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SCOPE

This document applies to Wise Health System including Controlled Affiliates ("WHS").

DEFINITIONS

When used in this document with capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context. Additional defined terms may be found in the WHS Policy and Procedures Definitions document.

Behavioral Emergency- A situation involving an individual who is behaving in a violent or self-destructive manner and in which preventive, de-escalating, or verbal techniques have been determined to be ineffective and it is immediately necessary to restrain or seclude the individual to prevent:

1. Imminent probable death or substantial bodily harm to the individual because the individual is attempting to commit suicide or inflict serious bodily harm; or
2. Imminent physical harm to others because of acts the individual commits

Chemical Restraint- The use of a drug or medication to manage patient behavior or restrict freedom of movement to prevent danger to self or others and which is not a standard treatment or dosage for the patient's condition.

Competence- Demonstrated knowledge, skill, and ability

Continuous face to face observation- An in-person line- of- sight that is maintained in an uninterrupted manner and is free of distraction

Emergency medication- A psychoactive medication that is used to treat the signs and symptoms of mental illness in a psychiatric emergency, when other interventions are ineffective or inappropriate

Face-to-face- Describes a contact with an individual that occurs in person. Face to face does not include a contact made through the use of video or telecommunication conferencing or technologies, including telemedicine.

Inappropriate psychiatric emergency- In no case may inappropriate designation of a situation as a "psychiatric emergency" be used to circumvent the process of obtaining consent or applying to the court for an order authorizing administration of psychoactive medication.

Mechanical or physical restraint- Any device, material, or equipment that immobilizes or reduces the ability of the individual to move his or her arms, legs, body, or head freely

Medications used as "Standard of Care"

1. Used within pharmaceutical parameters by the FDA and the manufacturer
2. The use follows established and recognized national practice standards
3. Use of medication to treat a specific clinical condition based on that patients target symptoms, overall clinical situation, and MD's knowledge of patient expected and actual response to medication

Expectation that the standard use of a psychotherapeutic medication to treat the patient's condition enables the patient to be more effective or appropriately function in the world around him/her than would be possible without the use of medication.

Non-violent, non-self-destructive behavior- Behavior related to a non-psychiatric medical condition or symptom that indicates the need for an intervention to protect the individual from harm.

Personal restraint/hold- Any manual method by which a person holds or otherwise bodily applies physical pressure that immobilizes or reduces the ability of the individual to move his or her body or a portion of his or her body. Physically holding an individual during a *forced administration* of a psychoactive medication, including court ordered medication, constitutes a personal restraint/hold. (**Maximum 15 minutes**). This is a one-time order further restraint requires a physician order for each episode.

Protective device- A device used to prevent injury or to permit wounds to heal.

Psychiatric emergency--A situation in which, in the opinion of the physician, it is immediately necessary to administer medication to ameliorate (improve) the signs and symptoms of a patient's mental illness and to prevent:

1. Imminent probable death or substantial bodily harm to the patient because the patient:
    a. Is threatening or attempting to commit suicide or serious bodily harm; or
    b. Is behaving in a manner that indicates that the patient is unable to satisfy the patient's need for nourishment, essential medical care, or self-protection; or
2. Imminent physical or emotional harm to others because of threats, attempts, or other acts the patient makes or commits

Psychoactive medication- Medication whose primary intended therapeutic effect is to treat or ameliorate (improve) the signs or symptoms of mental disorder, or to modify mood, affect perception, or behavior

Refusal to consent to administration of psychoactive medication (refusal)--Actions which include the following behaviors:

1. The patient or legally authorized representative communicates orally, through sign language, or in writing that he or she refuses psychoactive medication.
2. The patient communicates through behavior that he or she refuses psychoactive medication, e.g., refusing to swallow oral medication or refusing to submit to hypodermic injection of psychoactive medication.
3. The patient pretends to swallow oral psychoactive medications, and the attending physician determines that the pretending behavior is due to an unwillingness to take the medication.
4. The patient gives either no response or a noncommittal response after he or she has received the standard risk-benefit explanation.

Restraint- The use of any personal restraint/hold or mechanical restraint that immobilizes or reduces the ability of the individual to move his or her arms, legs, body, or head freely.
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 is a restraint, not as a standard of care or dosage for the patient's condition.

Seclusion- The involuntary separation of an individual from other individuals for any period of time and or the placement of the individual alone in an area from which the individual is prevented from leaving. Being in a locked room or posting a security guard at the door that is preventing the patient from leaving is seclusion.

Seclusion room- A hazard-free room or other area in which direct observation of an individual can be maintained and from which the individual is prevented from leaving.

Supportive device- A device voluntarily used by an individual to posturally support the individual or to assist the individual who cannot obtain or maintain normal bodily function.

