procedures we do at Richmond State Hospital.
Any time force is used to confine, move or immobilize a person against their will, harm can result to someone involved, even when proper technique is used.
Patients get injured
Staff members get injured
... and injuries are not confined to physical injuries

Patients subjected to seclusion or restraint are often traumatized...particularly those who already have a history of abuse and trauma.
Alternatives

Measures for preventing Seclusion and Restraint include:

Know your patients
Know your patients’ safety plans

- What helps them maintain self-control?
- What helps to relieve stress, anxiety and anger?
- What are their “cues” or “signs” that indicate they are not doing well or are suffering from anxiety, anger or distress?
- What are they most likely to respond to when they are losing self-control?
- What are their “triggers” that increase anxiety, anger, fear or loss of self-control?
What has been going on with your patients recently that might contribute to anxiety, fear or anger?

- Recent family issues or recent visit with family or loved ones that didn’t go well?
- Medication change that is contributing to increased psychotic symptoms or anxiety?
- Interpersonal conflicts with others that might contribute to behavioral outbursts or anger?
- Difficulty sleeping, mood fluctuations or instability, increase in psychiatric symptoms?
Alternatives

Measures for preventing Seclusion and Restraint include:

Observing and Monitoring for Potential Problems
• Are there patients on the unit who are exhibiting signs of increased tension, anxiety or anger?
• Some of these signs or symptoms might include:
  ◦ Pacing
  ◦ Social withdrawal
  ◦ Arguing
  ◦ Visible tension exhibited in body posture or movements
• Are there patients on the unit who are in conflict with each other?
Alternatives

Measures for preventing Seclusion and Restraint include:

Address potential problems early
Don’t wait to respond to potential problems until the problems actually erupt....

Take the initiative to prevent violent or threatening behavior before it starts!

Respond to potential problems early!
Most of the time, if you wait until a patient is already yelling, threatening, or becoming physically violent, you have missed the opportunity to resolve the situation without physical intervention.

Respond to potential problems early!
There are some things that you can do to prevent anxiety and fear from turning into behavior that necessitates physical management.
Touch base with the patient to check out your visual observations:

“John, you look like you might be upset about something. How can I help?”

(Let your knowledge of the patient guide how you approach and interact with them)
Try to engage the patient in an activity they enjoy...let the patient be your guide, whenever possible, when choosing an activity. This might be a way to separate patients who are in conflict, or engage a patient who is suffering from psychotic symptoms that are causing anxiety or anger.
Offer PRN medications to help with overwhelming feelings of anxiety or anger, if ordered.

Unit Staff should always alert the RN to any patients who seem to be having difficulty, or are on the verge of becoming extremely anxious or upset.

Possible Interventions
Comfort Room

Sometimes the unit environment is just over-stimulating at times for some patients. Spending some quiet time alone in a calm, comfortable environment may relieve the tension and anxiety that comes from being confined with 20-30 other people.
Sometimes the most important and useful tool to assist patients to maintain self-control and avoid destructive behavior is **ACTIVE LISTENING**.
The interventions you choose to help your patient maintain self-control and relieve tension, anxiety or anger depend on the patient and what will work for that individual, and also depend on your own relationship with the patient.
Despite the risks, Seclusion or Restraint may be necessary to maintain patient and staff safety when alternatives fail.
• To prevent self-harm
Sometimes patients are unable to interrupt self-harming behavior on their own and staff must intervene to prevent permanent or life-threatening injury to the patient.
To prevent harm to others (staff and patients)

When a patient threatens or attempts physical harm to others, either staff or patients, and the patient’s behavior is escalating and indicates loss of self-control, physical intervention becomes necessary to maintain safety.
• To prevent persistently agitated, threatening behavior exhibited by one patient from causing other patients to lose control and cause harm to patients or staff.

Sometimes a patient’s agitated, angry, threatening behavior becomes so persistent and intrusive to others that other patients start becoming fearful, agitated and threatening. If attempts to isolate the patient are not successful, the RN must direct the staff to intervene to remove the toxic stimulus so that other patients can maintain self-control and feel safe.
Implementing Seclusion or Restraint

Staff on the unit should enlist the help of the RN immediately whenever a patient is in danger of losing self-control and restraint might become necessary.
Sometimes a hold restraint becomes necessary with little to no warning in order to prevent harm to the patient or others. The RN assigned to the unit should be called immediately for assistance to monitor and direct the situation and to determine if mechanical restraints should be utilized to maintain safety.
Whenever it becomes necessary to restrain a patient, proper physical management techniques taught in Bridge Building training should be utilized. Unless the patient is already attacking you or someone else, you should yell for, or call for, assistance before physically laying hands on the patient...you should not attempt to restrain a patient without the necessary assistance from other staff.
**Seclusion** is the involuntary confinement of a person alone in a room where the person is physically prevented from leaving for any period of time (Hospital policy #140.02).

