I. OBJECTIVES
   A. The patient has the right to be free from restraint and seclusion that is not medically or legally necessary.
      1. Restraint/seclusion shall only be used when less restrictive interventions are ineffective to protect the patient, staff member or others from harm, and when there is an imminent risk of a patient physically harming themselves, staff, or others.
      2. The least restrictive method of restraint, that takes into account the patient’s condition, shall be used and documented in the medical record. Non-physical methods are preferred.
      3. Physiologic evaluation to determine underlying cause(s) of behavior and implementation of appropriate interventions to address cause(s) shall accompany use of restraint/seclusion.
      4. The patient’s dignity and well being shall be preserved.
      5. Patient shall be assessed frequently to assure that termination of restraint is done as soon as is clinically indicated, even before the time limited order expires, if applicable.
      6. Clinical leadership assessment of whether additional resources are needed to facilitate discontinuation or to minimize recurrent instances of restraint/seclusion shall occur.

II. INDICATIONS FOR USE
   A. This policy shall be implemented if the patient’s behavior becomes aggressive or violent, presenting an immediate, serious danger to the patient’s safety or that of others, and the least restrictive measure that will assure the patient’s or others safety is restraint or seclusion.
   B. SITUATIONS IN WHICH THIS PROTOCOL DOES NOT APPLY 4:
1. Use of restraint when the primary reason for use directly supports medical/surgical healing. See PAT002, Restraint (Physical) to Support Healing in the Non-Violent Patient.

2. USE OF STANDARD MEDICATION TREATMENT: Medication that is a standard treatment for a patient’s medical or psychiatric condition. Drugs shall never be used as a restraint.

3. TIME OUT: When the individual is restricted for 30 minutes or less from leaving an unlocked room and when its use is consistent with the patient’s treatment plan.

4. QUIET ROOM: Quiet Room; an unlocked room that patients are not physically prevented from leaving, which is designated for patients’ voluntary use to allow them time out of the company of other patients.

5. MEDICAL IMMOBILIZATION: Limitation of mobility or temporary immobilization for medical, dental, diagnostic, radiotherapy, or surgical procedures and the related post-procedure care processes (eg. positioning for operative or diagnostic procedures, IV arm boards, traction, protection of surgical and treatment sites in pediatric patients).

6. DEVICES WHICH CAN BE REMOVED BY THE PATIENT: If a device can be easily removed by the patient, it is not a restraint.

7. ADAPTIVE SUPPORT to compensate for a physical deficit and/or achieve maximum normative function that can be easily removed by the patient (eg. postural support, orthopedic appliances, tabletop chairs if patient is able to release the tabletop).

8. PROTECTIVE DEVICES OR EQUIPMENT used based on patient’s assessed needs to protect patient from injury resulting from a specific physical deficit (eg., helmets).

9. FORENSIC RESTRAINTS; Used for correctional need and not for clinical care (eg., handcuffs) (See Care of the Patient in Custody, PAT010).

10. 3 OR FEWER BED SIDE RAILS OR 4 SIDE RAILS IN CERTAIN SITUATIONS (See Definitions below) : Three (3) or fewer side rails up is NOT a restraint Four side rails up is NOT considered a restraint when a patient is on a stretcher, being transported, recovering from anesthesia, sedated, experiencing involuntary movement, unable to ambulate, or on certain types of therapeutic beds). When a patient is placed on seizure precautions and all side rails are padded and raised, the use of side rails is not considered a restraint as the padded side rails protect the patient from harm. Raised crib rails or other protective devices (such as seatbelts, high chair belts or crib covers) that are used for a small child are not restraints.

11. An enclosed bed when age or developmentally appropriate.

III. DEFINITIONS

<table>
<thead>
<tr>
<th>Physical Restraint</th>
<th>Definition</th>
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<tr>
<td>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 (eg. cloth/soft limb device, soft chest device, use of Geri-chair with tabletop to manage unpredictable behavior, enclosed bed). Restraints do not include devices that can be easily removed by the patient, orthopedic devices, surgical dressings or bandages, protective helmets, untied mitts or other methods that involve the physical holding of a patient for the purposes of conducting a routine physical examination or test or to permit the patient to participate in activities without the risk of physical harm or to protect the patient from falling out of bed (example: 4 side rails in certain situations as listed above I-B-j).</td>
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</tbody>
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Restraint and Seclusion, Management of Violent or Self-Destructive Patient Behavior and Behavior Presenting an Imminent Safety Risk to Self and Others

4 Side Rails as a Restraint

Four (4) side rails is considered a restraint when the intent of use is to restrict patient movement or immobilize or reduce the patient’s ability to move freely (e.g., if a patient is physically able to ambulate, even if it has been determined that they cannot safely ambulate, and the 4 side rails prevent this, then the 4 side rails must be defined as a restraint).