POLICY

WHS ensures clinical justification of restraint use, while protecting patient rights, dignity and well-being.

PROCEDURE

Exclusions to policy:

The following are **not** considered restraints and are not subject to the CMS, TAC, or TJC standards:

1. Limitation of mobility or immobilization for medical, dental, diagnostic, or surgical procedures, including post-procedure care
2. Adaptive support used in response to a patient's need (i.e. postural support, ortho appliances)
3. Protective equipment, papoose boards, IV arm boards, hand mitts that do not limit movement of fingers and are not tied down
4. Gurney or bed rails used for sedated patients or for those experiencing involuntary movements or on seizure precautions
5. Use of 4 side rails on a bed in constant motion for improved circulation or prevention of skin breakdown
6. Side rails on stretchers
7. Forensic restrictions (handcuffs, shackles, or seclusion) imposed by correctional authorities.
8. Holding a child for medical reasons such as to giving an antibiotic shot, starting an IV, or doing a lumbar puncture
9. Methods used to permit the patient to participate in activities without the risk of harm i.e. walkers

General Restraint Use

1. Family notification will be made as soon as feasible if patient consents to family being informed of condition.
    a. Family notification will be documented in the medical record.
        i. The date and time of the notification with the name of the staff member contacting the family and shall include any unsuccessful attempts made, the phone number called, and the name of the person with whom the staff member spoke
    b. Explain to the patient/family the plan and rationale for using restraints and the conditions/behaviors required for the release from restraints.
2. Modify plan of care when restraints are initiated, method is altered, or upon discontinuation of restraints
    a. The plan of care will reflect any use of psychoactive medication as part of an integrated treatment approach aimed at increasing the patient's functioning and quality of life.
3. Restraints will be discontinued at the earliest possible time. At any time during the restraint or seclusion process, they may be discontinued by a RN, physician, or AHP/LIP should re-evaluation determine they are no longer necessary.
    a. Discontinuation is documented in the medical record including the circumstances under which restraint or seclusion is discontinued.
4. If restraint or seclusion is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating the use of restraint or seclusion.
5. Restraint or seclusion orders **may not** be written as "standing" or "prn".
6. Apply the appropriate sized restraints snugly to the body part, but not tight enough to interfere with circulation or breathing.
7. When using a limb restraint, use a slip knot and fasten restraints to the bed frame, not to the side rails.
8. Place call light within reach of patient in restraints, when not in line of sight care
9. Hand-off communication, at shift change, will include information regarding the time of restraint or seclusion treatment was initiated, the current status of the patient's physical, emotional and behavioral condition, and the specific criteria for release necessary for the patient to be removed from restraint or seclusion
10. Patients in restraints will have an environment that is free of hazards, adequately ventilated and appropriately lighted.
11. Forensic patients with physical restrictions will be monitored for safety issues, circulation, ADL, nutrition, and hygiene needs

12. Forensic patients in the operating room requiring shackles will be restrained with appropriate nylon or plastic cable-tie restraints for OR safety.
    a. OR positioning will be done per the safety standards for safe positioning in collaboration with the correctional officer.
13. Restraints not in use should be removed from the individual's room
14. See "Restraint Application and Monitoring" in Elsevier Skills for proper restraint application techniques.

NOTE: Disruptive or behavior deemed dangerous to self or others may necessitate immediate intervention and restraint by trained security or other trained personnel in any treatment area of the facility. In such a case, the least restrictive method of restraint effective will be used, and restraint will be released when immediate danger is resolved. In the out-patient setting, the patient will be escorted from the premises when feasible or local law enforcement authorities will be contacted.

Least restrictive alternatives:

Restraints methods or devices are only used when less restrictive interventions have been determined ineffective to protect the patient or others from harm. Non-physical interventions will be used whenever possible. Restraint method selected will be the least restrictive method possible and will be applied with consideration of patient's age, physical abilities, and without restriction of circulatory or respiratory status. (For example, if a patient only requires 2 restraints instead of 4, then only 2 should be used).

