Use of restraint and seclusion is fraught with difficulties and is therefore a top focus of CMS and other regulatory bodies. This handbook is a quick way to cover the rules and how to apply them.

*The CMS Restraint Training Requirements Handbook* is a perfect resource to reference on the go. It covers everything you need to ensure you have the knowledge to safely use restraint and seclusion techniques and follow all the CMS guidelines.

This book will help you:

- Administer the application of restraints
- Understand the implementation of seclusion
- Monitor patients in restraint/seclusion
- Properly assess patients in restraint/seclusion
- Provide care to restrained/secluded patients
The CMS
Restraint Training
Requirements
Handbook

HCPro
a division of BLR
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Introduction

In January 2007, new patients’ rights regulations from the Centers for Medicare & Medicaid Services (CMS) went into effect, requiring hospitals to rewrite their policies about restraint and seclusion. The new regulations in the Conditions of Participation (CoP) set forth, among other things, new training requirements.

There are five sections to the patients’ rights standards. The first four sections were published without making any changes to the current CoP. The fifth section includes the patient’s right to be free from unnecessary restraint and seclusion. This section combined two separate sections on medical and surgical restraints and behavioral health restraints. It includes 14 rules on restraint and seclusion, covering:

- Freedom from restraint and seclusion
- Less restrictive interventions
- Orders
Notification
Care plans
Discontinuation
Assessment and reassessment
Performance improvement
Use
Time limits
Renewal
Staff education
Monitoring
Death protocol

It’s important to understand that the core definition of restraint remains essentially the same, with the distinction between the more restrictive time limitations clarified, not changed. The new definition says 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. It also includes 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. CMS says all patients have the right to be free from physical or mental abuse and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may be imposed only to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

A restraint does not include devices—such as orthopedically prescribed devices, surgical dressings or bandages, protective
helmets, or other methods that involve the physical holding of a patient for the purpose of:

- Conducting routine physical examinations or tests
- Permitting the patient to participate in activities without the risk of physical harm (this does not include a physical escort)

The definition of seclusion—the involuntary confinement of a person in a room or area in which the person is physically prevented from leaving—did not change.

Those who provide staff training on restraint and seclusion use must be qualified as evidenced by education, training, and experience in techniques used to address patient behaviors, according to the new regulations. All direct care staff must receive training in the hospital’s restraint and seclusion policies and approaches, and all staff who may be involved in the use of restraint must be trained in safe use of restraint, including the use of mechanical restraint devices, takedowns, and holding.

Hospital leadership sets the standards for the current restraint and seclusion policies (medical/surgical and behavioral). The policies should set clear expectations for a safe environment in which restraint and seclusion are used only as a last resort. Staff is expected to commit to minimizing the factors that might result in the need to restrain or seclude a patient.

The Training Requirements

The patient has the right to safe implementation of restraint or seclusion by trained staff. You must be able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion. Training should take place before staff
perform any of the actions specified in the training requirements, as part of orientation, and subsequently on a periodic basis consistent with hospital policy.

Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patient behavior. The hospital must document in staff personnel records that the training and demonstration of competency were successfully completed.

The new regulations spell out the following restraint and seclusion training requirements for staff.

**Safe application of restraints**

You should be able to demonstrate and ensure that when you select a type of restraint, you take the following steps:

- Select the proper size for the patient’s weight.
- Note “front” and “back” of the restraint and apply correctly.
- Pad any bony prominences.
- Use a knot that can easily be released (half-bow).
- Secure restraints to the bed springs or frame, never to the mattress or bed rails. When an adjustable bed is in use, secure the restraints to the parts of the bed that move with the patient. Never secure a restraint to a bed rail or mattress.
- Adjust restraint to maintain good body alignment, comfort, and safety.
- Ensure restraints are not too tight. (Test to be certain that you can insert two fingers in between restraint and skin.)
Implementation of seclusion

You need to demonstrate knowledge of the definition of seclusion, which is the involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving. Seclusion does not include confinement on a locked unit or ward where the patient is with others. Seclusion may be used only for the management of violent or self-destructive behavior. Seclusion is seldom used in general healthcare settings.

