Children's Hospital and Health System
Patient Care Policy and Procedure

This policy applies to the following entity(s):
☒ Fox Valley Hospital ☒ Milwaukee Hospital ☒ Surgicenter

SUBJECT: Restraints - Use of

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DEFINITIONS

De-escalation means a concept that involves a person's use of time, distance and relative position in combination with professional communication skills in an attempt to stabilize a situation, gain compliance and/or reduce the immediacy of the threat posed by an individual.

Licensed Independent Practitioner ("LIP"**)** means any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

Physical Escort means a "light" grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp this would not be considered a restraint. If the patient cannot easily remove or escape the grasp, this would be considered physical restraint and all the requirements would apply.

Physical Hold means holding a patient in a manner that restricts the patient's movement against the patient's will is considered restraint. A staff member picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient is not considered restraint. See below for additional physical hold methods that are not considered restraint.

Episode of restraint means the time during which the patient meets restraint use criteria. If the patient was released from restraint and subsequently exhibits behavior that can only be handled

by reapplication of restraint, this is a new episode and a new order would be required. Centers for Medicare and Medicaid Services (“CMS”) regulations prohibit use of a trial release. For example, removing restraint while a family visits and then reapplying when they leave would be considered a trial release.

Restraint means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely; or use of a drug or medication that is not a standard treatment or dosage for the patient’s condition to manage behavior or restrict a patient’s freedom of movement. See restraint exclusions below for exceptions.

Non-Violent Restraint (Non-behavioral Restraint in Fox Valley (“FV”)) means restraints used to promote medical healing/treatment, when a patient attempts to interfere with their treatment (e.g. removes invasive lines, surgical bandages, etc.), or when patient assessment indicates the patient’s developmental level does not allow them to follow directions related to their treatment.

Violent Restraint (Behavioral Restraint in FV) means use to stabilize a patient exhibiting violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others and requires management.

Chemical restraint means a 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. Whether a medication is ordered for a one-time dose or PRN does not, alone, determine if it is a chemical restraint. If the overall effect of a drug or medication, or combination of drugs or medications, is to reduce the patient's ability to interact with the world effectively or appropriately, then the drug or medication is considered a chemical restraint.

Seclusion means the involuntary confinement of a patient alone in a room or area from which they are physically prevented from leaving to address violent or aggressive behavior. Seclusion is not used at Children’s, even for violent or self-destructive behavior.

Temporary, Directly Supervised Release of Restraint (applies to non-violent restraints only) means an occurrence for the purpose of caring for patient needs (e.g. toileting, feeding, or range of motion) and is not considered a discontinuation of restraint as long as the patient remains under constant direct staff supervision.

Timeout means an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses. A timeout is not considered seclusion.

POLICY

All patients have the right to be free from restraint of any form that are not medically necessary or are imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. (Refer to CHW Patient Care Policy: Rights and Responsibilities of Patient-Parent-Guardian-Family)

The use of restraint requires consideration of alternative methods and clear indications, as well as safe application, monitoring and reassessment guidelines. A violent (behavioral) restraint is used only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. A non-violent (non-behavioral) restraint is used to promote medical healing/treatment and/or when a patient attempts to interfere with their treatment. Seclusion is not used as a method of restraint.

Ordering of Restraints:

Restraint orders are only permitted to be entered by the following providers: licensed physicians, residents/fellows with a Resident Educational License ("REL"), advanced practice nurse prescribers or physician assistants. Unlicensed residents and fellows are not permitted to enter restraint orders.

Initiation and Discontinuation of Restraints

Initiation and removal of restraints may be done by staff who are trained to safely implement restraints. The need for restraint intervention may occur so quickly that an order cannot be obtained prior to the application of restraint. In these emergency application situations, the bedside staff must notify an LIP immediately to obtain a restraint order. Public Safety staff or nursing may initiate an emergency application of restraint prior to obtaining an order from LIP to protect the patient or others from an immediate threat of physical harm or disruption of treatment.

