

POLICY ON BEHAVIORAL SECLUSION AND RESTRAINT

I. PURPOSE

This hospital is committed to preventing, reducing, and striving to eliminate the use of seclusion / restraint(s):

1. Preserving the individual's safety and dignity when seclusion / restraint(s) are used;
2. The use of alternative measures as preferred interventions;
3. Raising awareness among staff about how the use of seclusion / restraint(s) may be experienced by the individual;
4. Carrying out organizational responsibility to facilitate the discontinuation of seclusion / restraint(s) as soon as possible;
5. Limiting the use of seclusion / restraint(s) to emergencies in which there is an imminent risk of an individual physically harming himself or herself or others, including staff;
6. Preventing emergencies that have the potential to lead to the use of seclusion / restraint(s).

II. SCOPE

All members of the patient care team who assess and/or provide care to patients.

III. PATIENT POPULATION

This policy pertains to the following patient population groups:

Pediatric:	4 through 17 years old
Adult:	18 through 65 years old
Senior Adult:	older than 65 years old

IV. POLICY

1.0 It is the policy of this hospital to:

- 1.1 Prevent, reduce and eliminate the use of restraints or seclusion by:
 - 1.1.1 Preventing emergencies that have the potential to lead to the use of restraints and seclusion.

- 1.1.2 Limiting the use of restraints and seclusion to emergencies where there is a risk of the patient harming himself/herself or others.
 - 1.1.3 Using the least restrictive method.
- 1.2 Protect the patient and preserve the patient's rights, dignity and well-being during seclusion / restraint use by:
 - 1.2.1 Respecting the patient as an individual.
 - 1.2.2 Maintaining a clean and safe environment
 - 1.2.3 Encouraging the patient to continue to participate in own care.
 - 1.2.4 Maintaining the patient's modesty, preventing visibility to others, and maintaining comfortable body temperature.
 - 1.2.5 Provide for safe application and removal of the restraint by qualified staff.
 - 1.2.6 Monitor and meet the patient's needs while in restraints.
 - 1.2.7 Reassess and encourage release of restraints as soon as possible.
- 1.3 Leadership demonstrates its commitment to the aforementioned by providing and/or promoting:
 - 1.3.1 Ongoing staff orientation and training.
 - 1.3.2 Patient and family education, as appropriate.
 - 1.3.3 The development and promotion of preventive strategies; and the ongoing assessment/reassessment of alternative measures.
 - 1.3.4 The use of safe and effective alternative measures including adequate human resources when applicable.
 - 1.3.5 The integration of restraint/seclusion into the Performance Improvement (PI) program of the facility, for the purpose of reducing restraint or seclusion use.
- 1.4 Because the inherent risks of restraints is not solely dependent on whether those restraints are applied on medical patients or behavioral health patients, the strictest standards will be implemented as policy. Restraints will be used only in situations where the patient is demonstrating observable behaviors that indicate he/she is at risk of injuring himself/herself, others and/or the environment. **It is the policy of this facility to NOT engage in the use of medical restraint of patients.**
- 1.5 All staff will review and sign the facility Seclusion/Restraint Philosophy statement at the time of hire and all clinical staff will re-commit to this philosophy annually. See appendix C.

1.6 The hospital prohibits restraint or seclusion that are imposed as a means of coercion, discipline, convenience, or retaliation by staff.

1.7 Exceptions to Restraint Usage:

The following are not governed by this policy:

1.7.1 The use of handcuffs and other restrictive devices applied by law enforcement officials. These are considered forensic restrictions.

1.7.2 A positioning or securing device used to maintain the position, limit mobility or temporarily immobilize during medical, diagnostic or operative/invasive/other procedures (medical restraint). These mechanisms include, but are not limited to:

- ρ Body restraint during operative/invasive or other procedures

- ρ Area restraint (i.e. armboard) during intravenous administration,

- ρ Temporary physical restraint during Electroconvulsive Therapy, medical immobilization or anesthesia.

1.7.3 Use of protective equipment, such as helmets.

1.7.4 Use of voluntary mechanical or adaptive support in response to the assessed physical needs of the patient so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint (orthopedic appliances, etc.).

1.7.5 When devices such as a geri chair or side rails restrict the patient's movement and cannot be easily removed by the patient, then they are considered a restraint and are governed by acute medical restraint standards.