Monitoring of patients in restraint/seclusion

You must be able to discuss the monitoring of a patient in restraints. The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner (LIP), or trained staff that have completed the CMS training requirements.

This monitoring includes:

- Ensuring the physical and emotional well-being of the patient
- Maintaining the patient’s rights, dignity, and safety
- Documenting the type, location, and proper application of the restraining device(s)
  - Documented at least once per shift and when changed
- Assessing the rationale for restraint on an ongoing basis
  - Documented at least once per shift (observed condition or behavior)
- Considering alternatives to and less-restrictive forms of restraint
  - Documented at least once per shift
Completing other monitoring activities based on the currently approved medical restraint form

- Documented per policy

**Assessment of patients in restraint/seclusion**

You should conduct an initial assessment of a patient at the time of the patient’s admission to determine whether restraint is necessary. The assessment should include the following:

- Consideration of medical conditions or disability that might increase the risk of harm to the patient during a restraint episode
- Any history of sexual or physical abuse that might increase the risk to the patient during restraint
- Documentation that the patient—and, if appropriate, the patient’s family—was informed of the organization’s philosophy regarding use of restraint or seclusion

You must, when appropriate, discuss the role of the family in relation to restraint with the patient and family. You must also determine whether the patient has a mental health advance directive, which should indicate the patient’s preference for treatment in case the patient becomes dangerous to him- or herself or others. If the patient has an advance directive, the hospital must provide the information to staff.

When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within one hour after the initiation of the intervention. The patient may be assessed by a physician or other LIP or a registered nurse or physician assistant who has been trained in the CMS restraint and seclusion training requirements. Check to see whether your state has stricter requirements.
If the face-to-face evaluation is conducted by a trained registered nurse or physician assistant, that individual must consult the attending physician or other LIP who is responsible for the patient’s care as soon as possible after the completion of the one-hour face-to-face evaluation.

Simultaneous restraint and seclusion use is permitted only if the patient is continually monitored face-to-face by an assigned, trained staff member or by trained staff using both video and audio equipment.

Staff authorized to carry out restraint must be trained to measure vital signs and know the relevance of vital signs to restrained patients. They must be able to recognize and respond to needs for nutrition and hydration, proper circulation and movement of limbs, and hygiene and elimination.

**Providing care for a patient in restraint or seclusion**

You should modify the patient’s written plan of care to indicate the type of restraint and the goals of the restraint use.

**Techniques to identify triggers of circumstances that require use of restraint or seclusion**

You should watch for the following indications to consider using restraint or seclusion when less restrictive means would not be effective in protecting the patient:

- The patient is pulling at tubes, lines, or dressings
- The confused patient is interfering with the provision of care
- The patient’s actions are endangering him- or herself: for example, if the patient is thrashing around in bed or attempting to get out of bed in a way or under conditions
where it might cause harm (including when such behavior is related to acute withdrawal syndrome)

- The patient’s diagnosis or condition is such that he or she may unpredictably and suddenly awaken and harm him- or herself; e.g., when an intubated patient is being weaned from propofol or when an intubated patient has a neurological condition that may cause him or her to unpredictably and suddenly awaken with a significant risk of self-extubation before staff have an opportunity to intervene

**Use of nonphysical intervention skills**

You should be well versed in the use of nonphysical intervention skills, such as verbal and nonverbal communication, reduced stimulation, active listening, diversionary techniques, limit setting, and as-needed (PRN) medication.

**Choosing the least-restrictive intervention**

Restraint should not be used when less-restrictive interventions would be effective. These include environmental techniques such as:

- Designing the clinical unit to avoid patient crowding and provide some settings where patients can be by themselves to calm down
- Providing easy access to staff and facilitation of conversation with staff as a means of blowing off steam or getting advice
- Access to activities that will either preoccupy the patient’s attention or use up physical energy (e.g., interesting videos or exercise equipment)

Another type of less-restrictive intervention consists of steps that staff should take on the spot when it appears an individual is
about to go into crisis. These steps are generally called de-escalation and are heavily dependent on proper staff training to recognize the situation and deal with it.