Restraint Exclusions:

The intent of the health care team/provider, not the device itself, determines whether or not the items listed below are considered a restraint. This policy and procedure does not apply to:

A. Devices used to maintain position, limit mobility or temporarily immobilize during routine physical examinations, tests, procedures, or treatments.
   Examples include but are not limited to:
   - Arm boards used for standard IV therapy. (However, arm boards used for other purposes may be considered a restraint.)
   - Elbow immobilizers used for standard IV therapy. (However, elbow immobilizers used for other purposes may be considered a restraint.)
   - Using side rails on a gurney while transporting patients
   - Papoose boards

B. Mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility or to permit participation in activities without the risk of physical harm (does not include a physical escort) than would be possible without the use of such support including:
   - Postural support
   - Orthopedic appliances
   - Protective helmets
   - Splint fabricated by Occupational Therapy

C. Manually holding a patient to maintain position, limit mobility or temporarily immobilize during routine physical examinations, tests, procedures, or treatments. The patient is released when the examination, test, procedure, or treatment is complete. This is sometimes referred to as a “comfort hold”. Examples include but are not limited to:
   - Holding a child’s arm still during IV placement
   - Physically stabilizing a child’s arms during NG placement

D. Law Enforcement restraint or restrictive devices - Refer to CHW Patient Care P&P: Patients with Law Enforcement Involvement

   The use of handcuffs, shackles or other devices by law enforcement officers is not considered a restraint implemented on behalf of the Children’s care team to support care/treatment, and as such are not governed by CMS rule. Therefore, it does not fall within the hospital documentation or ordering standards for restraints. The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital’s patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer’s prisoner). Care providers may ask for the removal of the handcuff, shackle, or other device to provide care and treatment, however the ultimate decision to remove the law enforcement restrictive device lies with the law enforcement officer.

   Nurses should document in the electronic health record (“EHR”) the type of law

enforcement restraints or restrictive devices used and where they are applied in case of any skin or other injuries that occur as a result of the use.

E. For general patient safety:
   a. Cribs, side rails, and safety belts (e.g., to protect the patient from falling out of bed versus preventing the patient from getting out of bed).
   b. Enclosure bed – to protect the patient from falling out of bed. If intended to restrain or restrict freedom of movement, non-violent restraint procedures apply. Enclosure beds may also be referred to as Posey Beds, Vail Beds, or mesh beds.

F. "Time-out" for 30 minutes or less in an unlocked room consistent with patient's treatment plan. A patient in "time-out" remains under the care/supervision of the health care team.

PROCEDURE

A. Criteria for Restraint Use

- **Violent (behavioral):** Patient is demonstrating behaviors that present or threaten an immediate risk of physical harm to self or others. These behaviors could include but are not limited to actively or attempting to hit, kick, bite, spit, and throwing objects at others, creating an object as an improvised weapon with intent to harm self or others, self-harm, or grabbing others.

- **Non-violent (non-behavioral):** RN assesses and documents that the patient is at risk for at least one of the following criteria:
  - Removing invasive lines, surgical bandages, etc.
  - Developmentally unable to remember and/or follow simple instructions
  - Disoriented to person, time, and place
  - Agitation interfering with treatment

When considering both violent (behavioral) and non-violent (non-behavioral) restraint:

- Decision is based on the patient's needs in the immediate care environment and the interaction of the patient and staff with other patients in the environment.
- The decision is not based solely on prior history of dangerous behavior. Current clinical justification must exist.
- Restraint is initiated only when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. Alternatives attempted or the rationale for not using alternatives must be documented.

B. Least Restrictive Method

The use of restraint must be selected only when less restrictive measures have been judged to be ineffective to protect the patient or others from harm. It is not always appropriate for less restrictive alternatives to be attempted prior to the use of restraint. When a patient's behavior presents an immediate and serious danger to themselves or others, immediate action is needed. For example, when a patient physically attacks someone, immediate action is needed. While staff should be mindful of using the least intrusive intervention, it is critical that the intervention selected be effective in protecting the patient or others from harm.

