Division of Mental Health and Developmental Services
Policy #2.005 - Restraint/Seclusion of Clients
Page 1 of 20

The Division of Mental Health and Developmental Services (MHDS) no longer recognizes seclusion and restraint as a treatment option but as treatment failure. If seclusion and restraint are used on MHDS clients they are to be used only as last resort and only if there is no alternative measure available to staff to maintain safety (Attachment A contains definitions related to this policy).

NOTE: Part 2 of this policy addresses Developmental Services Residential Programs.

PART 1 - MENTAL HEALTH INPATIENT FACILITIES:

I. PHILOSOPHY OF CARE

The Division of MHDS recognizes that seclusion and restraint, including “chemical restraints,” are safety interventions of last resort and are not treatment interventions. Seclusion and restraint should never be used for the purposes of discipline, coercion, staff convenience, or as a replacement for adequate levels of staff or active treatment.

The use of seclusion and restraint create significant risk for people with psychiatric disorders, including dual diagnosis (psychiatric and developmental disabilities). These risks include serious injury or death, re-traumatization of people who have a history of trauma, loss of dignity, and other psychological harm. In light of these potential serious consequences, seclusion and restraint should be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible. When seclusion and/or restraints are applied they require the necessary safety procedures, documentation, physician’s order review, physician’s timely on site evaluation, and debriefing processes that must be followed by mental health inpatient facilities.

It is the goal of the Division of MHDS to prevent, reduce, and ultimately eliminate the use of seclusion and restraint and to ensure that when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained staff. This goal can best be achieved by:

1. early identification and assessment of individual who may be at risk of receiving these interventions
2. In administering seclusion or restraint interventions, as well as in attempting to prevent the necessity for subsequent/recurrent use, staff shall recognize and use the treatment plan and its components as a specific intervention tool. Treatment plans should address patient strengths, gender, trauma, age, and culture issues.
3. high quality, treatment programs operated by trained and competent staff who effectively employ individualized alternative strategies to prevent and defuse escalating situations
4. policies and procedures that clearly state that seclusion and restraint will be used only as emergency safety measures
5. effective continuous improvement monitoring activities
6. During initial intake and ongoing assessment staff should assess whether or not an individual has a history of being sexually, physically or emotionally abused, or has experienced other trauma including trauma related to seclusion, restraint, or prior psychiatric treatment. Staff should also assess past and present violent behavior. Once assessed, staff should discuss with each individual strategies to reduce agitation that might lead to the use of seclusion or restraint. Discussion should include what kind of treatment or intervention would be most helpful and least traumatic for the individual

These approaches help to maintain an environment and culture of caring that will minimize the need for the use of seclusion and restraint.

In the event that the use of seclusion or restraint becomes necessary, the following standards should apply to each episode:
- The dignity, privacy, and safety of individuals who are secluded or restrained should be preserved to the greatest extent possible at all times during the use of these interventions
- Seclusion or restraint should be initiated only in those individual situations in which an emergency need is identified. These interventions should be implemented only by competent, trained staff
- Only licensed practitioners who are specially trained and qualified to assess and monitor the individual's safety and the significant medical and behavioral risk inherent in the use of seclusion and restraint should order these interventions
- The least restrictive seclusion and restraint method that is safe and effective should be administered.
- Individuals placed in seclusion or restraint should be communicated with verbally and monitored at frequent appropriate intervals consistent with principals of quality care (see Safety Procedures section for appropriate intervals)
- All seclusion or restraint orders should be limited to a specific period of time (see Safety Procedures section); however, interventions should be ended as soon as it becomes safe to do so, even if the time-limited order has not expired
- Individuals who have been secluded or restrained, staff who have participated in these interventions, and appropriate other persons (see Client
and Staff Debriefing section) should participate in debriefings following each episode in order to review the experience and to plan for earlier, alternative interventions.

