Hospital Sisters HEALTH SYSTEM

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SYSTEM: Hospital Sisters Health System	**MANUAL(S): Executive Manual**
TITLE: HSHS Restraint and Seclusion Policy	**ORIGINATING DEPARTMENT: Quality and Physician Relations**
EFFECTIVE DATE: December 14, 2020	**REVISION DATE(S): 08/13/21, 05/25/2022**
SUPERCEDES: #D-22, 9/5/19, 6/7/18, 12/11/17, 7/29/16	

* As required by CMS Regulation §482.12 A-0043 Conditions of Participation: Governing Body, the following hospitals and entities are included as HSHS entities: ILLINOIS: (1) HSHS St. John's Hospital – Springfield (2) HSHS St. Mary's Hospital – Decatur, (3) HSHS St. Francis Hospital – Litchfield, (4) HSHS Good Shepherd Hospital – Shelbyville, (5) HSHS St. Anthony's Memorial Hospital – Effingham, (6) HSHS St. Joseph's Hospital – Highland, (7) HSHS St. Joseph's Hospital – Breese, (8) HSHS St. Elizabeth's Hospital – O'Fallon, (9) HSHS Holy Family Hospital – Greenville, (10) HSHS Physician Enterprise (HSHS Medical Group – Illinois, Prairie Cardiovascular Consultants). WISCONSIN: (1) HSHS St. Vincent Hospital – Green Bay, (2) HSHS St. Mary's Hospital Medical Center – Green Bay, (3) HSHS St. Clare Memorial Hospital – Oconto Falls, (4) HSHS St. Nicholas Hospital - Sheboygan, (5) HSHS Sacred Heart Hospital – Eau Claire, (6) HSHS St. Joseph's Hospital – Chippewa Falls, (7) HME Home Medical, (8) Libertas Treatment Center – Green Bay and Marinette, (9) HSHS Physician Enterprise (HSHS Medical Group – Wisconsin).

I. POLICY:

It is the policy of the Hospital Sisters Health System (HSHS) and all of its Local Systems including HSHS Holy Family Hospital, Greenville, IL, HSHS Sacred Heart Hospital, Eau Claire, WI, HSHS St. Anthony's Hospital, Effingham, IL, HSHS St. Clare Memorial Hospital, Oconto Falls, WI, HSHS St. Elizabeth's Hospital, O'Fallon, IL, HSHS St. Francis Hospital, Litchfield, IL, HSHS Good Shepherd Hospital, Shelbyville, IL, HSHS St. John's Hospital, Springfield, IL, HSHS St. Joseph's Hospital, Breese, IL, HSHS St. Joseph's Hospital, Chippewa Falls, WI, HSHS St. Joseph's Hospital, Highland, IL, HSHS St. Mary's Hospital, Decatur, IL, HSHS St. Mary's Hospital Medical Center, Green Bay, WI, HSHS St. Nicholas Hospital, Sheboygan, WI, HSHS St. Vincent Hospital Green Bay, WI and its entities to utilize the least restrictive form of restraints and only when alternatives have been considered and restraint use is clinically justified or warranted by patient behavior that threatens the physical safety of the patient, staff or others.

Restraints or seclusions may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a colleague, or others from harm.

II. PURPOSE:

A. To protect the rights of the patient to be free from restraints.

B. To ensure the safety of the patient, hospital staff, and others in the environment.

C. To maintain the dignity and safety of the restraint patient at all times.

D. To provide guidelines and ongoing education for multidisciplinary staff regarding the appropriate use of restraints.

E. To assure the assessment, planning intervention, and evaluation of restraint use in patient care.

F. To be sure safe and effective alternative methods are considered and/or used prior to using restraints.

III. SCOPE:

This policy is applicable to all HSHS hospitals*, Physicians' Organizations, and operating entities including their employees, agents and medical staff, as well as employed physicians of an HSHS Medical Group.

IV. DEFINITIONS:

A. In general, a restraint is 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, body, or head freely. Restraint definitions listed below and in table format (Attachment A).