V. PROCEDURE

1.0 Assessment of Behaviors

Data collection upon admission identifies patients who are at risk for harming self or others. It is also at admission that techniques, methods or tools are identified that would help the patient control his / her behavior. In addition pre-existing medical conditions or any physical disabilities and limitations that would place the patient at greater risk during restraint or seclusion and any history of sexual or physical abuse that would place the patient at greater psychological risk during seclusion / restraint is identified.

A comprehensive assessment of the patient must include those behaviors that the patient is exhibiting in order to determine the need for the use of

restraints and/or seclusion. An individualized assessment that considers the patient's characteristics, such as age, history, size, medical and mental condition, and preferences, are the basis for any intervention. This includes:

- 1.2 Behavior that is harmful to self, others and/or the environment. This includes hitting, hair pulling, throwing objects, striking at or biting staff, other patients and/or visitors and self-mutilation.
- 1.3 Behavior that may interfere with life saving and/or necessary medical treatment. This includes, but is not limited to, picking at an open wound, interfering with complex dressings, drains.
- 1.4 Behavior that indicates the patient is unable to follow directions to avoid self-injury. This may include climbing out of bed or wandering without the strength or cognition to safely do so.

These behaviors must be documented on the RN assessment along with alternative measures attempted.

2.0 Assessment of Causative Factors

A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint are outweighed by the risk of not using it. The use of an anatomical, physiological, and psychological assessment for risk factors by the Registered Nurse (RN) and/or the physician/Licensed Independent Practitioner (LIP) facilitates the limited, justified use of restraint and/or seclusion. Planning for, that is, being proactive rather than reacting to the patient's behavior protects the patient's health and safety and allows for the implementation of preventive strategies that would be of the greatest benefit to the patient. The following should be considered in the assessment of causative factors:

Possible physiological sources of behavior:

- 2.2 Medication changes/drug interactions
- 2.3 Oxygenation levels
- 2.4 Sedation/anesthesia effects
- 2.5 Abnormal laboratory levels
- 2.6 Uncontrolled pain
- 2.7 Alcohol and/or drug withdrawal
- 2.8 History of anxiety or mental health issues

Other possible reasons for behavior changes:

- 2.9 Altered comfort
- 2.10 Loss of control in hospital
- 2.11 Fears and anxieties
- 2.12 Satisfaction with care
- 2.13 Environment

3.0 Least Restrictive Interventions (Alternative Measures)

Alternative measures are to be considered prior to application of restraint devices or seclusion. Risks associated with any intervention must be considered in the context of an ongoing loop of assessment, intervention, evaluation and re-intervention.

A restraint can only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. Restraint / seclusion / physical hold may be used only as a last resort and in the least restrictive manner possible to protect the patient or others from harm; and the restraint / seclusion / physical hold must be removed or ended at the earliest possible time.

The greater the risks associated with the intervention, the more careful and thorough the assessment must be. If least restrictive methods cannot be used prior to seclusion / restraint use, or have failed, clear detailed documentation of rationale for restraint use will be noted on the RN assessment in the Behavioral S/R packet.

Examples of alternative measures are found in appendix B.

Patients will have routine PRN medications ordered and used by nurses at all appropriate junctures. The routine PRN is our first line of care to prevent escalation and prevent decompensation.

Occasionally, patients' conditions will escalate to potentially dangerous levels despite the judicious use of routine use of PRN medication and professional staff de-escalation techniques. In this instance, "Emergency Medications" are often needed in addition to the already scheduled PRNs. There are several scenarios that can occur in this instance:

- a. The physician is called for an order for Emergency Medication (PO or IM) and such is offered to the patient with a professional show of force and concern. If the patient accepts this emergency medication with no holding or physical restraint used, then there is no "restraint" in effect. In these cases, an emergency medication for a one time dose only. These medications are prescribed for their appropriate clinical condition treatment and are not chemical restraints by definition. A drug used as a restraint is a drug or medication 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.
- b. If a patient steadfastly refuses the ordered medication and needs to be held down or in any other physical way

restrained to receive the medication, then this will trigger all the elements of Behavioral Restraint and all the steps required of such.

Examples of alternative measures are found in appendix B.

4.0 Clinical Justification for the use of Restraint and/or Seclusion

When clinically indicated, the restraint and/or seclusion procedure is implemented by an RN who is trained in restraint and/or seclusion technique upon a physician's (LIP's) order. Unless there is an immediate and overriding concern for safety, the restraint and/or seclusion procedure is utilized only after all alternative, less restrictive treatment interventions have been tried without success. Prior to implementation of any restraint and/or seclusion, care team members will confer to determine that appropriate alternative measures have been attempted. Using the decision flow charts for patient behaviors and alternatives for use of restraints (*appendix C*), clinical assessment and utilization of restraint and/or seclusion should be based on patient's behavior that may place the patient or others at risk for harm.