Each facility/treatment setting under the scope of this document establishes and adheres to the following value statements:

- It is recognized that a rich and caring therapeutic milieu, which strives to enhance patience choice and self determination, is the most effective means to avoid the use of seclusion or restraint.
- Seclusion and restraint procedures may only be used as an intervention of last resort following a series of failed ongoing efforts by staff to promote more adaptive behavior by the patient and used only in emergency situations to prevent serious harm to anyone.
- Use of a seclusion or restraint intervention is viewed as an exceptional or extreme practice for any patient.
- Seclusion and restraint shall be as limited in time as possible. Staff and patients work together to lessen the incidence, duration, and induced trauma of these interventions.
- All clinical staff with a role in implementation of a seclusion or restraint intervention must be trained and demonstrate competency in their prevention and proper and safe usage.
- Leaders of the hospital, leaders of clinical departments, and leaders of wards/units are held accountable at all times for the initiation, usage, and termination of seclusion or restraint procedures. This accountability is demonstrated as a component of the hospital’s Performance Improvement efforts and staff competency evaluation.
- All clinical staff will be trained in procedures that lead to elimination of the need for seclusion and restraint.
- The patient, family, and/or advocate of the patient’s choice, as appropriate, are recognized members of the treatment team.
- The treatment plan shall address specific interventions to be used to avoid seclusion and restraint.
- It is recognized that seclusion and restraint are interventions that inherently violate patient dignity, however, such dignity shall be maintained to the extent possible during implementation of each of these interventions.
- In administering seclusion or restraint, as well as in attempting to prevent its use, staff shall recognize and use the strengths of the patient, and remain sensitive to issues of culture and trauma history.
II. CREATING A VIOLENCE FREE TREATMENT MILIEU (see Attachment B for examples of forms for this section)

There are many factors that lead to a safety environment and each agency is responsible for developing a culture of recovery. This culture should include individualized treatment options that are tailored to the needs of the person served and reduce the risk of future violence. In developing a culture of recovery:

- Agency Leadership needs to ensure a culture of respect (not power by hierarchy) by empowering staff at all levels to be to make day-to-day treatment decisions while sensitizing staff about the misuse of power
- Training on Recovery Models of care (including skills for self-monitoring and self-control)
- Clinical paradigm that addresses history of violence or trauma as part of the clinical picture – proper individualized assessment at intake that include past occurrences of violence behavior or trauma (agencies are to develop specific sections within current forms or develop tools to be used in conjunction with current assessment forms). This assessment will serve as a safety precaution in the prevention of seclusion or restraint
- Individualized treatment plans that include information from the assessment about violence and trauma
- Advanced Directives tailored to the people served by the agency and include information about Alternative Dispute Resolution to avoid future violence/conflict (please see attached Personal Safety Form as an example)
- Array of treatment options that are available at all times from which the client chooses
- Ongoing training that is constantly evolving – based on changing situations and type of people being served. This training should be developed in collaboration of consumers/survivors/ex-clients, as appropriate (see training section below)

III. NOTIFICATION

With the client’s consent, upon admission of the client, the client’s family shall be informed of the policies and procedures regarding the use of seclusion and restraint. With the client’s consent, as documented in the medical record, designated family members shall be informed of their opportunity to be notified of each occurrence of seclusion or restraint within the timeframe agreed to by the family and to participate in the client’s debriefing as appropriate. If there is no
family member available, the office of protection and advocacy may be used upon consent of the client.

IV. STAFF TRAINING

Staff training shall focus upon the development of skills and abilities needed to assess risk and trauma, identifying escalating behaviors, and effectively assisting patients to maintain control and learn safer ways of dealing with stress, anger, fear, and frustration.

Staff training shall include the primary importance of patient safety, at all times during the seclusion or restraint process. Training shall be provided to all direct-care staff during employment orientation and on a bi-annual basis.

Staff training in seclusion and restraint techniques and policies shall result in initial certification/demonstration of competency. Retraining and recertification, including demonstration of competency in the use of physical restraint, shall occur bi-annually. Competency shall be demonstrated and documented annually.

