I. **PURPOSE:**
   A. To establish hospital policy and procedural guidelines governing the use of Seclusion and restraint interventions used for a client who is at imminent risk of harming him/herself or others and no other less restrictive intervention is possible.
   B. To ensure clients are treated with safe practices, with dignity and respect, and to ensure client’s rights are protected in regard to the use of Seclusion and restraints.
   C. Riverview Psychiatric Center (RPC) is striving to decrease the use of Seclusion and restraint. Seclusion and Restraints are considered emergency measures or interventions of last resort to protect clients in imminent danger of harming him/herself or others. The use of Seclusion and restraint create significant risk for people with psychiatric disorders and for staff. These risks may include physical injury, including death, and the re-traumatization of people who have a history of trauma, loss of dignity and other psychological harm. Seclusion and Restraint episodes are considered treatment failures. Seclusion and Restraint should be considered where an emergent safety need is identified and only after other less restrictive measures have failed. In light of these potential serious consequences, Seclusion and restraint will 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.
   D. It is recognized that a rich and caring therapeutic milieu, which strives to enhance client choice and self-determination is the most effective means to avoid the use of Seclusion and restraint.

II. **POLICY:**
   A. Seclusion and Restraints are considered emergency measures or interventions of last resort to protect clients in imminent danger of harming him/herself or others.
   B. The least restrictive Seclusion/restraint method that is safe and effective will be administered.
C. Seclusion and/or restraints will never be used for the purposes of discipline, coercion, active treatment, staff convenience or as a replacement for adequate levels of staff.

D. Seclusion/Restraint is never part of a client’s treatment plan.

E. A PRN order for Seclusion and/or Restraint is prohibited.

F. Only those physical holds or mechanical devices approved by the Riverview Behavioral Response Leadership Committee and Hospital Administration will be used to physically restrain a client.

G. Definitions:
   1. **Time Out**: a voluntary intervention whereby the client chooses to temporarily move from their immediate environment to a quiet environment and the client is not prevented from leaving. If a Seclusion room is utilized, the client must be immediately released upon request. Since this intervention is voluntary, no physician’s order is required.
   2. **Assisted walk**: occurs when for the safety of the client and/or others, the client is physically assisted to walk from one environment to another. An assisted walk does not require a separate order for restraint. If client becomes resistive then the assistance becomes a restraint hands on hold and requires a doctor’s order.
   3. **Physical Redirection** may occur when a client places hands on staff’s body or clothing and the staff requests client to remove hands. If not, then staff remove hands. If client is cooperative this is considered a physical redirection. If the client is resistive this is considered a hands on hold and restraint procedures apply.
   4. **Combative**: striking out; having or showing an eagerness to fight.
   5. **Resistive**: not fully cooperating, arching, pulling away.
   6. **Seclusion**: any involuntary confinement of a client in a room or an area from which the person is physically prevented from leaving.
   7. **Blanket Release**: is a technique developed to facilitate the safe exit from the Seclusion room by staff, while providing a safe method of temporarily reducing movement of the client. Requires discretion of RN overseeing SECLUSION event.
   8. **Restraint**: direct application of physical force to an individual, without the individual’s permission, to restrict his/her freedom of movement. Restraint is any physical technique, physical/mechanical device, material or equipment attached to 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. Only those interventions, devices or holds approved by the Riverview Behavioral Response Leadership Committee and Hospital Administration will be used to physically seclude/restrain a client.
   9. **Drugs used as restraint**: a medication used for the emergency control of behavior and is not a standard treatment for the patient’s medical or psychiatric condition.
   10. **Clinical assessment for Seclusion and Restraint**: assessment in which a physician substantiates through documentation in the medical record that the reason for a client being placed in Seclusion/Restraint is in order to prevent
harm to self or others.

11. Criteria/ clinical justification for Seclusion or Restraint: behaviorally oriented criteria justifying the use of Seclusion/restraint to prevent the client from injuring themselves or others and when less restrictive interventions are inadequate, have been attempted and failed, unless a safety issues demand immediate physical response to prevent the behavior.

12. Emergency (behavioral health): an emergency is a situation where there is imminent risk of an individual physically harming themselves, staff, or others, when non-physical interventions are not viable, and safety issues require an immediate physical response to prevent injury to self or others.