Situations in which restraints / seclusion is clinically justified include:

- 4.1 Harmful to self or others, as evidenced by hitting, hair pulling, striking or biting staff or family, and self-mutilation, and appropriate alternative measures have been attempted.
- 4.2 Threatens placement and/or patency of necessary therapeutic lines/tubes, interfering with necessary medical treatment, and appropriate alternative measures have been attempted. Examples include self-removal of IV lines, complex dressings and picking at open wounds.
- 4.3 Unable to follow directions to avoid self-injury , and appropriate protective, alternative measures have been attempted. Examples are climbing out of bed, wandering in rooms or hallway without the strength or cognitive ability to safely do so.

5.0 Restraint and Seclusion Procedure

- 5.1 Follow policy regarding obtaining order. Note: many types of emergencies can occur, and staff are expected to effectively respond. In some emergency situations, the need for a restraint or seclusion intervention may occur so quickly that an appropriate order cannot be obtained before the application of restraints. In these emergency situations, the intervention is authorized by the RN and the order from the MD must be obtained either during the emergency application of the restraint or seclusion, or immediately after the restraint has been applied.
- 5.2 Document order on the MD order sheet and on the seclusion /

- restraint / physical hold packet. Use the seclusion / restraint / physical hold stamp to assist in documenting a telephone order in the MD order sheet.
- 5.3 Explain to patient and/or significant other the necessity of seclusion / restraints.
 - 5.4 Obtain appropriate ordered restraints and apply per training.
 - 5.5 Assessment is determined by condition of the patient but is to be visually performed at least every **15 minutes** for behavioral restraints or seclusion **via continuous 1:1 monitoring**.
 - 5.6 Assess every 2 hours for the following:
 - 5.6.1 Releasing the restraint to check for signs of injury
 - 5.6.2 Circulation, movement and sensation
 - 5.6.3 Skin integrity
 - 5.6.4 Respiratory status
 - 5.6.5 Orientation behavior
 - 5.6.6 Hydration and nutritional needs
 - 5.6.7 Hygiene and toileting needs
 - 5.6.8 Range of motion performed
 - 5.6.9 Patient dignity and rights
 - 5.6.10 Patient readiness for release from restraints
 - 5.7 Adhere to the documentation component of policy utilizing the seclusion / restraint / physical hold RN monitoring and assessment tool.
 - 5.8 When releasing 4 point restraints, release one restraint at a time, beginning with the ankles.

6.0 Initiation and Renewal of Orders

- 6.1 Physician Orders:

Orders for restraints and/or seclusion include:

 - 6.1.1 Date and time restraint or seclusion initiated
 - 6.1.2 Type of restraint (number of limbs to be restrained)
 - 6.1.3 Length of time restraint and/or seclusion to be utilized
 - 6.1.4 Reason or clinical justification for restraint or seclusion
 - 6.1.5 Criteria for release
 - 6.1.6 Physician name
- 6.2 Physical Restraint:

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; or a drug or medication when it is 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.

Physical Restraints are defined as any apparatus that restricts the freedom of movement or normal access to one's body, material or equipment, attached or adjacent to the patient's body that he or she cannot easily remove. It includes the use of devices to involuntarily restrain the movement of the whole or a portion of a patient's body as a means of controlling physical activity in order to protect the patient or others from harm.

6.2.1 Identified types of Physical Restraints used at this facility:

- 4 point restraints
- Physical hold

6.3 Behavioral restraint / seclusion / physical hold orders and face to face assessment:

6.3.1 A restraint order must be obtained for each restraint episode

6.3.2 The restraint order will be obtained within 1 hour of application or sooner based on patient's condition

6.3.3 A one hour face to face evaluation is conducted by a trained RN to assure patient safety, rule out possible underlying factors that might be contributing to the patient's behavior, to assess the patient's physical and psychiatric condition, and to decide whether restraint or seclusion continue to be necessary. The one hour face to face evaluation includes both a physical and behavioral assessment of the patient. The outcome of this assessment is documented in the seclusion / restraint / physical hold packet.

6.3.4 The RN who conducted the one hour face to face evaluation must communicate the outcome of his/her evaluation with the attending or covering physician as soon as possible. The purpose of this MD communication is to promote continuity of care, to assure patient safety, and to elicit information from the attending MD that might be relevant in choosing the most appropriate intervention for the patient.