1. Clinical Timeout
    a. A procedure in which an individual, in response to verbal suggestion from a staff member, voluntarily enters and remains for a period of time in a designated area from which the individual is not prevented from leaving
    b. Clinical timeouts will be documented in the patient's EMR and will include the condition under which the time was suggested and the individual's response to the suggestion.
    c. Prior to a clinical timeout, the staff member suggesting that an individual initiate a clinical timeout shall explain to the individual that the timeout is voluntary
    d. The decision by the individual to decline to begin, or remain in, clinical timeout or similar interventions may not result in the staff member's use of restraint or seclusion of the individual, unless it is permitted under the requirements for restraint and seclusion.
2. Quiet time:
    a. A procedure in which an individual, on the individual's own initiative, enters and remains for a period of time in a designated area from which the individual is not prevented from leaving. Unless clinically contraindicated, patient will be granted quiet time.
    b. Staff members may not mandate quiet time and the individual may terminate quiet time at any time.
    c. On every occasion that quiet time is denied or terminated for clinical reasons, a staff member shall document in the medical record the conditions under which the quiet time was denied or terminated.
3. For purposes of the unit, other alternatives may include:
    a. De-escalation and verbal techniques
    b. Redirection
    c. Meditation
    d. Problem solving
    e. Reflective listening
    f. Offer snack or other item(s)
    g. Reduce stimulation of environment, patients, or sounds
    h. Offer listening to music and watching TV in another location
    i. Remove other patients that are being bothersome
    j. Allow or disallow visitors (with appropriate doctor order)
    k. Move patient room if clinically appropriate
    l. Offer an extra smoke break (only when clinically appropriate and safe for patients and staff)
    m. Call to family or talk about their support system
    n. Offering other medications that could assist with pain, sleep etc. that could benefit the patient at the time of his/her escalation
    o. Obtain specific orders from the doctor if any patient rights or privileges are being restricted (i.e. telephone privileges, visitation, etc.)

NON-VIOLENT, non-self-destructive restraint use

Non-violent restraints are used for the purpose of promoting healing and to protect the patient's safety

1. Criteria for non-violent, non-self-destructive behavior restraint use (not all-inclusive):
    a. Attempted removal or dislodgment of intravenous lines, central lines, or other tubes by patient, resulting from confusion or inability to understand the potential benefits of these treatment modalities
    b. Attempted self-extubation of endotracheal tubes, resulting from confusion or inability to understand the potential benefits of these treatment modalities
    c. Determination is made that risks of removal or dislodgment may result in bleeding, infection, injury, or death
2. Non-violent, non-self-destructive restraints may include the following (list not all-inclusive):
    a. The use of 4 side rails for the purpose of preventing the patient from exiting the bed (only initial order required)
    b. Use of a net bed or enclosed bed
    c. Freedom splints for limb immobilization
    d. Use of a Geri chair with tray patient is unable to remove on his/her own (only initial order required)
    e. Soft wrist restraints
3. Restraint must be medically necessary, ordered by a physician, needed to ensure the individual's safety, and used only after least restrictive measures have failed.
4. Prior to the application of the restraint, the individual will be assessed and the determination made that the risks associated with the use of the restraint are outweighed by the risks of not using it.
5. The physician or other LIP shall examine patient within **24 hours** of initiation of restraints, entering written patient-specific order for restraints.
6. **Every 2 hours** trained staff will assess and document the following, as applicable:
    a. hygiene needs
    b. ADL needs,
    c. toileting
    d. feeding
    e. circulation to restrained extremities
    f. positioning needs
    g. mental status
    h. skin integrity
    i. cardiac function
    j. range of motion exercises
    k. level of distress
7. Care provided will be documented in the EMR
8. The physician must examine the patient and place a new order for continuation of restraints for non-violent patients every **calendar day.**
9. The restraints may be temporarily released and reapplied for the purposes of caring for the patient needs, such as elimination, feeding, range of motion, ADL care, etc.

VIOLENT or self-destructive behavior restraint and seclusion use

1. Criteria for violent or self-destructive behavior restraint/seclusion use (not all inclusive):
    a. The patient is violent, hitting staff or peers, throwing objects at staff or peers
    b. Is a danger to self or others
    c. Imminent probable death or substantial bodily harm to the patient because the patient:
        i. Is threatening or attempting to commit suicide or serious bodily harm; or
        ii. Is behaving in a manner that indicates that the patient is unable to satisfy the patient's need for nourishment, essential medical care, or self-protection; or
    d. Imminent physical or emotional harm to others because of threats, attempts, or other acts the patient makes or commits
2. The physician or other LIP for care will conduct an in-person evaluation within one hour per Medicare guidelines. This evaluation may be performed by a trained RN. If the 1 hour assessment is conducted by a trained RN or a LIP he or she consults with the attending physician or other physician responsible for the care of the patient as soon as possible.