Training in safe physical intervention techniques shall be provided only by approved/certified instructors using methodologies approved by the Division of Mental Health and Developmental Services Training Committee. Specific training components shall include:

1. agency and Division policies and procedures relating to the use of, documentation and monitoring of seclusion and restraint;
2. assessment skills needed to identify those persons who have a history of trauma (e.g., abuse, assault, etc.)
3. assessment skills needed to identify those persons who are at risk of violence to self or others;
4. treatment interventions that will reduce the risk of violence and increase the patient’s capacity to benefit from psychosocial rehabilitation and educational programs;
5. skills in developing a patient education program that will assist patients in learning more adaptive ways of handling the stress, frustration or anger that precipitates aggressive behavior;
6. conflict resolution, mediation, therapeutic communication, de-escalation, and verbal violence prevention skills that will assist staff to diffuse and safely resolve emerging crisis situations without resorting to seclusion or restraint;
7. the nature and identification of the possible negative psychological effects these measures have upon individuals, and positive therapeutic strategies to combat such effects;

8. trauma, gender and culturally informed treatment
9. use of safe physical intervention techniques and restraint techniques and devises;
10. use of alternative adaptive support or assistive devises and care strategies in lieu of protective restraints for body positioning and falls prevention;
11. recognition and management of signs of patient physical and psychological distress during seclusion and restraint, and appropriate follow-up;
12. recognition of the behaviors that indicate when restraint/seclusion may be safely terminated;
13. how to conduct a post procedure debriefing; and,
14. appropriate documentation

V. SAFETY PROCEDURES (Attachment C contains seclusion and restrain reporting forms)

This section of the policy and procedure includes safety procedures for initiating and/or providing care for clients in seclusion and/or restraint.

1. All potentially dangerous items shall be removed from the client and the room prior to placement in seclusion and/or restraint.

2. Sufficient staff shall be present to accomplish placement in seclusion and/or restraint in the safest manner possible.

3. No physical or mechanical restraint or body positioning of a client shall place excessive pressure on the chest or back of the client or inhibit or impede the client’s ability to breathe.

4. Clients are to be restrained in a manner to minimize potential medical complications. Staff must be aware of the possibility of client injury in the application and/or utilization of restraints. This includes, but is not limited to, the danger of aspiration of vomitus, impaired circulation and/or respiration, and damage to nerves and skin breakdown.
5. Staff must consider the potential negative impact of seclusion/restraints likely to occur in those clients with a history of trauma such as physical or sexual abuse and be particularly sensitive to the needs of these clients. Nursing will maintain a file of index cards, which will contain the following information on each client admitted to the inpatient unit: patient name, age, diagnosis, medical problems and history of trauma or abuse. This information card will be provided to and utilized by direct care staff involved in episodes of secluding or restraining any individuals to assure that staff members are aware of relevant medical and psychiatric history.

6. While the client is in seclusion he/she will be on constant, uninterrupted monitoring by staff either face-to-face for the first hour of seclusion is required by using both video and audio equipment in close proximity to the client. The client will receive face to face monitoring during the entire time of seclusion. The use of video and audio equipment does not eliminate the need for continuous assessment of the client’s needs and status.

7. Clients in seclusion and restraint simultaneously will be on constant one-to-one (1:1), uninterrupted observation, which includes face-to-face evaluation.

8. The condition of the restrained client must be continually assessed, monitored and re-evaluated. Frequency of monitoring must be made on an individual basis, reflecting consideration of the individual’s medical needs and health status. The rationale for this decision as to the needed frequency of assessment/monitoring must be documented in the medical record.

   a. The client in seclusion and/or restraint will have his/her vital signs taken and documented at a minimum of every two (2) hours and any concerns will be referred to the physician by the registered nurse.

   b. At a minimum of every 15 minutes the staff will document their ongoing continual assessment of the client’s hydration needs, level of distress and agitation, mental status, cognitive functioning, skin integrity, position, circulation, respiration, and safety.

       **Any** observed changes or problems associated with the client’s hydration needs, level of distress and agitation, mental status, cognitive functioning, skin integrity, position, circulation, respiration, and safety will be referred to the physician by the registered nurse.

   c. Any changes in gait or coordination shall be documented and referred to the physician by the registered nurse.
9. Staff will offer the client fluids, toileting and comfort measures every fifteen (15) minutes. Meals and snacks will be offered at regular times. Staff will assist the client with hand washing after toileting and before meals. Bathing will be provided at least once daily. Any exception to the above procedures must be clinically justified and noted in the medical record.