B. RESTRAINTS: The following are specifically defined as restraints for the purposes of this policy:

1. Restraints are used for the purpose of protecting the safety of the patient, staff members, or others,
2. Mittens, arm boards, or other protective devices if they are tied down,
3. Side rails if used for the purpose of preventing the patient from voluntarily getting out of bed,
4. Geri chairs, waist belts, or other adaptive devices if used for the purpose of preventing the patient from voluntarily getting out of a chair,
5. Devices used to protect a patient following anesthesia if use is continued once the patient has recovered from anesthesia and/or has been transferred away from a recovery or critical care unit,
6. A therapeutic hold or any involuntary holding for the purpose of giving medications or treatments to the patient,
7. A drug or medication (chemical restraint) used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

C. NOT RESTRAINTS: The following are not restraints for the purposes of this policy:

1. Any device used to maintain position, limit mobility, or temporarily immobilize the patient during a medical, dental, diagnostic, or surgical procedure,
2. Mittens that are not tied down, if the patient can flex their fingers and have access to his or her body,
3. Arm boards if not tied down and used to protect intravenous access,
4. Side rails used for the purpose of preventing the patient from accidentally falling out of bed,
5. Geri chairs, waist belts, or other adaptive devices if used for the purpose of preventing the patient from accidentally falling out of a chair,
6. Devices used to protect a patient following anesthesia while the patient is still in the recovery or critical care unit and has not yet recovered from anesthesia,
7. Cribs, covered bassinets and other devices normally used for the protection of infants or toddlers,
8. Light touching or holding during escort, treatment, or giving of medications if the patient voluntarily submits to the touching or holding,
9. Hand cuffs, shackles or other devices used under the supervision of a law enforcement officer if the patient is in custody (although such devices must never be used as clinical restraints).
    a. If a patient is handcuffed, shackled, or has other devices in place by law enforcement, law enforcement must remain with the patient.

D. Seclusion is defined as the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving, either through physical barriers (e.g., a locked door) or intimidation. Seclusion may only be used for the purpose of managing violent or self-destructive behavior.

E. Having a patient voluntarily agree to confine themselves within an unlocked room, or confining patients with other patient(s) in a locked unit or ward is not seclusion for the purposes of this policy.

F. Non-Violent Restraints: These restraints are applied to restrict the patient from removing such things as nasogastric tubes (NGS), breathing tubes, wound drains, dressings, lines, etc., which could then lead to infections or complications.

G. Violent/Self Destructive Restraints/Seclusion: These restraints are applied to patients who exhibit verbal or nonverbal indications that they will harm themselves and/or others, and which may require 3-5 point restraints or seclusion

V. GENERAL RESTRAINT INFORMATION:

A. A restraint or seclusion order must be initiated by a physician or Licensed Independent Practitioner (LIP). PRN restraint orders or "standing orders" for restraints are not permitted.

B. A trial release constitutes a PRN use of restraint or seclusion and therefore is not permitted. When restraint or seclusion is ended the hospital staff has no authority to reinstitute the intervention without a new order. Temporary removal of a restraint for the purpose of medical treatment does not require a new order.

C. **Exceptions** to the requirement of individual orders for each episode of restraint:

1. **Geri chair:** If a patient requires the use of a Geri chair with the tray locked in place in order for the patient to safely be out of bed, a standing order is permitted. Given that a patient may be out of bed in a Geri chair several times a day, it is not necessary to obtain a new order each time.
2. **Raised side rails:** If a patient's status requires that all bedrails be raised (restraint) while the patient is in bed, a standing order is permitted. It is not necessary to obtain a new order each time the patient is returned to bed after being out of bed.
3. **Repetitive self-mutilating behavior:** If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyhan Syndrome, and the patient engages in repetitive self-mutilating behavior, a standing order for restraint to be applied in accordance with specific parameters established in the treatment plan would be permitted. Since the use of restraints to prevent self-injury is needed for these types of rare, severe, medical and psychiatric conditions, the specific requirements (1-hour face-to-face evaluation, time-limited orders, and evaluation every 24 hours before renewal of the order) for the management of violent or self- destructive behavior do not apply. If a restraint or seclusion is deemed necessary; the least restrictive intervention is used based on the individual assessment of the patient.