Violent Behavior

Patient’s behavior which becomes aggressive, presenting an immediate, serious danger to the patient’s safety or that of others.

Seclusion

The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. (Includes OPEN AND locked door, and locked door quiet room in Pediatrics).

Standard Medication Treatment

• Medication used according to the Food and Drug Administration and the manufacturer for the indications it is labeled.
• The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization;
• The use of the medication to treat a specific patient’s clinical condition is based on that patient’s symptoms, overall clinical situation, and on the authorized prescriber’s knowledge of that patient’s expected and actual response to the medication.
• The expectation that the standard use of a medication to treat the patient’s condition enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of the medication.

Crisis Prevention Intervention (CPI) Children’s Control Position

• A technique designed to be used only with children on the CMSC 3 unit (see Aggression Management of Child/Adolescent Unit and /Day Hospital Program)

IV. RESPONSIBILITY

Psychiatry Department Admitting Officer (Applicable to Psychiatry Care Areas Only)

A. Inform the patient and family, as appropriate, of the organization’s philosophy on the use of restraint and seclusion to the extent that such information is not clinically contraindicated.
B. Ask the patient whether they desire that the family be notified in the event of a restraint/seclusion episode.

Psychiatry Department Clinical Director/ Designee (Applicable to Psychiatry Care Areas Only)

A. If a patient remains in restraint/seclusion for more than 12 hours or experiences two or more separate episodes of restraint/seclusion with 12 hours, the clinical director designee will:
   1. Assess whether additional resources are needed to facilitate discontinuation of restraint/seclusion.
   2. Assess whether additional resources are needed to minimize recurrent instances of restraint/seclusion.
B. If a patient’s treating authorized prescriber requests continued restraint or seclusion, the clinical director or the clinical director’s designee may authorize continued restraint/seclusion following a face-to-face evaluation of the patient in restraint or seclusion:
   1. For an additional 48 hours over the initial 48-hour period that a patient is restrained or secluded.
   2. For each period of seven days over the 96-hour period authorized.
C. The clinical director/designee shall countersign the authorized prescriber’s order in the patient’s medical record for continued restraint/seclusion each time that continued restraint or seclusion is authorized.

Psychiatric Treatment Team (Applicable to Psychiatry Care Areas Only)

A. At least daily, shall review use of seclusion/restraint for the patient.
B. Within 7 working days from the initiation of continuous seclusion/restraint, regardless of whether the patient remains in seclusion/restraint, the treatment team shall:
   1. When applicable, review the appropriateness of the continued use of seclusion/restraint;
   2. Establish and implement a plan calculated to eliminate the need for further seclusion/restraint;
C. Identify a team member who shall explain to the patient the potential risks and benefits of continuous seclusion/restraint.

Authorized Prescriber
MD, DO, Dentists, Podiatrists, Certified Registered Nurse, Certified Nurse Midwife, Certified Nurse Anesthetists and Certified Physician Assistants

A. Determine patient need for restraint/seclusion and make the decision to restrain/seclude.
B. Perform an in-person evaluation of the patient’s physical and psychological condition for management of violent or self-destructive patient behavior and behavior presenting an imminent safety risk to self or others:
   1. Initial: within one hour of initiation of restraint
   2. Ongoing: at least every 8 hours for adults ages 18 and older and every 4 hours for patients ages ≤ to 17.
C. Restraint or seclusion:
   1. Write a time-limited order for restraint/seclusion on Authorized Prescriber Ordersheet for Restraint/Seclusion for Violent or Self-Destructive Patient Behavior (Appendix A).
   2. Under no circumstances may a PRN restraint order be written.
   3. Each written order is limited to:
      a. Four (4) hours for adults (ages 18 and older).
      b. Two (2) hours for children and adolescents ages 9 to 17 years.
      c. One (1) hour for children under age 9.
   4. The attending physician shall be notified as soon as possible, if the attending physician did not write the order.
      a. On non-POE floors, the documentation of attending notification will be done by co-signature of attending on restraint paper orderset by end of next calendar day.
      b. On POE floors, the attending is notified by electronic means upon entry of an electronic restraint order.
5. Make any decision to continue to restrain/seclude the patient and provide a time-limited written or verbal order to continue the original order for another 4 hours (ages 18 and older) or another 2 hours (ages ≤ 17).