13. Trained staff: includes physicians, licensed nursing staff and other direct care staff who have been trained in de-escalation techniques, and safe management of Seclusion and Restraints.

H. Approved Restraints: The following only are approved restraints for resistive clients.

Only Riverview approved and instructed physical holds, both standing and floor techniques. They are:

1. Assisted Walk
2. Upright Still
3. Floor sitting and lying (supine or recovery when possible).
4. 5 point restraint
5. Mitts
6. Side Rails in medically compromised clients
7. Riverview approved mechanical transport equipment -- wheeled stretcher/spider restraints/scoop backboard per protocol as described in this policy section 10.0.
8. Blanket Release for safe staff exit from SRC protocol as described in this policy section 11.0 and Nursing procedure Blanket Release.

III. PROCEDURE

Staff who has received RPC approved training in de-escalation and safe management of Seclusion and restraint may participate in excluding or restraining clients.

A. Safety Needs and Hands on Intervention:
   1. Before hands-on intervention and/or placement in restraints, the RN who is directing the intervention shares the client’s unique safety needs with responding staff. The RN also informs the responding staff of any safety precautions that they should take during the hands-on interventions. All clients remain in their own clothing unless the clothing worn increases the risk of danger to self or others. The RN IV or designee shall assess and evaluate the client’s condition every 15 minutes to assure safety, assess the clients need for continued seclusion or restraint and document same.
   2. When a client with a physical disability has a history of agitation leading to hands-on interventions, the safety needs of the client are addressed in the treatment plan.
3. While in Seclusion and/or Restraints, the client is continuously under 1:1 observation.

4. If, during a Seclusion and/or Restraint or during an escort to Seclusion and/or Restraint, a client spits at involved staff, a disposable oxygen mask may be placed on the client to prevent the client from spitting and/or biting. A washcloth or small towel may be held in front of the client’s face to block the spit as an alternative to the use of the oxygen mask. At no time should the cloth or towel be placed inside the client’s mouth or held against the client’s face. Staff must use universal precautions (gloves and mask).

B. Seclusion and/or Restraint Orders Must be dated, timed and signed;
   1. Not to exceed 30 minutes for seclusion or restraints
   2. Must specify the type of Seclusion and/or Restraint;
   3. Identify alternative less restrictive measures attempted and the client’s response;
   4. Specify the maximum amount of time limit in Seclusion and/or Restraints, not to exceed limits cited above;
   5. Behaviorally justify the use of Seclusion and/or Restraints;
   6. Identify the earliest conditions under which the client may be released;
   7. Identify target behaviors for Seclusion and/or Restraint release; Identify level of staff supervision and/or assistance required during free movement if it differs from 1:1 observation;
   8. The specifics in the physician/physician assistant/nurse practitioner’s order and progress note provide the necessary documentation required for initiation of Seclusion and/or Restraints;
   9. The physician assistant/nurse practitioner contacts the physician backup as soon as practical to consult about the order to use Seclusion and/or Restraint. The physician backup countersigns the order with the date, time and signature within 72 hours;
   10. When a physician/physician assistant/nurse practitioner is not immediately available, the registered nurse (RN) assesses the client meets the criteria for Seclusion/restraint (poses an imminent risk of harm to self or others) he/she may order placement in Seclusion and/or Restraint pending immediate notification (no longer than thirty (30) minutes after initiation of intervention) of the physician/physician assistant/nurse practitioner. The RN documents the clinical justification for Seclusion and/or Restraint in the progress notes, charting the client’s behavior and assessment data based on the criteria above.

C. Following placement of the client in Seclusion and/or Restraint by the RN, the physician/physician assistant/nurse practitioner personally evaluates the client within thirty (30) minutes of initiating the Seclusion and/or Restraint. The physician/physician assistant/nurse practitioner documents the findings of the evaluation in a progress note. If the evaluation does not occur within thirty (30) minutes, the reason for the delay is documented in the client’s chart. The RN generates an incident report for any delay in this medical evaluation.
D. Per Department of Health and Human Services, Behavioral and Developmental regulations, Seclusion and/or Restraint of an MR client, or an MR client who is not under BDS with a dual diagnosis (mental retardation and mental illness), may be placed in Seclusion and/or restraints for up to one hour only.

