CHARTIS

Restraint simplified: Practical approaches to a persistent compliance challenge

On the Radar webinar series

July 2026

The webinar will start at the top of the hour.

MONTHLY INSIGHTS

Webinar schedule & topics

THE 3RD THURSDAY OF EVERY MONTH:

10AM Pacific, 1PM Eastern

TODAY

Restraint simplified

AUGUST

Clarifying requirements for contracted services

Past webinars available for streaming

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On the Radar

Chartis and Greeley explore practical and future-focused topics in quality, regulatory & medical staff.

UPCOMING WEBINAR

Seconds to contaminate, years to recover

Apr 09, 2026

This session will examine regulatory standards governing high-level disinfection and sterilization, with emphasis on how surveyors interpret and apply those requirements in acute and procedural settings.

> REGISTER NOW

Navigating the Zoom interface

Handouts:

Check the chat function for copies of the slides for note taking and any other handouts.

Questions and comments:

Please participate in the discussion by asking question through the Q&A function during the webinar.

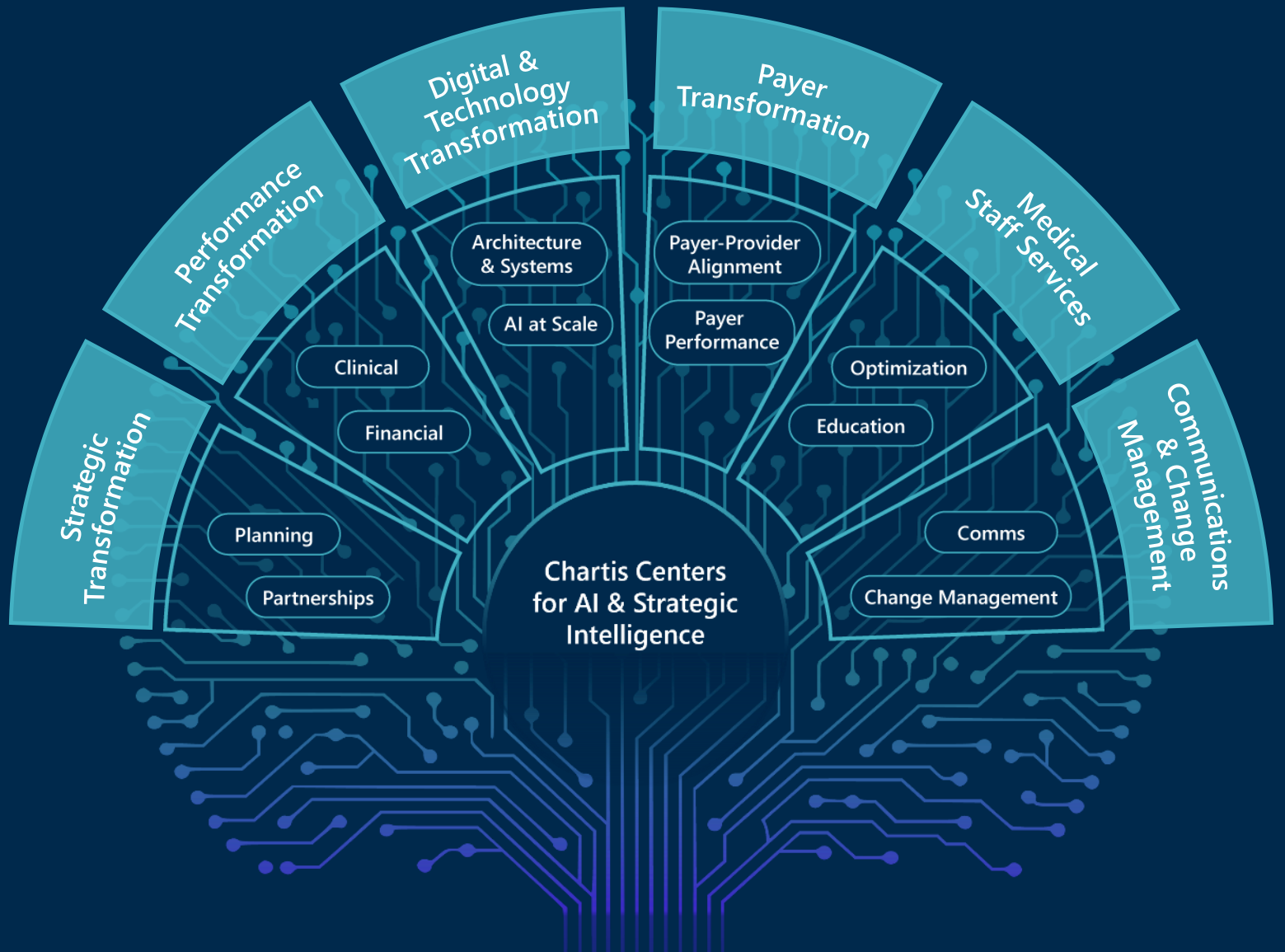
There will also be a survey you will receive immediately after the webinar that will give you an opportunity to ask additional questions or make comments.