3. Within **1 hour** of application of restraints physician, AHP/LIP or trained RN will evaluate and document a face to face with the following criteria (not limited to):
    i. Evaluation of the patient's immediate situation
    ii. Patient's reaction to the intervention
    iii. Patient's medical and behavioral condition
    iv. The need to continue or terminate the restraints/seclusion
4. **If a physical hold is used for forced medication is necessary, the 1 hour face to face requirement applies**.
5. During the in-person evaluation, the physician or LIP should attempt to identify methods to help the patient regain control, revise the plan of care, and provide a new written order, if necessary.
    a. The initial assessment will be included in the evaluation of the need for intervention entering written patient-specific order for restraint protocol, reason restraint is needed, alternatives tried prior to restraint, and criteria for discontinuation of restraints on medical record.
6. Maximum time allowed for violent or self-destructive restraint or seclusion is **4 hours for adults**
7. If continued restraint or seclusion is warranted after the first 4 hour period expires then a new restraint order will be needed with the elements listed above. There must be an RN assessment prior to a new order requested.
8. Trained staff will assess the patient upon initiation of restraints/seclusion for violent or self-destructive behavior **at 15 minute intervals** for the following:
    a. Correct application of restraints
    b. Signs of injury associated with restraint application
    c. Circulatory status
    d. Respiratory status
    e. Skin integrity
    f. Vital signs as deemed necessary for patient condition/assessment
    g. Physical and psychological status and comfort, response to restraints/seclusion
    h. Signs and symptoms of distress
    i. Patient's rights, dignity, and safety are maintained
    j. Readiness for less restrictive method or discontinuation of restraints
9. **At 1 hour intervals**, or more frequently as indicated, and if safe; the patient in restraint or seclusion will be provided:
    a. Range of motion of at least 5 minutes must be performed for each extremity restrained
    b. Changing of position
10. **At 2 hours intervals**, or more frequently if indicated, and if safe; the patient in restraint or seclusion will be provided:
    a. Bathroom privileges and appropriate hygiene
    b. Opportunity to drink water or other appropriate hydration (more frequently if requested and not clinically contraindicated)
11. Patient will receive regularly prescribed medications, unless otherwise ordered by the physician
12. Patient will receive regularly scheduled meals and snacks served on ware that is appropriate for safety
13. The ordering physician or LIP must renew restraint order for violent, self-destructive behavior per these time frames:
    a. Every 4 hours for patients ages 18 and older
    b. Every 2 hours for patients ages 9-17
    c. Every 1 hour for patients under age 9
    d. Personal restraint/hold not to exceed 15 minutes
14. A physician may renew the original order provided it would not result in a period exceeding:
    a. A personal restraint/hold beyond 15 minutes total from the time of initiation of the original personal restraint/hold
    b. 8 executive hours for adults
    c. 4 executive hours for ages 9-17
    d. 2 executive hours for ages under 9
        i. Prior to issuing a continuation order for restraint or seclusion beyond the above hours, the physician will perform a face-to-face evaluation of the patient. If continued restraint or seclusion is deemed medically necessary all procedures listed above will be addressed and a new order obtained.
15. During the reevaluation, practitioner should attempt to identify methods to help the patient regain control and review the treatment plan for effectiveness.

16. If the determination is made that the restraints are no longer needed)i.e. the patient is no longer violent, hitting staff or peers and is not a danger to self or others) restraints will be discontinued
17. A reapplication of restraints for subsequent episodes will require a new order for re-initiating restraints

Other considerations for Restraints and Seclusion

1. Any patient who is in both Restraint **and** Seclusion must be continuously monitored on a 1:1 basis. Restraint and Seclusion can only be used for patients who are violent and/or self-destructive.
2. The use of seclusion is prohibited except in behavioral emergencies or psychiatric emergencies.
3. Verify that the order for restraint/seclusion includes rationale for restraint/seclusion, length of time and type of restraints, if any, to be used, the extremity or body part(s) to be restrained. Determine if alternative, less restrictive methods have been attempted and were ineffective
4. Explain to the patient and/or the family the plan and rationale for using restraints/seclusion and the conditions/behaviors required for release of such
5. Trained staff must provide continuous in-person observation and monitoring of patient in restraint and seclusion. After the first hour, this may be done via remote video and audio equipment in close proximity of the patient, if consistent with patient's condition and wishes.

Ordering and Initiation of restraint use

Restraints and or seclusion may never be used as a means of coercion, discipline, convenience, or staff retaliation and will not be based solely upon patient history of dangerous behavior.

1. When non-physical interventions are ineffective or not viable, an order for restraint must be issued by a physician, LIP, or in their absence, by a trained RN based upon patient assessment.
    a. In the absence of the physician the RN must immediately notify the physician of restraint initiation, obtaining a telephone or written order.
    b. The RN initiating the restraint shall note in the patient's record the name of the physician contacted, the time of the contact and any correspondence he or she had with the physician.
    c. The attending physician must be consulted as soon as possible if the attending physician did not order the restraint.
    d. If the RN initiates restraint or seclusion contact the physician as soon as possible for restraint/ and or seclusion order.
    e. If order is taken by telephone, then must be authenticated within 24 hours by physician who ordered the restraint or seclusion
2. Physician's order will include:
    a. Date, Time, & Signature
    b. Type of restraint
    c. Extremity or body part(s) to be restrained
    d. Duration of the restraint
    e. The reason restraint is necessary
    f. Criteria for discontinuation of restraints/seclusion
    g. Frequency of assessment and how the individual's circulation, hydration, ADL, vitals, nutrition, mental status, and range of motion will be assessed and addressed.
3. In a behavioral emergency the physician can order restraint and seclusion taking into account any applicable medical or psychiatric contraindications to restraint or seclusion.
4. The RN can also initiate restraint and seclusion when the physician is not on the unit and must also take into account any applicable medical or psychiatric contraindications to restraint or seclusion.
5. If the ordering physician is not the treating physician, a consultation with the treating physician will be documented in the individual's medical record no later than the next business day