10. Range of motion and movement of limbs will be provided for at least ten (10) minutes and at least every two (2) hours. Relief from mechanical restraint will occur as long as it is deemed to be safe. If client has not regained sufficient control of his/herself to be considered safe, this must be documented in the progress note. During relief periods, the staff shall insure proper positioning of the client and provide movement of limbs as necessary.

11. Despite the length of the prescribed treatment order allows, the seclusion and/or restraint will be terminated when the behaviors that necessitated the seclusion and/or restraint order are no longer in evidence and the behavioral release criteria are attained. If the client is falling asleep or falls asleep an immediate assessment of the client and the release criteria will be made. Clients who are sleeping in seclusion and/or restraint must be evaluated and removed from seclusion and/or restraint if they meet release criteria.

12. In the event of any emergency requiring unit evacuation (including drills), the client shall be removed from seclusion and/or restraint, and staff will stay with the client on a 1:1 basis.

13. Precautions shall be taken to assure the protection of the client in restraints from being mistreated or harmed by other persons.

VI. NURSING FUNCTIONS

This section of the policy and procedure includes the Nursing staff procedures for initiating and/or providing care for clients in seclusion and/or restraint.

1. A registered nurse must be notified immediately if a client exhibits threatening or harmful behavior. The emergency use of seclusion and/or restraints requires an RN assessment.

   a. The RN assessment will include alternatives used prior to the use of seclusion and/or restraint. These may include, but are not limited to:
1) Client’s verbalization of feelings  
2) Verbal reassurance/redirection given to client  
3) 1:1 interaction for the client with staff  
4) Redirection in stimuli  
5) Environmental changes for the client  
6) Limit setting  
7) Time Out offered to the client  
8) Medication offered to the client  
9) Antecedent behaviors or events which triggered the escalation

2. Upon determination by a registered nurse that seclusion or restraint is necessary, a physician order is obtained. The RN notifies the physician of the client’s behavior, and his/her assessment of same.

3. Order to seclude and/or restrain:
   
a. Orders should be written on the Seclusion and Restraint Order Form no more than fifteen (15) minutes after employment of these measures. Verbal orders to a staff Registered Nurse are acceptable. The RN shall record the details on the Seclusion and Restraint Order Form and place the form in sequence in the order section of the client’s medical record. LCC has not, as a practice, included the yellow DOR form in the clients chart, please clarify)
   
b. No application of restraint or seclusion shall occur without a Division Mental Health and Developmental Services physician’s order, stating the reason for use.
   
c. The order will include the method of seclusion and/or restraint to be utilized and the clinical reason for seclusion and/or restraint (e.g. danger to self or others).
   
d. Neither restraint nor seclusion orders shall be written PRN orders.
   
e. The physician must perform a face-to-face evaluation within one (1) hour of the initiation of the episode/intervention regardless of the duration of the seclusion and/or restraint.
   
f. Restraint/seclusion orders are time limited and are valid for no longer than eight (8) consecutive hours.
      
      1) The original order shall be for a maximum of four (4) hours and the continuation order, which must be included in the original order, shall be for a maximum of four (4) hours, totaling a maximum of eight (8) hours for one order.
2) If, in the original order, the physician stated that the order could be extended once, not to exceed four (4) additional hours, the RN MUST document a FACE-TO-FACE reassessment of the client’s current behavior that warrants the extension of the restraint/seclusion.

3) The RN must contact the physician and review this reassessment prior to the extension of the original order.

4) If restraints or seclusion are discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating seclusion or reapplying the restraints.

g. The Nursing Supervisor must be notified within one (1) hour of all applications and removals of restraints and/or seclusions.