6.3.5 The MD must evaluate the patient in person as a "face-to-face" assessment within:

- 4 hours for adults ages 18 and older
- 2 hours for children and adolescents age 9-17.
- 1 hour for children under age 9.

6.3.6 If the adult is released prior to expiration of the original order (4 hours), the MD in-person evaluation is conducted within 24 hours of initiation of restraints/seclusion.

6.3.7 If the youth / child is released prior to the expiration of the original order (2 hours or 1 hour), the MD conducts the in-

person evaluation within 24 hours of initiation of restraints/seclusion.

- 6.3.8 The maximum length of time that an ordered intervention may be used is 24 hours.
- 6.3.9 Orders for behavioral restraints and seclusion are limited to:
 - 4 hours for patients 18 years of age and older
 - 2 hours for children and adolescents ages 9-17
 - 1 hour for children under age
- 6.3.10 The MD reorders restraint for an adult patient after an evaluation by qualified staff every 4 hours until the adult is released from restraint / seclusion. An in-person MD evaluation is conducted every 8 hours after the intervention is re-ordered
- 6.3.11 The MD reorders restraint every 2 hours for youth (9-17) until youth is released, and every 1 hour for children (under 9) until the child is released. An in-person MD evaluation is conducted every 4 hours for children and youth (17 or younger) until the child or youth is released.

Patient family/significant other cannot request the use of restraints.

7.0 Application, Monitoring, Assessment and Care of the Patient in Restraints/Seclusion

Only a Registered Nurse with documented current competencies to assess the initial or ongoing need for restraints may assess/reassess the patient. The purpose of monitoring a patient in restraints or seclusion is to address the individual's physical safety.

8.0 Behavioral Restraint/Seclusion Assessment and Monitoring:

If the patient is being restrained/secluded utilizing the behavioral criteria, the following is required:

- 8.1 Patient in restraint and seclusion will be monitored in person continuously by an RN who is competent and trained.
- 8.2 Patients in seclusion only will be monitored in person continuously by an RN who is competent and trained.
- 8.3 The patient in restraint/seclusion is monitored / reassessed every 15 minutes via continuous 1:1 by an RN who is competent and trained. The assessment should include:
 - ρ Checking for signs of injury, circulation, movement and sensation,
 - ρ Skin integrity,
 - ρ Respiratory status,
 - ρ Orientation behavior,

- ρ Hydration and nutritional needs,
- ρ Hygiene and toileting needs,
- ρ Range of motion performed,
- ρ Patient dignity and rights will also be assessed,
- ρ Patient readiness for release from restraints should also be assessed.
- ρ Documentation will include staff interventions employed to assist the patient in meeting criteria for removal from seclusion/restraints will also be recorded.

9.0 Discontinuing Restraint and/or Seclusion prior to Expiration of the Order:

Any patient who is requiring restraint and/or seclusion will be continuously monitored and evaluated for appropriateness of an early release. Such improvements may be based on:

- Improved mental status,
- Patient's agreement and compliance with instructions for safety
- Less restrictive measures are effective

A Registered Nurse (RN) with established competencies must assess whether the patient qualifies for an early release to assure appropriateness for the continued need. This assessment is conducted at least every 15 minutes via continuous 1:1 observation.

If the restraint and/or seclusion is discontinued prior to the expiration of the original order, and reinitiating of restraint and/or seclusion is indicated, a new order must be obtained and a face-to-face assessment completed.

10.0 Staff Competency

It is imperative that all staff applying restraining devices receive instruction and demonstrate competency in the safe application of restraints and subsequent monitoring of restrained patients. The staff also have ongoing training in techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion.

Those staff members, including new hires, who, in their job descriptions, may be required to apply restraining devices or monitor a patient in a restraining device, will be required to review this policy and complete the Skilled Competency Evaluation Check List.

The RN conducting the face to face one hour assessment is trained 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.

Evidence of these competencies will be required at least annually.