VI. RESTRAINT PROCEDURE:

A. Violent or Self-Destructive Behavioral Restraints/Seclusion

1. A face-to-face evaluation of the patient must be performed within one hour of the restraint initiation on a violent or self-destructive behavioral patient. Application of restraints or seclusion for such patients can only be initiated by a physician or LIP, physician assistance or RN trained in accordance with section XII of this policy.
2. The RN may initiate violent or self-destructive patient restraint or seclusion in an emergency. An order is obtained from physician or LIP who is responsible for the patient as soon as the situation that warranted application of restraints is stabilized. As soon as possible, but no longer than one hour, a face-to-face evaluation by a physician, LIP or an RN trained on initiation and assessment of restraints must occur.
3. The patient's plan of care is modified to include restraint management.
4. The use of restraints for violent or self-destructive behavior should be frequently evaluated and ended at the earliest possible time.
5. Patients who are simultaneously restrained and secluded shall be continuously monitored through face-to-face observation by staff members.
6. Patients in either violent restraint or seclusion shall be monitored on an ongoing basis for safety by staff members. Observations for safety shall be documented at minimum frequency of 15 minutes.
7. Monitoring and assessment: the RN responsible for the patient will determine the frequency of monitoring and assessment at intervals at minimum frequency of two (2) hours. Determination of necessary frequency will take into consideration the patient's condition, cognitive status, risks associated with the use of the chosen intervention and other relevant factors.
   Violent Restraint Assessment will include at a minimum:
   a. Visualization of patient safety documented at minimum frequency of 15 minutes
   b. Assessment of level of distress or agitation

c. Assessment of continued need for restraint
d. Range of motion (ROM) of the restrained limbs (while awake)
e. Check of circulation and skin integrity
f. Offering food and toileting (while awake)
g. Frequency of vital sign measurements will be determined by medical criteria

8. Orders for violent behavioral restraint or seclusion are limited to the duration listed below. Re-evaluation by a RN trained on initiation and assessment of restraints for the need to continue violent behavioral restraint, a new physician's order (phone order is acceptable) must take place:
   a. 4 hours for adults 18 and older,
   b. 2 hours for children and adolescents ages 9-17, and
   c. 1 hour for children under age 9.
9. Orders may only be renewed in accordance with the maximum intervals up to a total of 24 hours. After the order expires, a physician or LIP responsible for the care of the patient must see and assess the patient before issuing a new order. A new order must be obtained/renewed when:
   a. The time limit has expired
   b. A new cause for restraint has been identified
   c. The type of restraint needs changed
   d. **Illinois:** Renewal of an existing order may be given for the above durations if the indications for restraint or seclusion persist. However, continuation of restraint or seclusion for longer than 16 hours, rather than 24 hrs. (CMS) requires a new order (Illinois Mental Health Code (405 ILCS 5/2-108) and the required one (1) hour face to face assessment to evaluate the patient's mental status and determine the need for continued restraint(s).
10. **The RN will document the clinical justification for continued violent or self-destructive behavioral restraint uses according to the required age guidelines**. This evaluation includes as its primary focus moves to less restrictive interventions and/or discontinuation of the restraint.
11. Throughout the reassessment period, the RN will continually convey to the patient those behaviors that will allow for the reduction or the removal of restraints. Following restraint episodes, the patient will be evaluated for response to and effectiveness of the restraint episode.