Examples of less restrictive methods may include

- Revising the clinical plan of care
- Changing the dose or type of prescribed medication
- Using distraction or different behavioral interventions
- Obtaining additional consultation (e.g. Child Life Specialist, Creative therapies, Behavioral Assessment Team, etc.).
- Using a sitter or family member (see CHW Policy - Patient Sitter)
- Implementing environmental modifications
- A detailed list can also be found in the "Just In Time" teaching document for Managing Patient Behavioral events (PBE).

C. Process for initiation or application of restraints
    1. Non-violent (Non-Behavioral) Restraints
        a. The RN may apply a non-violent restraint when application criteria is met. The RN will then contact the LIP to obtain an order. Refer to Appendix A for more detail.
    2. Violent (Behavioral) Restraints
        a. When criteria for use is present, trained staff may initiate a violent restraint to ensure a safe environment for the patient and other staff. When possible, collaborative efforts should be utilized in restraints and planning for safety. If LIP is not already at the bedside, they should be contacted as soon as possible of restraint event for order placement and face-to-face completion.
        b. For manual holds as violent restraints:
            a. Trained staff may hold a patient in a safe manner until discontinuation criteria is met and patient no longer exhibits dangerous behavior. This may occur for a brief time period, such as walking safely to the room, or while advancing to the bed for mechanical restraints.
            b. A manual hold may be done with 2 trained staff members or more depending on the level of aggression/behavior
            c. In order to prevent positional asphyxia, staff should never lie across the patient's body (ie chest or pelvis) and should avoid facedown (prone) restraints.
        c. For mechanical restraints:

a. Public Safety generally leads the application of mechanical restraints and may seek assistance from bedside staff that are trained in order to safely apply the restraints to the bed and the patient.
b. After applying mechanical restraints, staff may:
    - Lower the bed to prevent tipping
    - Raise the side rails
    - Slightly elevate the head of the bed when possible

D. <u>Patient/Family Involvement & Education</u>

Whenever appropriate and/or possible the parent/caregiver/family will be:

1. Involved in the initial assessment of the patient, including identification of successful behavioral techniques, methods, or alternative strategies.
2. Involved in the decision to utilize restraints.
3. Notified in the event of a restraint episode.

The RN educates and informs the patient/family and documents the following education provided in the EHR:

- Reason for the restraint.
- Alternatives to restraints that were attempted.
- Assessment frequency (including comfort measures).
- Changes in behavior or clinical condition in order to initiate the removal of restraints.

ORDERING, ASSESSMENT & MONITORING

Refer to Appendix A

Discontinuation of Restraints

A. Occurs as soon as clinically indicated regardless of scheduled expiration of the order
B. Clinical indications may include but are not limited to:
    a. Patient is no longer an immediate danger to self or others and condition has improved
    b. If patient is asleep, they are not showing immediate danger to self or others
    c. Patient is able to cooperate and participate in care
    d. Least restrictive measures are available and effective
    e. Patient no longer has tubes, drains or devices to maintain
C. Discontinuation of restraint is based on the immediate assessment of the clinical team. Collaborative efforts to include Behavioral Assessment Team and Public Safety are encouraged for violent restraints.
    - If there is disagreement about discontinuation of mechanical restraints, bedside staff, LIP, and Public Safety should consider chain of command and involving appropriate unit leadership and/or Patient Care Manager (“PCM”) on call. PCM

will serve as facilitator or mediator, rather than decision maker.

D. The final decision to order/reorder/discontinue violent restraints rests with the LIP.
E. A written order is not required in the EHR for discontinuation

Emergent discontinuation of restraints:

If a patient's condition worsens to the point where emergent or lifesaving measures are required (i.e., Code Blue, seizing, vomiting) restraints should be discontinued immediately. Public Safety may be notified of the situation, but does not need to be present to remove the restraints in these situations.