11.0 Staff Education

- 11.1 Staff members who have direct patient care contact will have education and training regarding the use of restraints and seclusion at orientation and annually as part of the competency evaluation.
- 11.2 At a minimum, the following topics are included in education and training (included in initial and annual competency):

For **direct care staff** monitoring and/or applying/releasing restraints (Physician/LIP, Registered Nurse, Licensed Vocational Nurse, Licensed Psychiatric Technician, Mental Health Worker):

- Underlying causes of threatening behaviors of patients they provide care to
- Aggressive behavior related to medical conditions (such as hypoglycemia, delirium, pain, etc)
- How staff behaviors can affect the behavior of patients.
- The use of alternative measures
- Applying and releasing restraint devices
- Checking the patient's position, comfort and hygiene needs
- Initiating de-escalation, mediation, and self-protection techniques

For staff authorized to perform assessment of patients in need of and/or in restraints (**Registered Nurse, Physician, LIP**):

- 11.3 Topics outlined for direct care staff:
 - Taking vital signs and interpreting/assessing the relevance of restraints
 - Assessing/reassessing nutrition and hydration needs and addressing as needed.
 - Assessing/reassessing circulation and conducting range of motion of the restrained limb.
 - Assessing/reassessing and addressing the physical and psychological status and comfort of the patient.
 - Be aware of and assist the patient in meeting the criteria for discontinuation of restraints.
 - Recognizing the readiness for discontinuation through continuous reassessment.
 - Recognizing the need to contact the appropriate physician to evaluate and/or treat the patient as necessary.

12.0 Patient and Family Education

At the time of admission that patient and family (with appropriate consent) is informed of the facility philosophy regarding seclusion / restraint. Providing information about the reasons why restraint/seclusion is necessary and alternatives to restraints can make the restraint/seclusion experience less traumatic. Educating patient's family can facilitate their assistance in reducing the need for restraint/seclusion or at least in minimizing the negative aspects of the experience for the patient.

Patient/family education should be documented on the Patient / Family education form in the s/r packet.

Where appropriate, the patient and or family should assist in the identification of techniques that may help the patient control his/her behavior, at all times keeping in mind the patient rights to dignity and confidentiality. This is documented in the initial evaluation of the patient at the time of admission.

The RN will provide patient/family education with an explanation of restraint/seclusion utilization and the reason for restraints/seclusion. This should be done, where appropriate, prior to the application of restraints/seclusion. The policy, application and the criteria for release should also be explained.

13. Patient/Staff Debriefing

Staff debriefing will be conducted and documented as soon after the event as possible to assure that the intervention was conducted per facility policy, identify any employee injuries as well as have an opportunity to educate and /or reduce stress level among the clinical team. The documentation of this debriefing is immediately forwarded to the Nurse Manager for review and then to the QI Nurse for data collection and trend analysis.

A patient debriefing is conducted at the time of release from seclusion/restraints. This is documented on the patient debriefing form contained in the seclusion/restraint packet. This debriefing identifies, from the patient's perspective, what the patient and staff could have done differently that may have assisted in avoiding the use of seclusion/restraint. This information is to be included in the treatment plan of the patient.

14. Leadership

The role of leadership is to create an environment that minimizes the circumstances that may give rise to restraint/seclusion usage and maximizes safety. Clinical leadership (Administrator, Director Patient Services &/or Medical Director) should be notified of any instance whereby a patient is initially restrained/secluded for more than 12 hours or experiences 2 or more separate episodes of restraints and/or seclusion of any duration within 12 hours. Thereafter, the leadership is notified every 24 hours if either of the above conditions continue.

15.0 Risk Management Reporting

Any death or injury that occurs while a patient is restrained or where it is reasonable to assume that the patient's death is a result of restraint must be reported immediately to Risk Management and the facility's administrative staff (Administrator on Call), who will initiate referral to the appropriate agency.

APPENDIX A

DEFINITIONS

Licensed Independent Practitioner (LIP) is a Medical Doctor (MD), Osteopath (DO), Podiatrist (DM), or Dentist (DDS), privileged and credentialed as a member of the medical staff.

Seclusion is the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving and is separated from others.

Medical Restraints are used to limit mobility or temporarily immobilize the patient in direct relation to a medical, diagnostic or dental procedure or need. In this case, the patient is not displaying aggressive or violent behavior.

Physical Restraints are defined as any apparatus that restricts the freedom of movement or normal access to one's body, material or equipment, attached or adjacent to the patient's body that he or she cannot easily remove. It includes the use of devices to involuntarily restrain the movement of the whole or a portion of a patient's body as a means of controlling physical activity in order to protect the patient or others from harm.

Chemical Restraints are defined as medication used to control behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. The medications that comprise the patient's regular medical regimen (including PRN medications) are not considered chemical restraint, even if their purpose is to control ongoing behavior. The use of this medication should be addressed in the patient's treatment plan and medical record.