**Safe application and use of all types of restraint and seclusion used in the facility**

You must consider the following information when selecting the type of restraint you will use:

- The patient’s expressed preference provided at admission in the advance directive
- The initial assessment, which contains the patient’s history, physical strength and limitations, and vulnerabilities
- The dimensions of the emergency that the restraint is intended to end

You should receive training in how to recognize and respond to signs of physical and psychological distress (e.g., positional asphyxia).

Among the restraint options a hospital might consider having available are four-point leather restraints, two-point restraints, Posey vests, and seclusion. You need to be able to demonstrate and follow the manufacturer’s directions when applying restraints.

**Clinical identification of specific behavioral changes that indicate restraint is no longer needed**

You must discontinue the restraint when the behavior or condition that was the basis for the restraint order is resolved, regardless of the duration of the enabling order. You should be able to recognize the behavioral criteria for discontinuation of restraint
and assist patients in meeting these criteria. If you are not permitted to make the decision to discontinue restraint, you must call supervisory staff, who will then make the decision to release.

**Monitoring physical well-being of patient**

- **Continuous, in-person observation:**
  Monitoring of patients in restraint or seclusion is done through continuous in-person observation by a trained and competent staff member
  - If the patient is on a physical hold, a second staff person shall be assigned to observe the patient

- **Monitoring:**
  - You should assess the patient at the initiation of restraint or seclusion and every 15 minutes thereafter
  - The assessment should include the following, unless it is inappropriate for the type of restraint or seclusion employed:
    - Signs of any injury associated with applying restraint or seclusion
    - Nutrition and hydration
    - Circulation and range of motion in the extremities
    - Vital signs
    - Level of distress and agitation
    - Skin integrity
    - Mental status
    - Cognitive functioning
    - Hygiene and elimination
Physical and psychological status and comfort
Readiness for discontinuation of restraint or seclusion

Use of first aid techniques and certification in CPR use

You should be able to demonstrate competency in the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

Death Reporting

Previously, hospitals were required to report deaths that occurred while a patient was in restraint or seclusion, deaths that occurred within 24 hours after a patient was removed from restraint or seclusion, and deaths known to the hospital that occurred within one week after restraint or seclusion of the patient.

But in November 2013, CMS released a new death reporting form, CMS-10455, and modified its reporting requirements related to the use of restraint or seclusion. Hospitals no longer must report deaths to CMS if there was no use of seclusion and the only restraint used was two-point soft wrist restraints (CFR 482.13(g)). Staff must record the incident in an internal log or other system. The final rule also expanded the requirement to allow submission of death reports via telephone, facsimile, or mail. Email is not an acceptable means of reporting.

Hospitals must report the following deaths associated with restraint and seclusion directly to their CMS regional office no later
than the close of business on the next business day after learning of the patient’s death:

- Each death that occurs while a patient is in restraint or seclusion, excluding those in which only two-point soft wrist restraints were used and the patient was not in seclusion at the time of death.
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion, excluding those in which only two-point soft wrist restraints were used and the patient was not in seclusion within 24 hours of his or her death.
- Each death known to the hospital that occurs within one 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 types of restraints used on the patient during this time.