Restraint Associated Death Reporting Responsibility:

A. Children's Wisconsin will report to the Center for Medicare/Medicaid Services (CMS) any death associated with the use of a restraint. The following information must be reported:
    1. Each death that occurs while a patient is in a restraint.
    2. Each death known to the hospital that occurs within one week after restraint use where it is reasonable to assume that the use of restraint contributed directly or indirectly to a patient's death. ("Reasonable to assume" in this context includes but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.)
B. The Attending Physician (or designee) will report the death immediately to the medical examiner's office.
C. The patient care unit where the death occurred will report the death immediately to Risk Management and enter an event report.
D. When the circumstances of a patient's death involve only the use of soft two-point wrist restraints and no use of seclusion, Risk Management will maintain a log involving only soft two-point restraints that can be made available to CMS immediately upon request, and that the required information about these deaths must be entered into the log no later than seven days after the date of the death of the patient. In addition to attending physician, the name of the practitioner responsible for the care of the patient may be used in the log in lieu of the attending name.
E. When the circumstances of a patient's death involve all other types of restraints (i.e. four-point, violent (Behavioral) restraint) Risk Management will investigate and report the death to the CMS regional office by telephone no later than close of business on the next business day following knowledge of the patient's death.
F. Risk Management must document in the patient's medical record the date and time the death was reported to CMS.

Staff Training Requirements:

A. Applicable Staff

Staff having direct patient contact receive education and training in the proper and safe use of restraints, as described in Section B, Training Intervals. This includes Registered Nurses or qualified staff members which may include Nursing Assistants, Patient Safety

Companions, Behavioral Health Technicians, and Public Safety Officers. Departments caring for primarily infants do not require restraint competency.

By hospital policy, and in accordance with state law, health care providers who are authorized to order restraints (licensed physicians, residents/fellows with a REL, advanced practice nurse prescribers and physician assistants) must have a working knowledge of hospital policy regarding the use of restraints.

B. Training Intervals

Staff must be trained and able to demonstrate competency in the application, monitoring, assessment, and providing care for a patient in restraint:

1. As part of orientation
2. Before performing any restraint technique
3. Periodically when needed, as determined by department leadership

C. Training Content

1. Precipitating factors
   - Applicable antecedents and triggers to the use of restraints, both violent and nonviolent.
   - Potential underlying causes of dangerous patient behaviors.
   - Building a plan of care to incorporate individualized patient support needs to prevent a crisis leading to restraints.
   - How staff behavior can influence patient behavior.

2. Nonphysical interventions skills
   - Crisis prevention, de-escalation, self-protection and other techniques such as use of sensory tools, distraction, behavioral incentives, and labeled praise.

3. Restraint Knowledge
   - How to evaluate the least restrictive intervention.
   - The definitions of non-violent (non-behavioral) and violent (behavioral) restraint use.
   - Safe application of all types of restraints, monitoring, and care of the patient in restraints.

4. Monitoring
   - How to recognize signs of physical and psychological distress in patients who are being restrained.
   - Obtaining vital signs per provider orders and interpreting their relevance to the physical safety of the patient in restraint.
   - How to recognize nutritional and hydration needs of the patient in restraints.
   - Checking circulation, skin integrity, and range of motion in the extremities.
   - Addressing hygiene and elimination needs of the patient in restraints.

- Recognizing signs of incorrect application of restraints.
- Recognizing when to contact a provider to evaluate and/or treat the patient's physical status.

5. Use of CPR
   - Staff who are trained in restraint use must be certified in the use of cardiopulmonary resuscitation (CPR) techniques including required periodic recertification.

D. Trainer Requirements

Individuals providing staff training must be qualified as evidenced by education, training and experience in techniques used to address patients' behaviors that necessitate the use of restraint.

E. Training Documentation

The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

References:

Regulations

Wisconsin Administrative Code, Chapter Med 8, N6 and N8 and Wisconsin Statutes, Chapter 441.