Any questions not answered during the webinar will be addressed in a follow-up email or posting.

Chartis is uniquely built to *deliver the last mile.*

Our **integrated lines of business** work alongside the Chartis Centers for AI & Strategic Intelligence to deliver against the last mile necessary to **transform healthcare delivery.**

Connected capabilities.
Real healthcare transformation.



High Reliability Care

UNPARALLELED BREADTH AND DEPTH

Our clients are all striving toward the same goal of providing safe, high-quality care—something that's becoming even more important with the many distractions and disruptions in healthcare today. We help clients achieve their organizational reliability, quality, and safety goals, leading to results in areas that matter most—improved care outcomes, staff engagement, operational stability, and total cost of care, enhanced reputation, and better patient experience.

High Reliability Organization (HRO)

- High reliability organizational design and infrastructure
- Quality, Value, and Performance Improvement
- Quality ratings and rankings optimization
- Patient safety / harm reduction / safety and reliability culture
- Adverse event response and remediation / RCA
- High fidelity measurement / Clinical Documentation Integrity (CDI)
- Care facilitation

Clinical Compliance, Regulatory, and Physical Environment Solutions

- Adverse event response
- Adverse action regulatory response and remediation
- Accrediting body readiness assessment
- Regulatory readiness rehearsal / mock surveys
- Life safety and environment of care assessment
- Policy simplification
- Infection prevention program

Bylaws, Rules and Regulations, and Peer Review

- Bylaws and rules and regulations assessment and redesign
- Peer review assessment and redesign
- Medical staff / medical director structure and governance
- Credentialing, OPPE

External Peer Review

- Physician/advanced practice professional external peer review
- Focused Professional Practice Evaluation (FPPE)
- Ongoing case review in support of OPPE/FPPE
- Medical necessity reviews
- Patient safety/carequality case reviews

MEMBERSHIP AND PROFESSIONAL EDUCATION SERVICES

Today's *discussion*

Most hospitals and behavioral health settings have complicated restraint policies that defy consistent implementation.

Today's webinar will share our simple model restraint policy as a framework for addressing the most common related issues, including protocol orders, chemical restraint, and tips for quality monitoring.

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Today's *agenda*

Why is restraint so problematic?

Tips for making the complex simple(er)

How it fits together

Questions should be posted in the webinar interface throughout the presentation.
We will respond to any unanswered questions in writing following the webinar.

Why is restraint such a big issue?

Regulatory focus on restraint

Violent or self-destructive patients:

- Patient Harm
- Patients' Rights Advocates

Long term care patients

- Substitute for Staffing
- Confused Patients

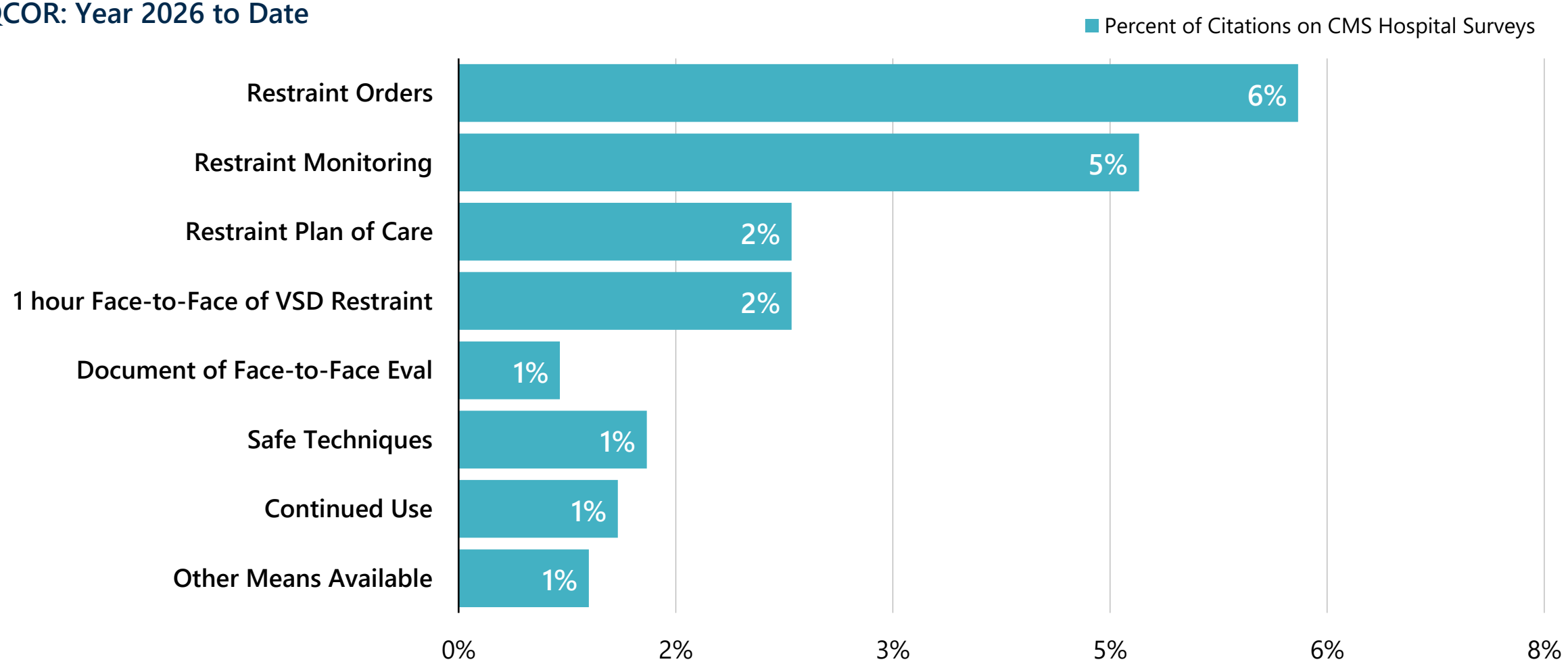
Acute critical care

- Caught in the Web
- 29 separate restraint related issues cited so far in 2026

(Note: Chemical Restraint did not make the list)

8 of the 29 restraint issues cited during CMS surveys

QCOR: Year 2026 to Date



Tips to make your life simpler

Introducing a few key concepts

A few things we've learned

- Non-violent restraint orders
  - Remember: YOU set the time frame for expiration. Some are confused by the 24-hour limit violent or self destructive orders. CMS allows the hospital to establish its own requirement for re-order of NON-violent restraint.
  - Consider protocol orders that expire based on the patient's situation vs. a set time frame.
  - If you must set a duration for Non-VSD orders, make it every calendar day … Do NOT place a 24 hour limit. This leads to a fiction about physicians re-ordering restraint in the middle of the night.
- Do not get tangled in the chemical restraint web.
- Keep it as simple and possible. Think about the new nurse on their first shift.
- More about these approaches later.

How it fits together

Highlights of the requirements based on our approach

Restraint categories

Non-Violent Restraint (Non-VSD)

- Dislodgement of device/disruption of treatment that may threaten life and/or interfere with necessary care.
- Impaired safety awareness: Observed actions/behaviors that place the patient at high risk for injury due to impaired safety awareness.
- Self-disruption of skin integrity.

Violent and Self-Destructive Behavior (VSD)

- Violent or Imminent risk of harm to self or others.
  - **Physical escort**
    - If the patient cannot easily remove the grasp, restraint applies
  - **Physical holding**
    - Therapeutic holding the patient against his/her will to help calm the patient
  - **Physical holding for forced medications**
    - The application of force to physically hold a patient, to administer a medication against the patient's wishes, is considered restraint
    - Use of force to medicate the patient requires a physician's order
    - Assisting the patient to voluntarily receive a medication is NOT restraint

Most patients are only in VSD restraints until their therapeutic meds have taken effect, then transitioned to non-violent restraints for impaired safety awareness.

Additional types of restraints

Forensic Restraints:
Handcuffs, manacles, shackles, other chain-type restraint devices

- Can only be used by **law enforcement** who maintain custody & direct supervision of the patient – restraint regulations are **not in effect in this situation!**
- When handcuffs are removed the officer **endorses** the patient to the hospital. If we transition a patient to hospital restraints, the restraint regulations come into effect.

Seclusion:
Involuntarily confining a patient alone to a room/area where the patient is physically prevented from leaving.