6. If restraint or seclusion is required for a period greater than a continuous 48 hours, the authorized prescriber may continue seclusion only in conjunction with the requirements of this protocol, and
   a. If the treating authorized prescriber’s clinical opinion is that the patient, if released from seclusion, would continue to present a danger to self or others or would present a serious disruption to the therapeutic environment, and
   b. With the authorization of the clinical director or the clinical director’s authorized prescriber designee, neither of whom may be the treating authorized prescriber.

7. A death known to the hospital that may have occurred within 1 week after restraint will be reported to the Quality Improvement Office (See Reportable Conditions, Section VI).

Registered Nurse (RN) A. The following interventions are only allowed for nursing staff with demonstrated and documented competency to monitor and care for a patient restrained or secluded.

1. Initiate physical restraint/seclusion in the absence of an authorized prescriber order with immediate notification of the authorized prescriber in order to assure the face-to-face evaluation and a time-limited order by an authorized prescriber.

2. Perform a re-evaluation of patient’s response to the restraint/seclusion episode and the need for continuation. This re-evaluation will include patient’s response to episode, indicators for continued use, and progress toward target behaviors or alleviation of symptoms.
   a. Every two (2) hours in patients > 9 years of age
   b. Every one (1) hour for children ≤ age 9

3. Discontinue restraint/seclusion as follows:
   a. May discontinue restraints (including 4-point-restraints), when clinically indicated, with authorized prescriber notification within one hour.
   b. May discontinue seclusion with a authorized prescriber order (Applicable to Behavioral Health areas Adult Psychiatry only)
   c. May order termination of seclusion with or without an authorized prescriber order (Applicable to Child psychiatry only), unless the authorized prescriber order specifically required authorized prescriber concurrence with the termination.

4. Initiate a debriefing of the seclusion/restraint episode with the patient, available staff members who were involved in the episode, and if appropriate, the patient’s family (Applicable to Behavioral Health areas only).
   a. Debriefing shall take place within 24 hours of restraint/seclusion discontinuation.
   b. Debriefing is used to:
Subject
Restraint and Seclusion, Management of Violent or Self-Destructive Patient Behavior and Behavior Presenting an Imminent Safety Risk to Self and Others

i. Identify precipitating factors and what could have been handled differently
ii. Ascertain that the patient’s physical well-being, psychological comfort, and right to privacy were addressed
iii. Provide patient counseling for any trauma that may have resulted from the incident. Modify the treatment plan, as appropriate

Licensed Practical Nurse (LPN)
The following interventions are only allowed for nursing staff with demonstrated and documented competency to monitor and care for a patient restrained or secluded.
A. Apply physical restraint based on authorized prescriber order.
B. Perform ongoing monitoring and interventions.

Unlicensed Nursing Staff (Clinical Nurse Externs, Clinical Associates, Patient Observers (Intrastaff))
The following interventions are only allowed for nursing staff with demonstrated and documented competency to monitor and care for a patient restrained or secluded.
A. Perform ongoing observations per the High Frequency Flowsheet (Appendix B).
B. Perform RN delegated interventions.

Quality Improvement Staff
A. Call Centers for Medicaid and Medicare Services (CMS) with required information when a patient dies while in restraints, dies within 24 hours of being restrained or dies within 1 week of being restrained, where it is reasonable to assume the use of restraint contributed to the death, no later than close of business the day after knowledge of the patient’s death.
B. Document the date and time of call in the patient’s medical chart.