In other words, any time a patient is forced to remain alone in any room against his/her will, it is considered seclusion.
Examples of Seclusion

- Escorting a patient to his bedroom, and then standing in the doorway to physically prevent him from leaving.

- Escorting a patient to his bedroom, and then closing the door with the intent to keep him involuntarily confined in his room.
Seclusion does not include:

- Requiring that a group of patients remain in a certain area to prevent from harm or to complete a unit search.
- Requiring a patient to remain out of an area to prevent the patient from coming in contact with certain objects or other patients.
- Verbally directing or requesting that a patient go to his room for awhile, and he willingly complies, provided that he is not physically restricted or prevented from leaving his room.
Confining someone involuntarily to their bedroom when their behavior is escalating and they are losing self-control may be a better, less traumatic and less restrictive alternative than mechanical restraints, but it must be documented as a seclusion incident and an order for seclusion must be obtained from the physician.
Definition of a Restraint

Restraint is any manual method or mechanical device, material, or equipment attached or adjacent to the patient’s body that he/she cannot easily remove that restricts the patient’s freedom of movement or normal access to one’s body.
Examples of Restraint

- Grabbing a patient’s arms to prevent him from hitting someone or harming himself.
- “Escorting” a patient to the bathroom to bathe by taking hold of her arms and pulling her where she does not want to go.
- Holding a patient down for the nurse to give an injection when he is refusing the medication and otherwise would not be cooperative to receive the medication.
Any time you must take hold of someone to prevent willful movement, or force the person to go in a direction they do not want to go, it is a “Hold” restraint and must be documented as such.
A “Hold” Restraint is not...

- Touching a patient, or “hooking” arms with a patient, to guide and encourage them to move in a certain direction, as long as the patient has the ability to move away from you and move in a different direction than you want them to go.
- Stabilizing involuntary movements of a patient to enable the nurse to administer an injection, as long as the patient is willing to take the medication voluntarily.
It is the responsibility of every staff member, nursing or non-nursing, who must implement, or who witnesses, a restraint or seclusion with a patient to tell the Unit RN immediately if the RN did not directly witness the incident.

When reporting the incident, the staff member should specifically label the incident to the nurse as a “hold” restraint or a seclusion so there is no misunderstanding of what happened.
If an incident occurs with a patient that required staff intervention and possible behavioral management, the RN should specifically ask the staff involved if a “hold” restraint or incident of seclusion occurred to assure that all restraint and seclusion incidents get reported and the proper orders and paperwork are completed.
RN Reporting Responsibilities for Restraints and Seclusion

• The RN, after completing initial assessment of the patient restrained or secluded, must contact the physician within 20 minutes to report the assessment findings and obtain a physician’s order for the restraint or seclusion.
The unit RN must call the Nurse Supervisor to report the restraint/seclusion so that the patient debriefing can be completed, and so that the Nurse Supervisor can assess the patient and the situation.

The Nurse Supervisor will also assure that the restraint/seclusion incident is recorded on the D.O.R.
A restraint/seclusion packet should be initiated and completed by the RN(s) completing documentation on the incident.
The progress note documentation should be sequential in nature (to reflect an accurate time-line of events) and should be completed by the actual staff involved in the incident, not by one person who summarizes what everyone else did.
Progress note documentation should include:

- Events or conditions leading up to the restraint or seclusion.
- Alternatives that were tried to avoid the restraint or seclusion.
- Description of patient behavior.
- RN assessment of patient’s condition following implementation of restraints.
- RN should document in progress notes on patient condition at least every hour while patient is in restraints or seclusion.
Documenting the S&R Incident

Progress note documentation should reveal:
- What led up to the incident
- What the patient did
- What the staff did
- The condition of the patient after implementation of restraints/seclusion
The RN should chart sufficient follow-up in the hours after an incident to document that the patient was checked/monitored regularly following a restraint episode

- Should address the status of any injuries sustained during the incident
- Should note patient’s response to seclusion or restraint, including any verbalization of trauma
- Should note patient’s response to any PRN medication administered during or prior to incident
For patients in mechanical restraints or seclusion longer than 15 minutes, a Seclusion & Restraint Flow sheet must be initiated. Documentation (with initials) on the flow sheet must be completed every 15 minutes by the staff member assigned to continuously monitor the patient AND the RN who is assessing the patient.
You have completed the inservice on
SECLUSION AND RESTRAINT
“Basic Refresher”

Signature: ________________________________

Printed Name: ____________________________

Date: ________________

Print this slide, sign and print your name, enter the date, and send the
completed document to Terry Slayback in the Nursing Administration
Office for credit for this mandatory inservice.