Monitoring and Observation of patients in restraints or seclusion

Patient assessments, monitoring, and observations will be documented in the EMR per the above guidelines:

1. A staff member of the same gender as the patient, if possible, will provide continuous face-to-face observation of a patient in a mechanical restraint or seclusion, unless the individual's history or other factors indicate this would be contraindicated (e.g. sexual or physical abuse perpetrated by someone of the same gender, in which case a staff member of the opposite gender may be used)
2. A staff member who is not physically applying personal restraint/hold shall maintain a continuous face-to-face observation of an individual in a **personal restraint/hold**

3. Respect for privacy will be maintained for any patient in any type of restraint
4. Nutrition, hydration, ADL, medications and treatments, and toileting needs will be met. An opportunity to bathe at least once daily (or more frequently and not contraindicated, or otherwise required by the individual's circumstances and physical or medical needs)

Documentation will include (not limited to):

Along with other required documentation mentioned in policy, the following will be documented:

1. Date and time intervention(s) began and ended
2. Name, title, and credentials of any staff members present at the initiation of the intervention, with the staff member's role in the intervention, including as observer, or status as an uninvolved witness, as applicable
3. Time and results of any assessments, observations, monitoring, evaluations, and attention given to personal needs
4. Physician's documentation
5. Any specific alternatives or least restrictive measures, including preventative or de-escalatory interventions that were attempted by any staff member prior to the initiation of restraint or seclusion, and the individual's response to any such intervention
6. The individual's response to restraint and seclusion
7. Patient/family education and restraint education comprehension

Release from Restraint or Seclusion

1. Staff will discuss with the patient (in a language that is understandable to the patient) as soon as possible after restraint and/or seclusion has been implemented:
    a. Specific behaviors that necessitated restraint or seclusion
    b. How the patient's behavior continues to meet the criteria for restraint or seclusion
    c. The behaviors that must be demonstrated by the patient to be released from restraints or seclusion
    d. Patient's suggestions about what staff can do to assist the patient in gaining release from restraint or seclusion
    e. If the patient does not appear to understand the information staff will attempt to re-explain it every 15 minutes until understanding is reached, or the order for restraint or seclusion has expired. Staff will document all attempts to communicate with the patient
2. Once the patient meets the criteria for release stated on the order then the patient must be released from restraint or seclusion immediately
    a. The determination for release will be based on patient's present behavior
3. A personal restraint/hold will be terminated immediately after the medication is given and no longer than 15 minutes.
4. If an emergency health situation occurs the patient will be released from restraint or seclusion immediately as dictated by the emergency
5. When a patient falls asleep in restraint or seclusion, a registered nurse will assess to determine if patient is asleep. If determined to be asleep, he/she will be released immediately
    a. Continuous observation of the patient will be maintained until the patient awakens and is evaluated
    b. A patient who falls asleep in restraint or seclusion, will be evaluated by the registered nurse or the physician upon awakening since they no longer meet the criteria for restraint or seclusion
    c. When the patient falls asleep in restraint or seclusion the door will be unlocked and open
6. Staff will take appropriate action to facilitate the patient's re-entry and the opportunity to return to ongoing activities and social milieu
7. The staff will observe the patient for at least 15 minutes and document in the EMR the steps taken and observations made of the individual's behavior during the transition period.
8. The patient will be placed back on level of observation as ordered by the physician

Note: For the Behavioral Health Unit; following release the treatment team will review alternative strategies for dealing with behaviors necessitating restraint or seclusion and provide written modification to the patient's plan of care. The treatment team will focus on least restrictive measures and alternative treatments as well as any new risk factors.

Psychiatric Emergencies

If a physician issues an order to administer psychoactive medication to a patient without the patient's consent because of a psychiatric emergency, then the physician will document in the patient's clinical record in specific medical or behavioral terms:

1. Why the order is necessary:
2. Other generally accepted, less intrusive forms of treatment, if any, that the physician has evaluated but rejected; and
3. The reasons those treatments were rejected.