V. PROCEDURE
A. TRAINING AND COMPETENCY REQUIREMENTS: See Appendix C
B. INITIAL ASSESSMENT
1. On admission, the RN will:
   a. Screen all patients for risk of situations that indicate use of restraint or seclusion.
   b. Conduct an assessment to identify factors that will place the patient at greater risk if restraint or seclusion were to be used. This assessment includes, but is not limited to pre-existing medical conditions or physical disabilities and any history of sexual or physical abuse.
   c. Assess for non-restraint/non-seclusion interventions that will help the individual control their behavior.
2. If patient’s behavior is such that they are at risk for harming self or others, the RN will conduct an assessment to identify and treat potential root causes.
   a. Assess need for restraint/seclusion. Criteria include, but are not limited to:
      • Behavior presents serious danger to patient/others.
      • Verbal aggression/threats against self, others, or objects.
      • Physical aggression/threats against self, others, or objects.
C. INITIATION OF RESTRAINT/SECLUSION

1. The RN may apply restraint/seclusion in emergency situations.
2. Notify authorized prescriber immediately and include a review of the patient’s physical and psychological condition.
   a. Obtain a time-limited authorized prescriber order for the least restrictive type of restraint that will be effective and safe. (Note: Pediatric patients < 12 years of age: four-point restraints may not be used for behavior management).
   b. Explain to patient the rationale for restraint/seclusion and reassure patient of frequent observation during the restraint episode.
3. The authorized prescriber shall notify or attempt to notify family of initiation of restraint/seclusion, if individual has consented to have the family informed and the family has agreed to be notified.
4. When placing patient in seclusion:
   a. Make a reasonable effort to verbally persuade patient to enter the seclusion room.
   b. Inspect the seclusion room for potentially dangerous conditions and, as appropriate, fully secure the room.
   c. Place patient in seclusion room in as dignified a manner as the situation permits, using the least amount of physical force necessary.
   d. Restraints will never be applied to a patient in locked door seclusion.
   e. Enlist additional personnel to place patient in seclusion, if indicated.
   f. Search patient and obtain/remove potentially harmful objects.
   g. Consider letting patient wear all or a portion of their own clothes or other form of attire, as appropriate.
   h. Consider letting patient wear eyeglasses, hearing aids, dentures or prosthetic devices, unless contraindicated for safety reasons.
5. When applying or re-applying physical restraint:
   a. Leave restraint loose enough to allow for adequate circulation and effective breathing pattern, prevent alterations in skin integrity, and facilitate quick release.
   b. Secure physical restraint to a section of the furniture/bed frame that moves vertically when the patient’s bed position is adjusted. Do not attach to side rails.
6. When applying the CPI Children’s Control Position (CMSC 3): See Aggression Management of Child/Adolescent Unit and /Day Hospital Program policy)
   a. A staff member that is not involved in the restraint activity will continuously observe the patient being restrained.
   b. The staff member applying the control position will stand behind or to the side of the child while gaining control of their arms.

D. AUTHORIZED PRESCRIBER ORDERS (Appendix A)

1. Authorized prescriber orders shall include:
   a. Date, time, and type of restraint (restraint, seclusion, or both.)
b. Duration of restraint/seclusion  
c. Alternative interventions/least restrictive approaches determined to be ineffective  
d. Clinical justification  
e. Special precautions, as indicated  
f. Patient wish for family notification of initiation of restraint/seclusion, if appropriate (NA in pediatrics)  
g. Notification of family or attempt to notify family, if appropriate  
h. Authorized prescriber signature and prescriber ID code.  

E. OBSERVATION (Appendix B)  
1. Four Point Restraints: Maintain constant in-person observation of patients in four-point restraint and/or seclusion.  
2. The following nursing staff observations will be conducted continuously for seclusion and at least Q 15 minutes or more frequently per patient’s condition for restraint. Documentation of the following nursing staff observations will be done at least every 15 minutes:  
   a. Behavioral indicators for continued use of restraint  
   b. Patency of airway/presence of respiration  
   c. Skin integrity  
   d. Neurovascular status (limb restraints only)  
   e. Maintenance of body alignment  
3. After the first hour, a patient in seclusion without restraints may be continuously monitored using simultaneous video and audio equipment, if consistent with the patient’s condition or wishes.  

F. INTERVENTIONS  
1. The nursing staff will provide the following interventions:  
   a. Range of motion every two hours while awake  
   b. Offer food/fluids every two hours while awake as per clinical condition.  
   c. Provide opportunity for toileting every two hours while awake  
2. At least two (2) staff members must be present when releasing restraints or entering seclusion for any reason (Exception: in Child psychiatry: one staff member may be sufficient for entering seclusion).  