B. Non-Violent or Non-Self-Destructive Restraints:

1. Restraint may be initiated by the Registered Nurse (RN) on an emergent basis.
2. A clinical assessment of the patient by a RN is required prior to instituting restraint and is to be documented in the patient's medical record.
3. The patient plan of care is modified to include restraint management.
4. An order is obtained from a physician or LIP who is responsible for the patient as soon as the situation that warranted application of restraint(s) is stabilized.
5. If the ordering physician is not the attending physician, the attending physician will be notified within 24 hours following the initiation. If the initiation of restraint is based on a significant change in the patient's condition, the RN notifies the attending physician immediately.
6. The order for non-violent patient restraint will remain in effect until the patient or situation no longer requires the use of restraint, or the indications for discontinuation are met.
7. The use of restraints will be evaluated frequently and ended at the earliest possible time.
8. Monitoring and assessment: The RN responsible for the patient will determine the frequency of monitoring and assessment at intervals **at minimum frequency of two (2) hours.**
   a. **Non-Violent Restraint Assessment will include at a minimum:**
      i. Visualization of patient safety at minimum frequency of two (2) hours
      ii. Assessment of level of distress or agitation
      iii. Assessment of continued need for restraint
      iv. Range of motion (ROM) of the restrained limbs (while awake).
      v. Check of circulation and skin integrity
      vi. Offering food and toileting (while awake)

vii. Frequency of vital sign measurement will be determined by medical criteria

VII. QUALIFICATIONS:

A. Staff members qualified to initiate restraints and re-evaluate patients for the need to continue restraint is limited to physicians, LIPs, and RNs who have completed the training described in section XII.

B. Staff members qualified to monitor patients while in restraints, and remove/reapply restraints include RNs, Student Nurse Interns, and Patient Care Assistants who have completed training and competency assessment in these skills in nursing orientation and annually thereafter.

C. RNs are qualified to conduct one-hour face-to-face evaluations by demonstrating competence to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion.

D. Physicians and LIPs authorized to order restraint and seclusion must have demonstrated a working knowledge of hospital restraint and seclusion policy.

VIII. RESTRAINT APPLICATION:

A. All non-violent restraint application straps should be secured by using quick-release ties. Restraints designed for use in bed should be secured only to the non-moveable part of the bed frame. Never secure restraints to the bed rails.

B. In the use of violent restraints that involve key-lock, the key will remain with the staff member responsible for the 1:1 observation of the patient in key-lock restraint(s).

C. Clinical staff (Respiratory Therapy, Physical /Occupational/Speech and Recreational Therapy, Imaging, and Laboratory) may remove/reapply a restraint after completion of restraint training to include proper reapplication.

IX. DISCONTINUATION OF RESTRAINTS:

A. Restraints of all types are discontinued at the earliest possible time.

B. Patients are to be made aware of the rationale for restraint use and the behavior criteria for discontinuation.

C. Restraints are to be discontinued by the RN once the behavior(s) or situation(s) that served as the basis for the restraint are no longer present and the safety of the patient, staff members, or others may be assured through less restrictive means.

X. DOCUMENTATION (see Attachment C – Restraint Documentation Checklist)

A. The patient restraint order is entered in the medical record by the physician or LIP.

B. The individualized patient plan of care will include restraint care management.

C. For behavioral health patients in Illinois the Restriction of Rights Notice, see Attachment D, must be completed promptly and the professional responsible for overseeing the patient's care plan must give notice of use of restraint or seclusion and the reason to:

1. the patient and, and if such patient is a minor or under guardianship, his parent or guardian;
2. a person designated by the patient that they want notified;

3. the charge RN; and the patient's substitute decision maker, if any.

D. Documentation shall include the following:

1. A description of the patient's behavior and intervention used,
2. Alternatives or other less restrictive interventions attempted (as applicable),
3. The patient's condition or symptom(s) that warranted the use of restraint or seclusion, and
4. The patient's response to the intervention(s) used, including the rationale for continued use of the Intervention
5. The patient and family education regarding use of restraints.

E. Monitoring and assessment: The RN responsible for the patient will determine the frequency of monitoring and assessment at minimum frequency of two (2) hours. Determination of necessary frequency will take into consideration the patient's condition, cognitive status, risks associated with the use of the chosen intervention and other relevant factors.