E. The RN is authorized to carry out the physician/physician assistant/nurse practitioner order for Seclusion and/or Restraint.

F. Use of SRC gown and/or hospital attire is written in the physician/physician assistant/nurse practitioner’s order.

G. Each initiation of seclusion or restraint requires a new order and the requirements restart (even if this occurs during the original time frame)

H. Prolonged Episodes of Seclusion and/or Restraint:
   1. Each extension of Seclusion and/or Restraint requires a new physician/physician assistant/nurse practitioner’s order and will meet the same standards as outlined in above.
   2. The total length of time in Seclusion and/or Restraint is not to exceed twenty-four (24) hours. The Medical Director or designee must review the need to continue Seclusion and/or Restraint use longer. A medical assessment by the physician/physician assistant/nurse practitioner is done with this review. This medical assessment includes vital signs, nutrition, hydration, and treatment of any injuries. The physician/physician assistant/nurse practitioner notifies the guardian of the medical assessment findings and treatment recommendations.

I. Notification, Ongoing Assessment & Documentation Requirements for Seclusion and/or Restraint:
   1. The physician/physician assistant/nurse practitioner or RN notifies the client’s guardian or representative as soon as possible of the need for Seclusion and/or Restraint.
   2. The client’s identified family member is notified promptly of the initiation of Seclusion/restraint, in cases where the client has consented to have family kept informed regarding his/her care and the family has agreed to be notified (the client identifies a family member for contact during the safety assessment process, if no such person has been identified, this is documented on the safety assessment)
   3. A Progress Note is written by the physician/physician assistant/nurse practitioners when Seclusion and/or Restraint is started and for any extensions. The Progress Note must describe the rationale for Seclusion and/or Restraint, with behavioral descriptions; precipitating factors and client behavior prior to intervention and all less restrictive alternatives used including the client’s response.
   4. The RN and Mental Health Workers (MHW) document the following
information on the Seclusion / Restraint Monitor Sheet

a. Rationale for Seclusion and/or Restraint, with behavioral descriptions; precipitating factors and client behavior prior to intervention
b. All less restrictive alternatives used including the client’s response;
c. RN assessment at time of initiation and notification of attending provider;
d. Behavioral criteria for release;
e. Assistance provided to the client to help him/her meet the behavioral criteria for discontinuation of Seclusion/restraint (e.g., ability to contract for safety, orientation to the environment, and/or cessation of verbal threats);
f. Evidence of continuous monitoring;
g. Description of client behaviors every fifteen (15) minutes;
h. Offer of food and fluids and personal hygiene measures at least every 30 minutes and more frequently if necessary;
i. Sequential release and exercise of extremities: circulation check every 15 minutes;
j. Ongoing nursing assessment by an RN IV or designee and assessment for release at least every 15 minutes for Seclusion and/or Restraints; If the nursing assessment is not completed by an RN IV, and incident report describing why a designee was used is required.
k. When the RN questions the need for the client to stay in Restraint, the nurse will make an assessment while releasing each extremity sequentially. The time for the sequential release procedure is not to exceed twenty (20) minutes. The RN assesses if the client continues to pose a danger to self/others. If anytime during the sequential release procedure, the client is assessed not to need continued restraints, the RN will release the client from restraints. The RN documents the ongoing assessment data based on criteria outlined above.

J. Use of Mechanical Equipment to Transport clients in extreme behavioral situations:
   1. In general, the movement of combative clients is to be avoided because of potential risk of injury. However, in extreme behavioral situations, where all other physical, psychological or pharmacological interventions have failed or increased the risk of harm, the attending psychiatrist or his/her designee may direct and personally supervise the safe transport of clients, if this is medically indicated.
   2. Guidance governing the use of mechanical devices in transport includes:
      a. All efforts at psychological de-escalation, dispute resolution, appropriate pharmacological interventions and Riverview approved hold techniques for a minimum of 30 minutes have been made with non-resolution of the behavioral crisis. An emergency situation as defined in this policy may necessitate action prior to the completion of 30 minutes of physically holding as deemed necessary by the supervising medical staff with immediate notification to the hospital Medical Director and Administrator on Call;
b. Multiple attempts to verbally redirect the client to walk, assisted or unassisted, to an alternative environment have been unsuccessful.