4. The RN must document the clinical rationale for the use of seclusion and/or restraint. This documentation shall include, but not be limited to:

   a. An assessment of the client’s behavior and clinical justification necessitating the use of seclusion and/or restraint. The justification shall clearly specify the nature of the dangerous behavior. The use of seclusion and/or restraint may not be based on past history, criminal behavior, convictions or commitment status. (past history of violent assaultive behavior is a significant consideration and therefore should be included in the assessment, i.e., punched several client’s, with severe injury, in the past two days, etc.)

   b. The treatment techniques attempted prior to using seclusion and/or restraint (e.g., administration of medication, counseling, quiet time).

   c. The reason for the use of seclusion and/or restraint and the criteria for termination of seclusion and/or restraint will be explained to the client. This shall include the behavior that will determine their readiness for release from seclusion and/or restraint.

   d. A description of interventions implemented to assist the client in meeting the release criteria.

   e. A summary of the client’s current physical assessment, including vital signs.

5. The client must be continuously assessed, monitored and re-evaluated as to the need for seclusion and/or restraint. This review and assessment will be documented within one hour following the initiation of seclusion and/or restraint and every two hours, anytime there is a change in the client’s physical status and at shift change by the RN coming on duty. The review will address the following:
a. Mental Status and behaviors client is exhibiting at the moment justifying continuation of seclusion and/or restraint.
b. Why less restrictive alternatives are not appropriate.
c. The client’s physical condition including vital signs and circulation.
d. If there is evidence of any potential injury, restraints must be readjusted, repositioned, padded, or removed if necessary. If there is evidence of actual injury, the appropriate physician must be notified, proper treatment initiated including readjustment, repositioning, padding or removal of restraints and/or any other medical treatment that may be necessary. Complete documentation in the medical record is required.
e. Review with client criteria necessary for release from seclusion and/or restraint and any additional counseling and/or education needed.

6. The action recorded on the seclusion and restraint order form will be considered an emergency plan of care with the release criteria established as the immediate goals for the client to accomplish. Other actions as documented by the physician and nursing staff are considered interventions to assist the client in accomplishing the emergency behavioral plan. Modifications of the original plan of care are not necessary.

7. If a client remains in seclusion or restraint when a nursing shift ends, the RN going off duty and the RN coming on duty must assess the client together. This should be documented in a progress note.

8. All progress notes and observation report entries on each client shall be in chronological order in the medical record.

9. Following release from seclusion or restraint, when clinically appropriate, a mental health professional will meet with the client for the purpose of:
   a. Assisting the client to develop an understanding of the precipitants, which may have evoked the behaviors necessitating the use of seclusion and/or restraint and discussing the client's perception and observation of the episode and to provide feedback to the staff.
   b. Assisting the client to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations/emotions/thoughts re-occur.
   c. Developing and documenting a specific plan of interventions for inclusion in the treatment plan for the purpose of reducing or eliminating seclusion and restraint.
   d. The mental health professional shall document the client interview process in the client's medical record.
VII. PHYSICIAN FUNCTIONS

This section of the policy and procedure includes the Medical Staff procedures for initiating and/or providing care for clients in seclusion and/or restraint.

1. The physician must assess the client and shall document in the medical record:
   a) Clinical reason for seclusion and/or restraint, which includes an assessment of risks and benefits to client.
   b) The type of external control (e.g., seclusion, seclusion and restraint).
   c) An on site assessment of the client’s behavior necessitating the use of seclusion and/or restraint within one hour of the event. The justification shall clearly specify the nature of the dangerous behavior.
   d) Alternative interventions attempted.
   e) Treatment recommendations.
   f) Medical or other contraindications to seclusion and/or restraint.
   g) The maximum length of time seclusion or restraint is to be employed.
   h) A statement of the SPECIFIC desired behavior for discontinuation for seclusion or restraint.

2. Only upon completion of a face-to-face clinical assessment by the physician, may the client be secluded and/or restrained beyond one hour. The physician order will include the length of time, up to four (4) hours, and the method of seclusion and/or restraint to be utilized. The physician will be contacted for any continuation of the order for seclusion and/or restraint.

3. If a client who is restrained for aggressiveness or violence quickly recovers and is released before the physician arrives to perform the assessment, the physician must still see the client face-to-face to perform the assessment.