1. **Violent Restraint Assessments will include at a minimum:**
   a. Visualization of patient safety documented every 15 minutes
   b. Assessment of level of distress or agitation
   c. Assessment of continued need for restraint
   d. Range of motion (ROM) of the restrained limbs (while awake)
   e. Check for circulation and skin integrity
   f. Offering food and toileting (while awake)
   g. Frequency of vital sign measurement shall be determined by medical criteria
2. **Non-Violent Restraints:**
   a. Assess the status of the patient at minimum frequency of two (2) hours and check restraints and snugness. Check circulation of the extremities at minimum frequency of two (2) hours, being certain to pass a finger under the restraint. Change the patient's position and assess skin integrity at minimum frequency of two (2) hours.
   b. Patients are assessed for determining if there is a potential contributing factor for the patient's inability to follow commands.
   c. Alternative interventions are considered prior to the use of any restraint:
      i. Patient care observation
      ii. Reposition/Mobilize
      iii. Re-evaluate equipment (evaluate the need of the equipment)
      iv. Disguise equipment
      v. Pain management
      vi. Alarm (trial use of an alarm with the restraint off)
      vii. Offer family options to stay with patient
      viii. Communication/Reorientation
      ix. Decrease stimulation
      x. Low bed

   d. At minimum frequency of two (2) hour assessment, observation and monitoring will include:
      i. Patients continued need for restraint
      ii. Patient/Family education needs
      iii. Skin integrity and CMTS (Color, Motion, Temperature, Sensation)
      iv. Soft ankle and wrist restraints will be released
      v. Patient's response

XI. REPORTING RESTRAINT-RELATED DEATHS:

A. Hospital staff shall promptly contact hospital leadership.

B. Hospital Leadership shall report patient deaths to the Region V CMS Office using the CMS format for those patients who expire while in restraint or within 24 hours of removal of restraint. The date and time of CMS notification shall be documented in the medical record. In addition, any death within one week of restraint where it is reasonable to assume the use of restraint contributed directly or indirectly to the death of the patient is also reported to CMS.

C. **Violent or Self-Destructive Restraint Death:** All restraints except soft wrist restraints, described in XI. D. below. Deaths in the following circumstances must be reported to the CMS (by Fax utilizing the F-62470 Client/Patient/Resident Death Determination Form) by close of business on the next business day following the knowledge of the patient's death:

1. Each death that occurs while a patient is in restraint or seclusion
2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
3. Each death known to the hospital that occurs within one (1) week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

D. **Non-Violent or Non-Self-Destructive Restraint Death:** Deaths in the following circumstances are not reported to CMS, but must be entered an internal log and meet the following criteria noted below.

1. When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which such 2-point soft, cloth-like non-rigid wrist restraints include:
    a. Each death that occurs while a patient is in such restraints or
    b. Each death that occurs within 24 hours after a patient has been removed from such restraints.

E. **The internal log entry/tracking system (Attachment B) must meet the following criteria:**

1. The entry must be made not later than seven (7) days following the death of the patient.
2. Each entry must document the patient's name, date of birth, date of death, name of attending physician or other LIP responsible for the care of the patient as specified under, medical record number, and primary diagnosis(es).
3. Make the information in the log available to CMS, either electronically or in writing, immediately upon request.

F. Wisconsin Act 336 indicates that certain deaths must be reported. If there is reasonable cause to believe that the death of an inpatient was related to the use of physical or psychotropic restraints or a suicide, the death must be reported to the Department of Health and Family Services, within 24 hours after death. The notification will be made by the Department Director of the involved department. The F-62470 Client/Patient/Resident Death Determination Form available at http://www.dhs.wisconsin.gov/forms/DQAnum.asp and shall be completed and faxed to the Bureau of Quality Assurance Supervisor at the Western Regional Office – Fax number: (715) 836-2535.

XII. TRAINING:

A. Hospital and medical staff who assess patients for restraints or who apply restraints shall receive education in the following subjects as appropriate for assigned duties performed under this policy. Such education shall take place at orientation and before the new staff member is asked to implement the provisions of this policy and shall be repeated periodically as indicated in the hospital's education plan, which shall be based on the results of quality monitoring activities.