When the psychiatric emergency is no longer imminent or present, medication prescribed without consent on an emergency basis must be safely discontinued. If medication is to be continued on a regular basis, the physician must comply with state laws as appropriate.

In no case may inappropriate designation of a situation as a psychiatric emergency be used to circumvent the process of obtaining consent or applying to the court for an order authorizing administration of psychoactive medication.

Treatment of the patient with the psychoactive medication will be provided in the manner, consistent with clinically appropriate medical care, least restrictive of the patient's personal liberty.

Psychoactive medications

The prescribing of psychoactive medication will be in accordance with accepted guidelines. Use of psychoactive medication that falls outside accepted guidelines may be permissible if the clinical rationale is documented in the patient record.

1. In no case will psychoactive medication be used for punishment, for convenience of staff, as a substitute for appropriate psychosocial treatments, or in amounts that interfere with a patient's quality of life or plan of care.
2. The patient's plan of care will reflect any use of psychoactive medication as part of an integrated treatment approach aimed at increasing the patient's functioning and quality of life.
3. The prescribing professional will document the rationale for initiating, continuing, or discontinuing psychoactive medication in the clinical record.

The following practices are prohibited:

1. A personal restraint/hold or mechanical restraint shall not be used that:
    a. Obstructs the individual's airway, including a procedure that places anything in, on, or over the individual's mouth or nose;
    b. Impairs the individual's breathing, including applying pressure to the individual's torso or neck;
    c. Restricts circulation;
    d. Secures an individual to a stationary object while the individual is in a standing position;
    e. Causes pain to restrict an individual's movement (pressure points or joint locks); and
    f. Inhibits, reduces, or hinders the individual's ability to communicate
2. Chemical restraints
3. A prone or supine hold shall not be used during any restraint or hold. Should an individual become prone or supine during a restraint, then any staff member involved in administering the restraint or hold shall immediately transition the individual to a side lying or other appropriate position.
4. Neither restraint nor seclusion shall be used:
    a. As a means of discipline, retaliation, punishment, or coercion;
    b. For the purpose of convenience of staff members or other individuals; or
    c. As a substitute for effective treatment or habilitation.
5. Damaged devices shall not be used to restrain an individual and shall be repaired or discarded. A staff member shall inspect a device before and after each use to ensure that it is clean, in good repair, and is free from tears or protrusions that may cause injury.
6. The following types of devices shall not be used to implement a restraint:
    a. Those with metal wrist or ankle cuffs
    b. Those with rubber bands, rope, cord, or padlocks or key locks as fastening devices
    c. Long ties (e.g., leashes)
    d. Bed sheets

   e. Gags
   f. Spit hoods, or anything that obstructs an individual's airway, including a device that places anything in, on, or over the individual's mouth or nose
   g. Strait jackets
7. The use of seclusion is prohibited except in a behavioral emergency/psychiatric emergency

Training and Competency Requirements

1. The training program shall be consistent with the requirements of applicable laws:
   a. Target the specific needs of each patient population being served
   b. Be tailored to the competency levels of the staff members being trained
   c. Emphasize the importance of reducing and preventing the use of restraint and seclusion
   d. Be evaluated annually, which shall include evaluation to ensure that the training program, as planned and as implemented, complies with the requirement of this section
   e. Incorporate evidence-based best practices
   f. Provide information about declarations for mental health treatment, including:
      i. The right of individuals to execute declarations for mental health treatment; and
      ii. The duty of staff members and other health care providers to act in accordance with declarations for mental health treatment to the fullest extent possible.
2. **Before any staff member may initiate any restraint or seclusion the staff member shall receive training and demonstrate competence** in:
   a. Safe and appropriate initiation and use of seclusion as a last resort in a behavioral emergency;
   b. Safe and appropriate initiation and application, and use of personal restraint/hold as a last resort in a behavioral emergency;
   c. Safe and appropriate initiation and application, and use of mechanical restraint devices as a last resort in a behavioral emergency or as a protective or supportive device, and knowledge of the mechanical restraint devices permitted and approved by the facility
   d. Management of emergency medical conditions in accordance with the facility's policies and procedures and other applicable requirements for:
      i. Obtaining emergency medical assistance; and
      ii. Obtaining training in and using techniques for cardiopulmonary respiration and removal of airway obstructions.
3. Before assuming job duties, and at least annually thereafter, a registered nurse or a physician assistant who is authorized to perform assessments of individuals who are in restraint or seclusion shall receive training, which shall include a demonstration of competence in:
   a. Monitoring cardiac and respiratory status and interpreting their relevance to the physical safety of the individual in restraint or seclusion
   b. Recognizing and responding to nutritional and hydration needs
   c. Checking circulation in, and range of motion of, the extremities
   d. Providing for hygiene and elimination
   e. Identifying and responding to physical and psychological status and comfort, including signs of distress
   f. Assisting individuals in de-escalating and alternative strategies, including through identification and removal of stimuli, that meet the criteria for a behavioral emergency if known
   g. Recognizing when continuation of restraint or seclusion is no longer justified by a behavioral emergency
   h. Recognizing when to contact emergency medical services to evaluate and/or treat an individual for an emergency medical condition.
4. Before assuming job duties, and at least annually thereafter, staff members who are authorized to monitor, under the supervision of a registered nurse, individuals during restraint or seclusion shall receive training, which shall include a demonstration of competence in:
   a. Monitoring respiratory status
   b. Recognizing nutritional and hydration needs
   c. Checking circulation in, and range of motion of, the extremities
   d. Providing for hygiene and elimination
   e. Addressing physical and psychological status and comfort, including signs of distress
   f. Assisting individuals in de-escalating and alternative strategies, including through identification and removal of stimuli, if known