3. The PA or NP shall consult with the on-call psychiatrist (if the event occurs after hours) and the hospital Medical Director and both must certify the necessity for the use of the mechanical transport devices prior to the initiating the transport. In the event the hospital Medical Director is unavailable, the Administrator on Call must be consulted/informed of the use of the mechanical transport devices.

4. The medical staff member in attendance personally ascertains that the client can safely be moved by sufficient numbers of staff trained in the use of mechanical transport devices and directly supervises any such transport.

K. Blanket release:
   1. The Blanket Release will be used at the direction of the RN responsible for the oversight of the Seclusion Event, and applied by the staff that has been trained to perform the Blanket Release technique.
   2. There will be an awareness of medical history (i.e. respiratory difficulties and physical impediments), and a nursing visual assessment of same. Careful observation by the nurse during and after the application of the Blanket Release is required.

M. Debriefing:
   1. With client and involved staff:
      a. The client’s guardian or representative may be present at the debriefing.
      b. In the event that Seclusion and/or Restraints are used late in the evening or at night, and if client fatigue requires deferment of the debriefing, a copy of the full report of the incident will be given to the treatment team the following morning. The appropriate team members including the RN and physician or designee will convene the debriefing.
      c. The client’s physician or designee will facilitate the debriefing.
      d. The RN and physician or designee will complete and sign the “Seclusion and Restraint Monitor Sheet” including the client’s response to the use of Seclusion and/or Restraints.
      e. Modifications to the client’s Treatment Plan, as indicated, will be drafted and documented.
      f. If the client requests that a specific staff person not be present at the debriefing, that request will be honored. The issue will be addressed during the debriefing to formulate a plan for conflict resolution.
   2. With involved staff:
      a. The client’s physician or designee will conduct the debriefing with involved staff immediately following the use of Seclusion and/or Restraint.
      b. Documentation of this debriefing will be included on the “Staff Debriefing/Stat Call Critique” form.
      c. The RN and physician or designee will also complete and sign the “Seclusion and Restraint Monitor Sheet”.

N. Client/Family Education:
   1. Education regarding the hospitals philosophy and policy regarding
restraint/Seclusion is reviewed with each client upon admission during the safety assessment.

2. Alternatives to Seclusion/restraint are identified during the safety assessment.

3. A family member or significant other is identified for notification of Seclusion/Restraint intervention during the safety assessment. If none identified this is documented.

4. The RN provides education regarding the restraint episode for the client and family.

5. The RN documents the teaching and client/family response, along with the plan for follow-up education in the Progress Notes.

O. Performance Standards:
   1. Staff who place clients in Restraints will have documented NAPPI training in the proper techniques and in less restrictive alternatives to Restraint.
   2. Continuous Performance Improvement studies of restraint data provide the basis for measuring compliance to restraint policy and performance standards. Any new restraint devices or techniques to be implemented by the hospital will be reviewed and thoroughly researched consulting with outside facilities in order to provide recommendations for effectiveness and appropriateness of its utilization. Based on thorough review of the recommendation by the Medical Executive Committee and the Executive Leadership Committee, a decision is made regarding hospital implementation.

P. Equipment Maintenance:
   Restraint devices are washed after each use and are examined for safety at the time of return to the restraint bag. Restraints are examined semi-annually by the nurse educator to assure safety in utilization. Seclusion rooms are cleaned after each use. Mattress and floors are washed, walls are washed and clean linens are placed on mattress. If the room is used as a quiet room then the room shall be cleaned as above. A safety assessment of the room is completed: 1) Mats are whole and intact, 2) no foreign objects are present.

IV. RESPONSIBILITY: All Staff
V. POLICY STORED IN: Superintendent’s office
VI. POLICY APPLIES TO: Riverview Psychiatric Center Direct Care Staff
VII. KEY SEARCH WORDS: Seclusion and Restraint
VIII. REFERENCE: Joint Commission – PC.12.10 – PC.12.190
     DHS – 42 CFR SECTIONS 482.61 & 482.62
     XXV.B XXV.C.1 – 4A
     CMS - §482.13(F)
     Maine Rights of Recipients VII