1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint.
2. The use of nonphysical intervention skills.
3. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
4. The safe application and use of all types of restraint used by the staff member, including education in how to recognize and respond to signs of physical and psychological distress (e.g., positional asphyxia)
5. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary.
6. Monitoring the physical and psychological well-being of the patient who is in restraint, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation of patients restrained for the management of violent or self-destructive behavior.
7. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic re-certification.

B. Primary Health Care Providers or LIP who have been appointed by the respective medical staff by the respective Boards will receive a copy of the HSHS Restraint and Seclusion Policy upon orientation to the hospital.

C. Hospital and medical staff members who observe restrained patients shall be educated in the recognition of signs of physical and psychological distress, including the signs of asphyxia.

D. Restraint education will be documented in colleague personal records that the training and demonstration of competency were successfully completed.

XIII. RESTRAINT DISINFECTION PROCEDURES:

A. Patients that may be violent often struggle when restraints are applied. The restraints may come in contact with bodily fluids and require cleaning. The following procedures are to be used for care and cleaning of restraints:

1. Soft restraints designed for single-use-only will be disposed of after use.
2. Cotton and polypropylene restraints (e.g., Velcro cuffs) will be laundered according to the manufacturer's instructions.
3. Hard restraints, such as those made of synthetic leather or biothane will be thoroughly wiped with a hospital grade disinfectant according to the manufacturer's instructions. The restraints shall be dry before being returned to storage.

XIV. PERFORMANCE IMPROVEMENT:

A. Data on the use of restraint/seclusion will be collected to monitor and improve performance related to restraint use. Opportunities to introduce preventive strategies, alternatives, and process improvements will provide focus for department and hospital leadership.

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XV. RESTRAINT POLICY EXCEPTIONS FOR BEHAVIORAL HEALTH PATIENTS:

A. All Behavioral Health patients who are placed in restraints or seclusion will have a member of the facility remain with the patient at all times and documentation will occur at minimum frequency of 15 minutes.

XVI. REFERENCES:

A. CMS Interpretive Guidelines for the Condition of Participation: Restraints (42 CFR 482.13)

B. Joint Commission Accreditation Standards

C. Posey Company Safety Information for the Use of Posey Limb Restraining Products

D. Illinois Use of Restraints (210 ILCS 85/6.20)

E. Illinois Mental Health Code (405 ILCS 5/2-201)

F. Wisconsin Mental Health Act Chapter 51

G. Approved by CNO Committee 4/20/2018

ORIGINATOR: Marc Shelton, M.D.
Chief Physician Executive

ACCOUNTABLE LEADER: Marc Shelton, M.D.
Chief Physician Executive

Administrative Approval: Damond Boatwright
President & CEO

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Attachment A: Definition of Restraint

Device	Not Restraint	Restraint
Sedating Medication	Standard use of a medication to treat the patient'scondition, even if given on a PRN basis.	Not a standard use ofthe medication to treat the patient's medical or behavioral condition.
Devices to protect the patient following anesthesia	Prior to recovery in the post anesthesia recovery room or intensive care unit.	Once the patient has recovered or has been transferred to a different unit.
Mittens	Not tied down. Patient can flex fingers and has access to hi s/her body.	If tied down or if so tight as to prevent use of the hands.
Arm Boards	To protect intravenous access	If tied down or the entire arm Immobilized preventing the patient from having access to his or her body.
Standard Practices During a Procedure	Used to maintain position, limit mobility, or temporarily immobilize the patient during a medical, dental, diagnostic, or surgical procedure.	Not used in association with a procedure
Adaptive Devices: Seat belts, waist belts, Geri chairs, etc.	The patient can remove the device (or remove themselves from the device) in the same way it was applied.	The patient cannoteasily remove the device.
Covered bed	Covered bassinet for infants or toddlers.	For adults to keep them from getting out of bed (when closed).
Protective interventions for infants, toddlers and pre- school children	Stroller safety belts, seat belts for highchairs, etc.	
Holding the patient	Light touching during escort.	Therapeutic hold
Holding to give medications or treatments	Voluntary	Forced
Forensic Devices (hand cuffs, shackles)	Used for patients in custody.	May not be used as a device for restraint.