   g. Recognizing when continuation of restraint or seclusion is no longer justified by a behavioral emergency
   h. Recognizing when to contact a registered nurse.
5. Documentation shall include the date that training was completed, the name of the instructor, a list of successfully demonstrated competencies, the date competencies were assessed, and the name of the person who assessed competence.
6. When a staff member's duties change, the facility will reassess the staff member's training to determine necessity of retraining based on the staff member's new duties.

Medical Emergencies or Emergent Evacuation Procedures

1. If an individual experiences an emergency medical condition while in restraint or seclusion, the staff member providing continuous face-to-face observation of the individual or other staff member must release the individual from restraint or seclusion as soon as possible, as indicated by the emergency medical condition, and the medical condition shall be assessed and treated.
   a. The facility shall ensure that the individual's emergency medical condition is promptly addressed and that aid is rendered to the extent possible in accordance with the facility's policies and procedures for management of emergency medical conditions.
   b. Unlocking the seclusion room door or fully releasing the restraints ends the episode.
   c. If the situation continues to meet the criteria for a behavioral emergency after the individual's emergency medical condition is addressed, a staff member must obtain a new order for restraint or seclusion.
2. Emergency evacuation. If an emergency evacuation or evacuation drill occurs while an individual is in restraint or seclusion, the staff member providing continuous face-to-face observation of the individual or other staff member must release the individual from restraint or seclusion as soon as possible, as indicated by the circumstances that prompted the emergency evacuation or the evacuation drill, and staff members shall implement the facility's established procedures to ensure the individual's safety.

Special Considerations

1. Before ordering restraint or seclusion, the physician shall take the following into consideration:
   a. Information about the individual that could contraindicate or otherwise affect the use of restraint or seclusion;
   b. Information obtained during the initial assessment of each individual at the time of admission or intake, including, but not limited to:
      i. Pre-existing medical conditions or any physical disabilities and limitations, including, without limitation, cognitive functioning, substance use disorders, obesity, or pregnancy, that would place the individual at greater risk during restraint or seclusion
      ii. Any history of sexual abuse, physical abuse, neglect, trauma, or previous restraint or seclusion that would place the individual at greater psychological risk during restraint or seclusion
      iii. Any history or trauma that would contraindicate seclusion, the type of restraint (personal or mechanical), or a particular type of restraint device for the individual
      iv. Cultural factors
      v. Information contained in a declaration for mental health treatment, if there is one

2. Staff member responsibilities. Staff members shall:
   a. Protect the patient while in restraints (e.g. from assault)
   b. Respect and preserve the rights of an individual during restraint or seclusion
   c. Provide an environment that is protected and private from other individuals and that safeguards the personal dignity and well-being of an individual placed in restraint or seclusion
   d. Ensure that undue physical discomfort, harm or pain to the individual does not occur when initiating or using restraint or seclusion
   e. Use only the amount of physical force that is reasonable and necessary to implement a particular restraint or seclusion
   f. Use psychoactive medication in an emergency only in accordance with state laws
   g. The treatment team will review and, when appropriate, implement and document alternative strategies for dealing with behaviors in each of the following circumstances:

i. Any case in which behaviors have necessitated the use of restraint or seclusion for the same individual more than two times during the individual's facility or program admission, or within any 30-day period, whichever period is shorter
ii. When two or more separate episodes of restraint or seclusion of any duration have occurred within the same 12 hour period;
iii. And when an episode of restraint or seclusion has reached the maximum time permitted under applicable laws

h. Treatment plan modification. If the circumstances recur or continues after treatment team review of alternative strategies, the treatment team shall consult with the facility's chief medical physician administrator or designee to explore alternative treatment strategies and a written modification of the individual's treatment plan.