- Seclusion is always a VSD Restraint

Seclusion is NOT:

- Confinement on a locked unit or ward where the patient is with others (an emergency department)
- Having the patient agree to confine their movements to a room with an open door
- A "time out" in a quiet (unlocked) location

Emergency medications & chemical restraints

Emergency medications

Medications should always be given to ENABLE the patient to participate in their plan of care, not to DISABLE the patient.

- If we are giving the med that is **standard treatment** and **standard dosing**, we aren't disabling. We are enabling the patient to de-escalate and wake up to participate in their care
- A face-to-face evaluation must be performed because of the **PHYSICAL HOLD** associated with administering the "forced medication"….*unless* the patient willingly takes the emergency medication

DOCUMENT

Patient behaviors necessitating the need for the emergency medication MUST be clearly documented such as:

- The patient was attempting to stab himself with a pen.
- The patient was yelling and hitting his head on the wall.
- The patient was threatening staff, waving fists at nurses.

Chemical restraints: We *don't* do this

- **Chemical restraints:** Medications that are NOT part of a patient's standard medical or psychiatric treatment, and are administered outside of the standard dosage for the patient's condition
- Regulations are not intended to interfere with appropriate doses of sleeping medication prescribed for patients with insomnia, anti-anxiety medication prescribed to calm a patient who is anxious, or analgesics prescribed for pain management.
- Medication is given to treat the patient's condition/symptoms, NOT to "manage their behavior"

I AM a chemical restraint:

- Off-label use of an antipsychotic medication to manage violent behavior.
- Use of anti-anxiety or sedating medication in doses not intended for the symptom (higher doses than necessary)
- Sundowner patient who is wandering the halls and is prescribed meds to "put them down" (staff convenience)

I am NOT a chemical restraints:

- Ativan for the management of violent behavior of unknown etiology
- Geodon used for the management of violent behavior in patients suffering from schizophrenia or bipolar disorder
- Haldol for extreme anxiety and inability to calm patient to perform necessary assessments
- FDA-approved use of an antipsychotic medication to manage violent behavior

These are *NOT* restraints

- Orthopedically prescribed devices
- Surgical dressings or bandages
- Protective helmets
- Methods to protect the patient from falling out of bed
- Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or test
- Methods to permit the patient to participate in activities without the risk of physical harm
- Use of an IV arm board to stabilize an IV line is generally not considered a restraint unless the entire limb is immobilized, or the arm band is tied down.
- Positioning/securing device used to maintain the position of the patient during diagnostic or surgical procedures.
- Recovery from anesthesia when the patient is in a critical care or PACU. This “allowance” stops when the patient is transferred to another unit or recovers from the effects of the anesthesia (whichever occurs first).
- Methods to protect the patient from falling out of bed

Assessment & monitoring requirements

Non-violent restraints

Restrained patients should be subject to ongoing monitoring and assessment as specified in the patient's plan of care.

- Monitoring and assessments should occur **at least every two hours.**
- (Concurrent documentation **not required per policy**)

Violent restraints

Restrained or secluded patients should be monitored by trained and competent individuals.

- Simultaneously **restrained and secluded** patients should be continuously monitored. (1:1 monitoring) *(This should be extremely rare!)*
- Assessments by a Practitioner or trained registered nurse should occur as often as indicated by the patient's physical and mental status, behavior, and environmental considerations, and *monitored* **at least every 15 minutes.**

Restraint documentation requirements

MD/practitioner	**Orders for restraints**
MD/practitioner	**Face to face evaluation by practitioner within 1 hour of application of VSD restraint**
Nursing	**Restraint flowsheet** Includes start/stop times, type of restraints, location, monitoring/assessments, attending notification, alternatives, discontinuation criteria
Nursing	**Nursing care plan** Should be modified to address interventions implemented to assure the patient's safety and encourage the least restrictive means of protecting the patient
Nursing, MD, practitioner	**Education** As early as possible, notify patient/family of the reason for restraint initiation as part of the patient's plan of care and criteria for discontinuation.

A quick recap on restraints

AS A REMINDER

Discontinue restraints and seclusion when the patient's behavior or situation no longer requires restraint.

Patient Safety and Quality (PSQ) is required to report deaths associated with restraint and seclusion to CMS. Refer to death policy at each hospital for details.

Violent restraint

Don’t apply behavioral (violent) rules when it is **NOT** indicated by the patient’s condition/behavior.

- Don’t apply “behavioral” rules to confused patients (Dementia/Alzheimer's) who are striking at care givers.