42 CFR Part 482 CMS Hospital Conditions of Participation: State Operations Manual Appendix A; eff. 02/21/20

TJC *Comprehensive Accreditation Manual for Hospitals, Provision of Care, Treatment and Services.*

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Related Policies and Procedures

Behavioral Outbursts- Care of the Patient
Emergency Detention
Medical Staff Rules and Regulations
Patient Care Orders
Patient Sitter
Rights and Responsibilities
Security Risk
Violence in the Workplace

Approved by the:
Joint Clinical Practice Council August 15, 2022
Surgicenter Medical Executive Committee August 25, 2022
Fox Valley Medical Executive Committee September 7, 2022
Milwaukee Medical Executive Committee October 3, 2022

Appendix A

ORDERING, ASSESSMENT & MONITORING

	Non-Violent Restraint (Non-behavioral)	Violent Restraint (Behavioral)
Criteria	Utilization of a 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. Positive patient assessment for at least one of the following: • Removing invasive lines, surgical bandages, etc. • Developmentally unable to remember and/or follow simple instruction • Disoriented to person, time and place • Agitation interfering with treatment	Patient is demonstrating behaviors that present or threaten an immediate risk of physical harm to self or others. These behaviors could include but are not limited to actively or attempting to hit, kick, bite, spit, and throwing objects at others, brandishing an object as an improvised weapon with intent to harm self or others, self-harm, or grabbing others. *Staff can immediately contact Public Safety for assistance.* *Milwaukee: Dial 88* *Fox Valley: Dial 444 or hit panic button.* *Surgicenter: Dial 9-1-1 in the event of violent behavior that cannot be deescalated* Assigned RN is encouraged to notify Patient Care Manager/Supervisor/Charge nurse of patients in restraints for violent/self-destructive behavior.
Order Justification	• Medically necessary AND • Not used for punishment, coercion, discipline, retaliation, or convenience AND • Needed to improve the patient's well-being AND • Least restrictive interventions are attempted and/or considered to be ineffective	• EMERGENCY situation to ensure physical safety of patient/self or others AND • Not used for punishment, coercion, discipline, retaliation, or convenience AND • Needed to improve the patient's well-being AND • Least restrictive interventions are attempted and/or considered to be ineffective
Who May Order (Both Non-Violent & Violent Use)	• Licensed physicians • Physician residents/fellows with a REL • Advance Practice Nurses & Physician's Assistants with prescriptive authority	

	Non-Violent Restraint (Non-behavioral)	Violent Restraint (Behavioral)
Initial Order	• Orders are time-limited (24 hours or less) • Order is obtained as soon as possible after initiating restraint • PRN orders are prohibited If the initiation of restraint is based on a significant change in the patient's condition, the registered nurse immediately notifies the provider.	• Orders are time-limited, based on the patient's age: 4 hours for age 18 & older 2 hours for 9 to 17 1 hour for age 8 & younger • PRN orders are prohibited RN should obtain violent (behavioral) restraint order as soon as possible after initiation. If Attending Physician did not order the restraint they are notified as soon as possible.
	Each episode of restraint requires a new order. Staff cannot discontinue then reinstitute restraint under the same order even if the time limit was not exceeded.	
Renewal Orders	• If restraint use is needed after initial order, a new order is written with the appropriate time limits. • After 24 hours provider must assess patient before writing the renewal order. • Renewal order is written no less than once per calendar day.	Orders may be **renewed** according to the time limits (see above) for a maximum total of 24 hours. In order to support the goal of least restrictive environment, if/when violent restraints are required to be renewed, consider additional resources early such as Social Work, Case Management, Public Safety, Behavioral Assessment Team, Psychiatry consultation, Psychology services, and others deemed necessary to develop sustainable behavioral safety plan. If a child reaches the maximum limit of consecutive reordered violent restraints for 24 hours and has not yet reached discontinuation criteria, the LIP must evaluate the child face to face and place a **new** violent restraint order.
Face to face evaluation within 1 hour of intervention	No	Yes- LIP to complete at bedside Even if patient recovers and is released within that 1 hour Evaluation criteria: • Patient's immediate situation • Patient's reaction to the intervention • Patient's medical and behavioral condition • Need to continue or terminate the restraint