4. The on-call psychiatrist is responsible for all seclusion/restraint on site timely (within one hour) evaluations and orders on Saturdays, Sunday, holidays, and after working hours on all non-holiday weeknights (5:00 p.m. to 8:00 a.m.). The treating physician will be consulted as soon as possible.

5. Continuation of seclusion and/or restraint beyond eight (8) hours requires a new face-to-face assessment by the physician and a new physician order and progress note as outlined above.

6. All progress notes and observation report entries on each client shall be in chronological order in the medical record.
VIII. CLIENT AND STAFF DEBRIEFING (see Attachment D for a debriefing form)

An initial staff debriefing shall occur immediately after the seclusion or restraint but prior to any shift change. Findings from the staff debriefing and proposed administrative changes or strategies to prevent reoccurrence shall also be documented on the seclusion and restraint form and forwarded to the Division’s Medical Director and Agency Director for their review and action. A second full debriefing process shall be initiated within 24 hours of the end of each incident or seclusion or restraint, unless further delay is clinically indicated. This information shall be available to the treatment team prior to its next meeting with the client.

After each incident of seclusion or restraint, a mental health professional and members of the treatment team shall meet with the client for the purpose of:

a. Assisting the client to develop an understanding of the precipitant which may have evoked the behaviors necessitating the use of the restrictive technique(s).

b. Assisting the client to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations/emotions/thoughts recur.

c. Identifying stress reduction methods and teaching identification of antecedent trigger events which may cause stress.

d. Using admission forms, treatment plans, and any other agency forms when discussing what might have occurred (“went wrong”) that led to an initiation of seclusion or restraint and what changes need to occur that would lessen future occurrences.

e. Developing and documenting a specific plan of intervention for inclusion in the comprehensive individualized treatment plan, for the purpose of reducing or eliminating the need for restrictive techniques. The team member shall document the debriefing process in the progress notes in the client’s medical record. Documentation of the new intervention to be used shall be included in the comprehensive individualized treatment plan the first working day after termination of the seclusion or restraint and shall be reviewed with the client.

IX. CONTINUOUS IMPROVEMENT MONITORING

The Agency Director and the leadership staff of each inpatient facility shall maintain a performance improvement program designed to continuously review, monitor and analyze the use of those measures shall be employed.
The Agency Director and Medical Director are responsible for insuring that ongoing documentation and monitoring of clients placed in seclusion or restraints are maintained. Monitoring shall consist of reviewing the necessity for use or continuation of these measures based upon documentation of unsuccessful, less restrictive alternatives, attempts at patient education of stress reduction behaviors and trigger identification, as well as appropriate rationale and justification. Client “debriefing” health teaching, clinical response to seclusion, treatment plan revisions, and incidents of failure to meet timelines as outlined in this policy.

For incidents of seclusion or restraint that exceed 12 hours, or experiences two or more separate episodes of restraint and/or seclusion within a 12 hour period, Agency Administration and clinical leadership shall be notified within 1 hour. For episodes in excess of twelve (12) hours, daily administrative review and clinical rationale to continue seclusion and/or restraint shall be provided by a non-treating psychiatrist or designee of the Medical Director.

A formal interdisciplinary Treatment Plan Review will be held for all clients placed in seclusion or restraints. This shall be documented in the medical record.

All events of seclusion and/or restraint must be reported each business day to the Agency Director/designee, Medical Director/designee and to the Director of Nursing/designee.

The Director of Nursing, Medical Director and Agency Director will review copies of all seclusion orders and restraint orders.

The Agency Director/designee will forward the order copies (without client names) and reviews to the MHDS Administrator bimonthly for review. Copies of all documents are maintained in the medical record.

A monthly uniform summary of all reports of seclusion and restraint shall be compiled by the Nursing Director. Copies shall be submitted to the agency Performance Improvement Department and to the Division of MHDS.

The MHDS Administrator will review and report seclusion and restraint orders to the Mental Health and Developmental Services Commission.

Leadership staff of each state psychiatric hospital will include the review of seclusion and restraint data in the facility performance improvement program.