Emergency medications

The medication is **NOT** a chemical restraint **IF**:
The medication is a standard treatment or dosage for the patient’s [medical or psychiatric] condition

*Remember: If the patient does **NOT take it voluntarily**, restraint rules kick in and:*

- *There must be an order.*
- *The face-to-face rules apply.*
- *There must be an evaluation of the patient’s tolerance of the hold (which the face-to-face provides).*

Know the *difference*

Restraint is NOT:

- A soft tie or other device to protect the patient from accidental extubation during recovery.
- Use of side rails to protect the patient from falling out of bed.
- Use of padded side rails for seizure precautions.

Restraint IS:

- Continuation of the restraint once the patient has been transferred to the receiving unit or, in the case of patients recovered in critical care, the patient has sufficiently "recovered."
- Use of side rails to keep the patient from getting out of bed (this is also generally felt to be an unsafe practice and for staff convenience).

Know the *difference*

Violent/self-destructive behavior is NOT:

- The behavior of a patient with acute withdrawal syndrome who's **forceful, involuntary movements** threaten his/her welfare
- An elderly patient with altered mental capacity who is frightened or scared and tries to push you away, swats at you, or tries to kick you if you approach their bed.

Violent/self-destructive behavior IS:

- Aggressive and violent behavior of an intoxicated patient who is trying to **harm him/herself** or others.

Know the *difference*

Seclusion is NOT:

- Confining the patient to a locked room with other patients.
- Having the patient agree to confining their movements to a room with an open door.
- A “time out” in a secluded but unlocked location.

Seclusion IS:

- Confining the patient to a locked room alone.
- Physically preventing the patient from leaving an unlocked room.
- Preventing the patient from leaving through intimidation.

Restraint examples

Device Type	The Device is **NOT** Restraint Under the Listed Circumstance(s)	The Device **IS RESTRAINT** Under the Listed Circumstance(s)
Devices to protect the patient during a procedure or anesthesia	During a procedure or anesthesia/sedation	Once the patient has recovered from anesthesia/sedation or the procedure has ended
Side Rails x 4	Used to keep the patient from **falling** out of bed	Used to keep the patient from **getting** out of bed (Order may be PRN). *Not recommended due to risk of entanglement.*
Mittens	Not tied down, allows use of hand and fingers (as a group or independently)	Patient cannot flex fingers; the mitten is tied down restricting movement of the arm/hand; or the mitten restricts access to the patient's body
Arm Boards / Immobilization Devices	Used to protect site of intravenous access from flexing motions	Used to prevent the patient from having access to his or her body
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 (e.g. unlatching a seat belt, untying a knot, letting side rail down)	The patient **cannot** easily remove the device or remove themselves from the device (Orders for a locked "Geri-chair" may be PRN if criteria for application and release are specified)
Covered Bed	Covered bassinet for infants or toddlers. Keep adult patients from **falling** out of bed	To keep adults from **getting** out of bed
Protective interventions for infants, toddlers and pre-school children	Stroller safety belts, seat belts for highchairs, etc.	None
Holding the patient	Light touching during escort	"Therapeutic" hold, patient cannot remove or escape grasp
Holding to give medications or treatments	Voluntarily received by patient	Forced medication or treatment
Forensic Devices (handcuffs, shackles)	Used for patients in the direct custody of a law enforcement officer	**May not be used as a device for restraint**
SECLUSION	This is **NOT Seclusion**	This **IS CONSIDERED Seclusion**
	Confinement on a locked unit or ward where the patient is with others	Confinement in a locked **room** or other area apart from other patients
	Patient agrees to confine their movements to a room with an open door	Physically preventing a patient from leaving an unlocked room
	A "time out" in a quiet (unlocked) location	Preventing a patient from leaving an unlocked room
CHEMICAL RESTRAINTS **Not permitted by CMS** "We give meds to **ENABLE** a patient to participate in their care, never to **DISABLE**"	This is **NOT a Chemical Restraint**	This **IS CONSIDERED** Chemical Restraint
	Common use and dose of medications within the standards of care and practice and well-documented by literature; used for the safety of patient or others and to help the patient more effectively interact with their environment; documentation describes the behavior supporting the use of the medication.	Use of a medication to restrict the patient's freedom of movement that is not a standard treatment for the patient's new or continuing medical or behavioral condition; uncommon or outmoded use of medications for the management of behavior; lack of documentation of the behaviors indicating the need for the medication; used for staff convenience.
Additional Interventions that would **NOT be considered a Restraint**	Orthopedically prescribed devices, surgical dressings, bandages, protective helmets, physically holding a patient for the purpose of conducting a routine physical exam or for testing (drawing labs, applying blood pressure cuffs, etc.)	

Questions

Thank *you*

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