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Attachment B: Restraint Internal Log

Date/ Time of Log Entry	Patient Name	Date of Birth	Medical Record/ Account #	Attending MD	Primary Diagnosis(es)	Date of Death

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Attachment C: Restraint Documentation Checklist

Physician or LIP Order

Emergency use of restraints may be intitated before obtaining a physician or LIP's order based on a RN assessment.

Modification of the Plan of Care

In Electronic Health Recrod (EHR)

Face-to-Face Evaluation

Evaluation of patient's immediate status, reaction to the intervention, medical and behavioral condition and the need to continue or discontinue the restraint or seclusion.

Monitor & Assessment

Non-violent or non-self-destructive restraints document in EHR at minimum frequency of two (2) hours.

Violent or self-destructive restraints document in EHR at minimum frequecy of 15 minutes.

Resassessment

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Attachment D:

State of Illinois
Department of Human Services

NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUALS

Reference: 405 ILCS 5/2-102, 2-103, 2-104, 2-107, 2-108, 2-109, 2-200, and 22-201

Name: _____ I.D.: _____ Unit: _____ Facility: _____

PART I (Physical Hold/Restraint/Seclusion/Emergency Medication Restrictions)

On _____ (Date) at _____ (Time)

Individual was: ☐ placed in physical hold ☐ placed in restraint ☐ placed in seclusion ☐ administered emergency medication

Reason(s) for the identified restrictions(s):

In accordance with the Mental Health and Developmental Disabilities code, the individual designated his or her preference for emergency intervention if circumstances arise as indicated below (check one):

☐ The individual indicated "No Preference" for emergency intervention(s)

☐ The individual preference was utilized (see Treatment Plan)

☐ The individual preference was **NOT** utilized for the following reason(s):

PART II (Other Restrictions)

From: _____ (Date and Time) to: _____ (Date and Time)

Had a restriction placed on certain rights (checked and explained below):

☐ To refuse medical services - x-ray ☐ To refuse medical services - laboratory specimens ☐ To retain personal property

☐ To refuse other medical services ☐ To refuse search of person or living area ☐ Other: _____

☐ To manage personal hygiene ☐ To refuse dental services

☐ To be allowed communication via: ☐ Telephone ☐ Mail ☐ Visitation ☐ Other: _____

Reason(s) for the identified restrictions(s) include:

PART III (Applies to Parts I and II)

A copy of this notice was given to the individual in: ☐ English ☐ Spanish ☐ Other: _____

☐ Individual wished no one be notified of this Notice **(Exception: Guardian must always be notified)**

☐ Individual wished Guardian and/or Designee notified as indicated below:

Guardian: _____ Address: _____

Designee: _____ Address: _____

I certify that I have completed this form. Copies of this notice were given to the individual, mailed to all indicated individuals, and placed in his or her medical record.

Date/Time: _____ Signature: _____

Printed Name and Title: _____

NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUAL

IL462-2004M (R-05-20 (MHDD-4) Notice Regarding Restricted Rights of Individuals
Printed by Authority of the State of Illinois - 0 - copies

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State of Illinois
Department of Human Services

NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUALS

Reference: 405ILCS 5/2-102, 2-103, 2-104, 2-107, 2-108, 2-109, 2-200, and 22-201

NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUAL

Additional Notice to Individual

If your right to mail a letter or package, have visitors, or use the telephone is restricted, you have the right to have the facility notify the affected parties.

When the restriction is over, you also have the right to have facility notify the affected parties.

You may tell the staff member giving you this NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUAL or your caseworker if you would like the facility to notify the affected parties.

If you need assistance regarding this Notice, ask your caseworker or another staff member for help.

Information about the health care services you receive at a mental health or developmental disabilities facility is protected by privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 CFR 160 and 164. Your personally identifiable health information will only be used and/or released in accordance with HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110).