APPENDIX B

EXAMPLES OF ALTERNATIVE MEASURES

Physiological Measures:

- ❑ Routinely take the patient to bathroom or bedside commode.
- ❑ Assess the patient's comfort level and give care as needed. For example do they need a position change? Do they want to get up in a wheelchair, or be put back to bed? Does the patient need pain medication? Is the patient too hot/too cold?
- ❑ Assess the patients' physical care needs. For example, is the patient hungry or thirsty?
- ❑ Insure adequate hydration
- ❑ Increase frequency of observation
- ❑ Reorientation
- ❑ Bed in lowest position
- ❑ Minimize obstacles to mobility
- ❑ Noise reduction
- ❑ Toilet every 2 hours while awake and every 4 hours during the noc
- ❑ Adjust master treatment plan

Psychosocial Measures:

- ❑ Orient or reorient the patient to person, place or time.
- ❑ Encourage verbalization of feelings.
- ❑ Validate the patient's feelings.
- ❑ Acknowledge the patient's tension and be physically available to initiate therapeutic interventions in potentially stressful situations.
- ❑ Instruct the patient in relaxation techniques and/or deep breathing exercises.
- ❑ Be physically available to patients during periods of increasing tension.
- ❑ Respect a patient's need for personal space.
- ❑ Offer television, books, and / or "busy work".
- ❑ Set consistent limits on type and degree of aggression that is tolerated. Review consequences if behavior is not controlled.
- ❑ Pay attention to threats of physical aggression.
- ❑ Recognize the need for clear-cut staff and/or patient boundaries.
- ❑ Determine and anticipate the need for medications.
- ❑ Avoid sudden movement around a potentially violent patient.
- ❑ Allow the patient to participate actively in their care to decrease frustration.
- ❑ Keep the patient well informed of their treatment to reduce fear.
- ❑ Speak to the patient in a calm reassuring voice.
- ❑ Always treat the patient in a dignified and respectful manner.
- ❑ Determine if medication intervention is necessary. Check PRN medications available and discuss symptoms and behavior with the patient's physician as needed.
- ❑ Explain procedures carefully and assess understanding.
- ❑ Attempt to redirect agitated patients to another topic. For example reminiscence is often effective with cognitively impaired patients.

- ❑ **Put the patient on a higher level of observation with regular checks to provide for safety and increase staff contact.**
- ❑ **Play soothing music.**
- ❑ **Assess whether television has a calming or agitating effect of the patient.**
- ❑ **Sit the patient close to the nursing station. Assess whether this has a calming or agitating effect.**
- ❑ **Provide the patient with a safe therapeutic diversional activity.**
- ❑ **Use verbal redirection techniques.**
- ❑ **Use de-escalation techniques such as non-violent crisis prevention.**
- ❑ **Provide clock in room; provide calendar in room**
- ❑ **Review medication and management**
- ❑ **Isolate the situation**
- ❑ **Adjust master treatment plan**

Environmental Measures:

- ❑ **Place the patient in a room closer to the nurses station**
- ❑ **Use appropriate lighting.**
- ❑ **Modify the environment to reduce sensory stimulation**
- ❑ **Create a safe, protective environment by removing potentially hazardous articles.**
- ❑ **Assure the call bell is within reach and night light on,**
- ❑ **Orient the patient frequently to his or her surroundings**
- ❑ **Place personal items within reach**
- ❑ **Place the bed in low position if possible**
- ❑ **Provide non-slip/grip footwear**

Appendix C

Assault Response Decision Tree

Is this behavior Dangerous?	NO →	Will the treatment plan solve this problem?	YES →	Use the tx plan.
YES ↓		NO ↓		
Is there an immediate danger of injury?	↑ NO →	Will routine back-up plans solve this problem?	YES →	Use routine back-up plans.
YES ↓		NO ↓		
Is serious injury being threatened?	↑ NO	↓		
YES ↓ →		Do we understand why this is happening?	YES →	Identify function of behavior & make adjustments in approach per tx plan.
		NO ↓		
		Can we talk the attacker into stopping the attack?	YES →	Use verbal crisis intervention.
		NO ↓		
		Will the attacker stop if we briefly avoid the attack?	YES →	Use evasive self-defense.
		NO ↓		
		Will we have to restrain this person from hurting self or others?		
		YES ↓		
		Do we have enough trained staff to restrain this person with minimum risk to the person and the staff?	YES →	Use physical intervention, containment, seclusion, restraint

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