Hospitals must record deaths that occur in the following circumstances in an internal hospital log or other system:

- Each death that occurs while a patient is in restraint but not seclusion and the only restraints used on the patient were applied exclusively to the patient’s wrist(s) and were composed solely of soft, nonrigid, cloth-like materials.
- Each death that occurs within 24 hours after the patient has been removed from restraint, when no seclusion has been used and the only restraints used on the patient were applied exclusively to the patient’s wrist(s) and were composed solely of soft, nonrigid, cloth-like materials.
The log entry must be made no later than seven days after the patient’s death. The log must include the information specified in 42 CFR 482.13(g)(4)(ii), which includes:

- Patient’s name
- Date of birth
- Date of death
- Name of attending physician or other LIP who is responsible for the care of the patient
- Medical record number
- Primary diagnosis/diagnoses

The following must also be documented in the medical record for any patient whose death is associated with the use of restraint or seclusion:

- The date and time the death was reported to CMS for deaths required to be directly reported
- The date and time the death was recorded in the hospital’s internal log or other system for deaths that are required to be logged and not directly reported to CMS
Sample Competency Form: Application of Restraints

<table>
<thead>
<tr>
<th>Name: ___________________________</th>
<th>Date: ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restraints, application of _______</td>
<td>____________________</td>
</tr>
<tr>
<td>Skill: __________________________</td>
<td>____________________</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Steps</th>
<th>Completed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Verbalizes need to assess patients requiring restraints and identifies alternative to restraints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Identifies nurse’s and physician’s roles in application of restraints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Describes time frame for patient assessment/documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Documents restraints on restraint log (including date, time, medical record number, etc.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 5. Chest restraint  
  a. Applies chest restraint and adjusts waist belt to fit  
  b. Demonstrates how to secure to bedspring frame (not side rails) or back frame of wheelchair | | |
| 6. Soft restraints  
  a. Verbalizes criteria for application of restraints to extremities (single restraint, wrists only, all extremities)  
  b. Applies soft restraint to extremity and removes | | |
<table>
<thead>
<tr>
<th>Steps</th>
<th>Completed</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 7. Mitt restraints  
  a. Applies mitt restraint | | |
| 8. Leather restraints  
  a. Verbalizes role of personnel in applying leather restraints  
  b. Applies according to policy/procedure | | |

<table>
<thead>
<tr>
<th>Self-assessment</th>
<th>Evaluation/validation methods</th>
<th>Levels</th>
<th>Type of validation</th>
<th>Comments</th>
</tr>
</thead>
</table>
| ☐ Experienced  
  ☐ Need practice  
  ☐ Never done  
  ☐ Not applicable (based on scope of practice) | ☐ Verbal  
  ☐ Demonstration/observation  
  ☐ Practical exercise  
  ☐ Interactive class | ☐ Beginner  
  ☐ Intermediate  
  ☐ Expert | ☐ Orientation  
  ☐ Annual  
  ☐ Other ___  
  | | | |

Employee signature _____________________________ Date __________

Observer signature _____________________________ Date __________
# Sample Competency Form: Restraints (Role of Nursing Assistant)

<table>
<thead>
<tr>
<th>Name: ___________________________</th>
<th>Date: ______________</th>
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</thead>
<tbody>
<tr>
<td>Restraints (role of nursing assistant)</td>
<td></td>
</tr>
<tr>
<td>Skill:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Steps</th>
<th>Completed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Verbalizes nursing assistant’s role in safety evaluation of restraints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. States how and where to document restraints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Soft restraints:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Demonstrates how to remove and reapply soft restraints to extremities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Demonstrates how to secure to bedspring frame (not side rails) using slipknot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Mitt restraints:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Demonstrates how to remove and reapply unit restraints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Leather restraints (optional):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Demonstrates how to remove and reapply leather restraints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-assessment</td>
<td>Evaluation/validation methods</td>
<td>Levels</td>
</tr>
<tr>
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<td>-------------------------</td>
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<tr>
<td>□ Experienced</td>
<td>□ Verbal</td>
<td>□ Beginner</td>
</tr>
<tr>
<td>□ Need practice</td>
<td>□ Demonstration/observation</td>
<td>□ Intermediate</td>
</tr>
<tr>
<td>□ Never done</td>
<td>□ Practical exercise</td>
<td>□ Expert</td>
</tr>
<tr>
<td>□ Not applicable (based on scope of practice)</td>
<td>□ Interactive class</td>
<td></td>
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Employee signature ___________________________ Date __________

Observer signature ___________________________ Date __________
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