G. AUTHORIZED PRESCRIBER RE-EVALUATION  
1. The authorized prescriber will perform an in-person re-evaluation and will make any decision to continue to restrain/seclude the patient.  
   a. This re-evaluation will include working with the staff to revise the patient care plan as needed and to identify ways to help the patient to regain control.  
   b. This re-evaluation will be done:  
      1. At least every 8 hours for adults ages 18 and older  
      2. At least every four hours for patients ages ≤ 17  
2. The authorized prescriber shall provide a time-limited written or verbal order to continue the original order for up to 4 hours (ages 18 and older), 2 hours (ages≤17), or one hour (ages 9 and below).  
   a. A new order is required once the original order expires.  
   b. Verbal orders must be co-signed by an authorized prescriber within the next calendar day.  

H. DISCONTINUATION OF RESTRAINT/SECLUSION  
1. The RN may discontinue restraints (including 4-point restraints) as soon as the reason for implementation is resolved,
Restraint and Seclusion, Management of Violent or Self-Destructive Patient Behavior and Behavior Presenting an Imminent Safety Risk to Self and Others

2. The RN may discontinue seclusion as follows:
   a. With a written or verbal authorized prescriber order (Adult Psychiatry)
   b. With or without a authorized prescriber order (Child Psychiatry), unless the authorized prescriber order specifically required authorized prescriber concurrence with the termination

3. The treatment team will review the degree of continued patient monitoring required.

4. Staff cannot discontinue a restraint or seclusion intervention and restart it under the same order. This constitutes a PRN order. A “trial release” constitutes a PRN use of restraints or seclusion and is not permitted.
   a. A temporary, directly-supervised release that occurs for the purpose of caring for a patient’s needs (e.g. toileting, feeding, range of motion exercises) is not considered a discontinuation of a restraint or seclusion intervention. As long as the patient remains under direct staff supervision (i.e., staff remains in patients room), the restraint is not considered to be discontinued because the staff member is present.

I. DEBRIEFING (APPLICABLE TO PSYCHIATRY CARE AREAS ONLY)
   1. The RN will initiate a debriefing of the seclusion/restraint episode with the patient, available staff members who were involved in the episode, and if appropriate, the patient’s family (per Section III. C. 3).
   a. Debriefing shall take place within 24 hours of restraint/seclusion discontinuation.
   b. Debriefing is used to:
      1. identify precipitating factors and what could have been handled differently
      2. ascertain that the patient’s physical well-being, psychological comfort, and right to privacy were addressed
      3. provide patient counseling for any trauma that may have resulted from the incident
      4. modify the treatment plan, as appropriate.

J. PATIENT EDUCATION TO INCLUDE:
   1. Reason for restraint/seclusion
   2. Behavioral criteria for discontinuation of restraint
   3. Assessment procedures
   4. Supportive interventions

K. PATIENT TRANSPORT
   1. If the patient must be transported to/from the nursing unit while in physical restraints, a trained direct care provider must accompany the patient until the patient’s care is handed off to another trained direct care provider in the receiving area.
   2. Direct care providers do NOT include support associates, clerical associates, escort personnel, or family members.

VI. REPORTABLE CONDITIONS
A. Notify authorized prescriber of the following:
   1. Patient’s actions resulting in injury to self or others
   2. Patient exhibits inability to tolerate restraint with increased agitation
   3. Ineffective breathing patterns
   4. Impaired skin integrity
5. Impaired neurovascular status

B. If patient remains in restraint/seclusion for > 12 hours or experiences 2 or more separate episodes of restraint/seclusion of any duration within 12 hours: (Applicable to PSYCHIATRY CARE AREAS only):
   1. Notify Clinical Director or Authorized prescriber Designee via FAX.
   2. Thereafter, notify Clinical Director or Authorized Prescriber/Designee every 24 hours if either of the above continue.

C. Staff to notify the Quality Improvement Office by faxing the Official Report on Death of Patient form for report to the Centers for Medicaid and Medicare Services (CMS) for the following situations (See Death, After Care Policy, ADT009):
   1. A death that occurs while a patient is in restraint or seclusion.
   2. A death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
   3. A death known to the hospital that may have occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly to the patient’s death, i.e. death related to restriction of movement for prolonged periods of time, chest compression, or asphyxiation.