	Non-Violent Restraint (Non-behavioral)	Violent Restraint (Behavioral)
Subsequent Evaluations	Every 24 hours, a licensed physician or other authorized licensed independent practitioner sees and evaluates the patient before writing a new order.	
Restraint Initiation	• RN may apply restraint device for non-violent use. • Apply devices properly to maintain body alignment and patient comfort. • Keep the restraints clean and dry.	• Trained staff may utilize a manual hold in a safe manner until discontinuation criteria is met and patient no longer exhibits dangerous behavior. This may occur for a brief time period, such as walking to the room, or while advancing to the bed for mechanical restraints. • A manual hold may be done with 2 trained staff members or more depending on the level of aggression/behavior. • Public Safety generally leads the application of mechanical restraints and may seek assistance from bedside staff that are trained in restraint in order to safely apply the restraints to the bed and the patient safely.
	Non-Violent Restraint **(Non-behavioral)**	**Violent Restraint** **(Behavioral)**
Assessment *(RN)*	Initiation of Restraint • Length of order • Order obtained • Restraint type • Alternative strategies • Justification for restraint • Behavior requiring restraint • Family notification and education • Discontinuation criteria Every 2 hours • Visual check- current behavior • Circulation • Range of Motion • Fluids • Nutrition • Elimination/incontinence	Initiation of Restraint • Provider notification • Order obtained • Length of order • Appropriate restraint type • Alternative strategies • Justification for restraint • Discontinuation criteria • Family notification and education • Visual check- current behavior • Physical comfort- position • Circulation & skin integrity • Supportive interventions Every 15 minutes • Visual Check- current behavior • Physical comfort- position • Circulation

		• Skin integrity • Supportive interventions Every 2 hours (if applicable) • Range of Motion (“ROM”) • Offer Fluids • Offer Nutrition • Elimination/incontinence
Specific Monitoring	Continuous observation is recommended if significant motor agitation or restlessness occurs, or if the patient struggles against the restraint.	A patient in violent restraint(s) should have continuous observation of a trained staff member in case of any medical or psychological emergency. It may be appropriate for the patient condition for staff to only remain in visual observation to allow complete de-escalation. Patients with the following conditions may pose additional risk and should be monitored accordingly: • Epilepsy • Vomiting • History of physical abuse or neglect • Psychosis • Suicidality • Pregnancy

Review of Comprehensive Documentation in Medical Record: (Both Non-Violent Restraint & Violent Restraint Use unless otherwise specified)	**Nursing Staff will document in the patient's medical record:** Plan of Care: • Modification made in plan of care • Patients with behavioral challenges are advised to have the care plan "Risk for Behavioral Outbursts" in Milwaukee or "Restraint use Behavioral/Self Destructive Behavior" or "Restraint Use Non Behavioral /Non Destructive Behavior" in FV. Restraint Flowsheet: • Provider notification and order obtained • Public Safety notification (for violent restraints only) • Restraint type(s) • Less restrictive alternatives • Clinical justification • Discontinuation criteria • Response to explanation • Caregiver response • Family notification • Visual check • Physical comfort (violent restraint only) • Circulation • Skin integrity • Supportive interventions • ROM • Fluids and nutrition • Elimination or Incontinence Patient Education: • Reason for the restraint. • Alternatives to restraints that were attempted. • Assessment frequency (including comfort measures). • Changes in behavior or clinical condition in order to initiate the removal of restraints. Optional Progress Note: Any elaboration needed on the above or: • If physician not present, indicate time they were notified. • Clinical justification for each restraint episode by describing patient's condition or symptoms. • Measures taken to protect the patient's rights, dignity, and well-being, including monitoring and re-assessment. • If applicable, medications administered to promote de-escalation • Evaluation for release (including time and outcome) and condition of patient post release.

	• Injuries related to restraint use • Criteria used to make decision to discontinue restraint. • Debrief communication and planning **<u>Licensed physician, physician residents/fellows with REL, advanced practice nurses and physicians' assistants with prescribing privileges document (any of the above and below):</u>** • **For Non-violent (Non-behavioral):** Initial order and renewals, changes to plan of care • **For Violent (behavioral):** Initial order, face-to-face findings, and any subsequent evaluations, including changes to plan of care **<u>Public Safety (for Violent (behavioral) Restraint Use)</u>** • Public Safety will complete a Security Risk Assessment according to Security Risk P&P.