The data will be systematically aggregated and analyzed on an ongoing basis by Leadership staff at each agency.
Ongoing efforts to reduce the utilization of seclusion and restraint shall be employed by each facility.

The facility Chief Executive Officer of each state psychiatric hospital is responsible for assuring that ongoing documentation and monitoring of clients placed in seclusion and/or restraint is maintained.
1. The hospital will report to the MHDS Administrator, CMS and State of Nevada, Division of Health Bureau of Licensure and Certification any death that occurs while a client is restrained or in seclusion or where it is reasonable to assume that a client’s death is a result of restraint and/or seclusion.

2. Each agency of the Division, which is regulated by CMS, shall develop and implement their own written procedures to implement the provisions of this policy.

3. All other agencies of the Division shall develop written procedures to meet the requirements of state law with respect to client restraints.

Attachment A

DEFINITIONS
SUGGESTION: JCAHO has the following definitions –

Seclusion: The involuntary confinement of an individual served alone in a room, which the individual served is physically prevented from leaving, for any period of time. Seclusion does not include involuntary confinement for legally mandated but nonclinical purposes, such as confining a person facing serious criminal charges, or serving a criminal sentence, to a locked room.

Restraint: The direct application of physical force to an individual served, with or without the individual’s permission, to restrict his/her freedom or movement. The physical force may be human, mechanical devices, or a combination thereof.

Time-out: A procedure used to assist the individual to regain emotional control by removing the individual to a quiet area of unlocked quiet room. (The standard that references time-out also states that the use of time-out is limited to use of no more than 30 minutes.)

A. “Restraint” includes either a physical restraint or a medication that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the client’s body that he or she cannot easily remove that restricts freedom of movement or normal access to one’s body. Restraint is differentiated from mechanisms usually and customarily employed during medical or diagnostic procedures that are considered a regular and usual part of such procedures, (i.e., restraints to prevent a non-ambulatory or confused client from falling out of bed or out of a chair).

This policy may include the use of devices such as bed rails, tabletop chairs, protective nets, mitts, or helmets when used as protective devices; any physician ordered item devised by personnel to prevent perpetual self-mutilators from inflicting injury to themselves, which inhibits the bending of the elbow, wrist, or fingers; or the use of orthopedic appliances, braces, and other appliances or devices used for postural support of the client or to assist the client in obtaining and maintaining normal bodily functions if they are used for the purpose of restraining a client. Physical restraint may be used on a client to conduct medical examinations or treatments on clients that are necessary. In such cases a Denial of Rights for Written Consent to Medical Treatment will be initiated.

Medications that comprise the resident’s regular medical regimen are not considered chemical restraints, even if their purpose is to control ongoing behavior. Medications shall not be used as chemical restraints (N.R.S.
433.5503 and 433.5456 allows use of chemical restraint. Many times Haldol may be given on an emergent basis, where the routine antipsychotic would be some other medication). Medications are only to be used to treat the symptoms of the client’s psychiatric condition. When a client is given medication without previously signing a written medication consent, a Denial of Rights for Written Consent to Medical Treatment will be initiated.

B. **Seclusion**: The involuntary confinement of a client in a locked room or a specific area from which the client is physically prevented, or psychologically coerced, from leaving. Seclusion does not include confinement on a locked inpatient treatment unit or ward, where the client is with others receiving inpatient care.

C. **Emergency**: Emergency is defined as a serious, probable, or imminent threat of bodily harm to self or others where there is the real potential to cause bodily harm. It may be an unanticipated situation where the client’s behavior is violent or aggressive.

D. **Imminent**: Likely to occur immediately.

E. **Time Out**: Allowing the client to voluntarily be alone in an unlocked room for 30 minutes or less for quiet time purposes and to promote a calming effect so they may return to the therapeutic milieu. Time out is not seclusion (see facility policy on time out).

F. **Mental Health Professional**: A person professionally qualified in the field of Mental Health (N.R.S. 433.209).

G. **Client**: The individual defined as “client” in statute will hereinafter be referred to as “client.”

ATTACHMENT B