VII. DOCUMENTATION

A. Authorized Prescriber:
   1. Authorized Prescriber Ordersheet for Restraint (Physical) for Management of Violent or Self-Destructive Patient Behavior (Appendix A)
   2. Progress Notes (Appendix B)

B. Nursing Staff:
   1. Aggressive Patient Management Indicator Tool, applicable to patients being primarily managed by the Department of Psychiatry. (Appendix F)
   2. Violent or Self-Destructive Patient High Frequency Flowsheet/Progress Notes (Appendix B):
      a. Condition or symptoms that warranted the use of restraint
      b. Consideration or failure of less restrictive interventions (Appendix D/E)
      c. Date/time each episode was initiated and discontinued
      d. Assessments of the individual’s status
      e. Observations/interventions to meet comfort, nutritional and elimination needs
      f. Patient’s response to the intervention used, including the rationale for the continued use of the intervention.
   3. Patient Debriefing Post Seclusion/Restraint (Appendix H)
      a. understanding patient perspective of incident that led to the dangerous behavior
      b. provide patient the opportunity to express thoughts/feelings about the incident
      c. develop and individualized prevention plan of care
   4. Progress Notes:
      a. Any pre-existing medical conditions or any cognitive or physical disabilities that would place the patient at greater risk during restraint.
      b. Any history of sexual or physical abuse.
      c. Any injuries that are sustained and treatment received for these injuries (Note: report patient events related to physical restraint in Patient Safety Net as per hospital policy)
d. Any significant changes in the patient’s condition.

C. Plan of Care:
   1. Written modification to the patient’s plan of care to include restraint use upon initiation and ongoing based on patient assessment and evaluation.

D. Staff Personnel Records:
   1. Training and demonstrated competency in the application of restraints, monitoring, assessment, and providing of care for a patient in restraint as part of orientation and ongoing.

E. Death Reporting (See Reportable Conditions, V-A):
   1. Time and date of call to CMS must be documented in the patient’s medical chart:

VIII. SUPPORTIVE INFORMATION

See Also:

JHH Interdisciplinary Clinical Practice Manual

- Care of the Patient in Custody, PAT010
- Death, After Care, ADT009
- Restraint (Physical) for Medical Surgical Healing, PAT002

Pediatric Therapeutic Hold Protocol

Department of Psychiatric Nursing Practice and Organization Manual, Section I

- Organizational Policies; 102 Provision of Patient Care Services deptmed.med.som.jhmi.edu/mednurse/manuals/operations/org/102.pdf

Department of Psychiatric Nursing Practice and Organization Manual, Section II

- Staff Practice Standards; 202 Guidelines for Charge Nurse Responsibilities deptmed.med.som.jhmi.edu/mednurse/manuals/operations/admin/202.pdf

Department of Pediatrics

- Aggression Management of Child/Adolescent Unit and/Day Hospital Program

References:


Restraint and Seclusion, Management of Violent or Self-Destructive Patient Behavior and Behavior Presenting an Imminent Safety Risk to Self and Others

6. Title 10 Department of Health and Mental Hygiene. Subtitle 21 Mental Hygiene Regulations. Chapter 12 Use of Quiet Room and Use of Restraint. Authority: Health-General Article, 10-101(e) and 10-701, Annotated Code of Maryland
7. Title 10 Department of Health and Mental Hygiene. Subtitle 21 Mental Hygiene Regulations. Chapter 13 Use of Quiet Room and Use of Restraint. Authority: Health-General Article, 10-101(e) and 10-701, Annotated Code of Maryland

Communication & Education:

1. Authorized prescriber will be responsible for having a working knowledge of the JHH restraint policies.
2. Department management will be responsible for training new employees to policy.
3. Important aspects of the policy will be printed in Hospital publications.
4. This policy will be placed in the Interdisciplinary Clinical Practice Manual on the JHH Intranet site www.insidehopkinsmedicine.org/icpm. Paper distributions will be made to the Functional Unit Nursing offices in the event of web access difficulty.

Sponsor:

Clinical Quality Improvement Committee

Developers:

- Behavior Management Restraint/Seclusion Work Group
- Department of Psychiatry
- Nursing Standards of Care Committee
Subject
Restraint and Seclusion, Management of Violent or Self-Destructive Patient Behavior and Behavior Presenting an Imminent Safety Risk to Self and Others

Review Cycle - Three (3) years
Medical Board - Approval Date: 11/25/2008; Effective Date: 12/1/08

Date: ____________________________ Date: ____________________________