3. Debriefing opportunities will be provided to all BHU patients and the staff and will provide an opportunity for the patient to discuss the experience privately within 24 hours following release and this information will assist staff to plan appropriate treatment. Staff shall conduct or attempt to conduct debriefings based on the following:
    a. Identify what led to the episode and what could have been handled differently
    b. Identify strategies to prevent future restraint or seclusion of the individual, taking into consideration suggestions from the individual and the individual's declaration for mental health treatment, if any
    c. Ascertain whether the individual's physical well-being, psychological comfort, including trauma, and right to privacy were protected or otherwise addressed, as applicable
    d. Counsel the individual in relation to any trauma that may have resulted from the episode
    e. Staff will also have the opportunity to discuss the process of restraint and seclusion, discuss alternative treatments, specific risk factors identified with the patient, and the modification to the plan of treatment in order to minimize any future use of restraint or seclusion.
    f. Staff members who were involved in the episode, other staff members who the facility determine are appropriate, and supervisors shall debrief together as a support mechanism and to identify successes, problems, or necessary modifications as soon after the episode as is practicable in light of facility operations
    g. When clinically indicated and at a time when the individual has cognitive capacity to understand what could have been done differently to avoid restraint or seclusion, a staff member or members shall conduct a private discussion with the individual, the LAR, and family members, as applicable, appropriate, and with the consent of the individual.
    h. If the individual has been discharged from the facility, does not have the cognitive capacity to understand, or where clinically inappropriate, the facility does not need to attempt the debriefings with the patient
    i. Debriefings with the patient will be documented in the EMR. If debriefing was not conducted, the reasons for not completing the debriefing with the patient will be documented in the individual's EMR

Performance Improvement

1. Use of restraints will be reported at quarterly departmental meetings, or in absence of quarterly departmental meetings, restraint use will be reported via established hospital performance improvement processes.
2. Restraint processes will be subject to continuous review and improvement as identified at the systems level
3. Staff will complete an occurrence report for any patient injured in restraints and/or seclusion
4. Any injury to a person in restraints will be reported to Risk management and a determination made as to whether a report is filed under the safe medical device law. A report must be filed with CMS regional office.

Reporting Requirements

NOTE: Any death of a patient while restrained in any manner will be immediately reported to the CNO or Risk Manager

1. The following information is reported to the Centers for Medicare & Medicaid Services (CMS) regarding deaths related to restraint or seclusion (this requirement DOES NOT apply to deaths related to the use of soft wrist restraints and the soft restraints did not cause death). These are reported to CMS by telephone, fax, or electronically no later than the close of the next business day following knowledge of the patient's death:
    a. Each death that occurs while a patient's in restraint or seclusion

   b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
   c. Each death known to the hospital that occurs within 7 days after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death.
2. When no seclusion has been used and when the only restraint used on the patient are wrist restraints composed of solely of soft, non-rigid, cloth-like material, quality management records in a log any death that occurs while a patient is in restraint or any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within 7 days of the date of the death of the patient, is recorded in the EMR, and includes the following:
   a. Name
   b. Date of birth
   c. Date of death
   d. Name of attending physician or LIP responsible for the care of the patient
   e. MR number
   f. Primary diagnosis
3. The facility shall report a death or serious injury to the Patient Quality Care Unit of DSHS Division for Regulatory Services
   a. Ph: 1-888-973-0022 Fax: 512-834-4504
4. Risk Management shall take appropriate action to identify and correct unusual or unwarranted utilization patters on a systemic basis, and shall address each specific use of restraint or seclusion that is determined or suspected of being improper at the time it occurs.
5. A file shall be maintained with the following information:
   a. Age, gender, and race of the individual
   b. Deaths or injuries to the individual or staff members
   c. Length of time the restraint or seclusion was used
   d. Types and dosage of emergency medications administered during the restraint or seclusion, if any
   e. Type of intervention, including type of restraint used
   f. Name of staff members who were present for the initiation of the restraint or seclusion
   g. Date, day of week, and time intervention was initiated

ATTACHMENTS

Form 10455

RELATED DOCUMENTS

None

REFERENCES

Centers for Medicare and Medicaid Services (2017). State Operations Manual Appendix A

Department of State Health Services (2017). Texas Administrative Code Title 25, Part 1, Chapter 414. Rights and Protections of Persons Receiving Mental Health Services.

Department of State Health Services (2017). Texas Administrative Code Title 25, Part 1, Chapter 415. Provider Clinical Responsibilities- Mental Health Services

Texas Health and Safety Code (2009). Chapter 574, Subchapter G, §574.10. Psychiatric Medication

Texas Health and Safety Code (2009). Psychiatric Medication-as that term is defined in Chapter 415, Subchapter A of this title (relating to the Prescribing of Psychoactive Medication)

The Joint Commission (2017). Comprehensive Accreditation Manual for Hospitals.