I. Purpose

To establish policies and procedures governing the use of seclusion or restraint at Northern Virginia Mental Health Institute in order to minimize use of these restrictive procedures, maximize protection and safety for patients and staff and preserve patients’ dignity when seclusion or restraint is required.

II. Policy

For individuals who have histories of physical or sexual abuse or neglect, the loss of power and control experienced when hospitalized is exacerbated with the use of seclusion and restraint. In addition, seclusion or restraint can trigger increased emotional distress or crises because the seclusion or restraint mimics the traumatizing abuse of his/her past, thus causing retraumatization. For a patient without an abuse history, the use of seclusion and restraint may be his/her first experience of trauma and could lead him/her to avoid contact with the mental health system, even when in extreme need. Staff also may experience emotional trauma, as well as physical injury, by having to restrain or seclude patients.

Because of the trauma inducing aspects of seclusion and restraint, as well as the potential for physical and psychological harm and loss of dignity, seclusion or restraint shall only be utilized in emergency situations that pose an immediate risk of a patient physically harming him or herself, staff or others and when less restrictive interventions are not viable or have been ineffective. Staff and patients shall collaboratively develop strategies that support minimizing the potential for a behavioral emergency and/or the need for seclusion or
restraint. The decision to utilize seclusion or restraint shall take into account the individual’s specific, unique characteristics. The Institute’s physical and social environment as well as treatment processes and approaches shall be directed toward preventing and reducing the use of restrictive methods as well as fostering self management while providing for the safety of the individual and others in the treatment environment.

When seclusion or restraint is utilized, the patient’s rights, dignity and well-being shall be protected and preserved and every effort shall be utilized to facilitate the discontinuation of restraint or seclusion as soon as possible. The contents of this policy shall govern all use of seclusion, physical restraint and mechanical restraint.

Seclusion or restraint shall not be utilized as part of a behavioral treatment program. NVMHI will comply with the highest standard for seclusion/restraint as required by any applicable regulations or standards and shall strive to prevent, reduce and eliminate the use of seclusion and restraint through effective performance improvement initiatives.

III. Definitions:

A. Attending Physician – The psychiatrist responsible for the psychiatric and medical/surgical non-psychiatric care and treatment of the patient.

B. Constant Observation – The continuous one-on-one observation of a patient by a staff person who is not performing any other duties or activities and has no other assignments; is assigned to the patient on a one-on-one basis; and is within arm’s length of the patient, unless there is a documented medical or psychiatric contraindication for this level of proximity. The patient must be within the staff member’s vision in toilet or shower stall areas; the observing staff member shall continue to respect patient privacy to the extent possible.

C. Continuous Monitoring – The continuous in-person observation of a patient by an assigned staff person who is at arm’s length distance from the patient, within vision at a distance sufficient to intervene or through the seclusion room door. The physician shall determine whether this monitoring is accomplished by constant observation or visual constant observation.

D. Emergency – An emergency is an instance in which there is an imminent risk of an individual harming him-or herself or others, including staff; when nonphysical interventions are not viable; and when safety issues require an immediate physical response.

E. Restraint – Three types of restraint are defined below:

1. Mechanical Restraint – The use of approved mechanical devices that:
a. involuntarily restrict the freedom of movement or voluntary functioning of a limb or a portion of a person’s body as a means of controlling his/her physical activities, and

b. the patient does not have the option to remove.

2. Pharmacologic Restraint – A medication that is given involuntarily to control extreme behavior during an emergency when such medication is not the standard treatment for the patient’s medical or psychiatric condition. A medication must meet three criteria to be classified as a pharmacologic restraint:

   a. it must be administered involuntarily

   b. it must be ordered for the purpose of behavior management, and

   c. the medication ordered is not the standard treatment for the patient’s medical or psychiatric condition.

3. Physical Restraint – Also referred to as “manual hold”; the use of approved physical interventions or “hands on” holds to prevent a patient from moving his or her body to engage in a behavior that places him/her or others at risk of physical harm. Physical restraint does not include the use of “hands on” approaches which occur for extremely brief periods of time, never exceed more than a few seconds duration and are used to:

   a. intervene in or redirect a potentially dangerous encounter in which the patient may voluntarily move away from the situation or hands on approach

   b. quickly de-escalate a dangerous situation that could cause harm to the patient or others

   c. interrupt dangerous behavior in order to interact with the patient to establish lesser restrictive alternatives.

F. Seclusion – The involuntary placement of a patient in a locked room or in a room or area where he or she is physically prevented from leaving.

G. Treatment Plan – The written document that reflects the integrated focus of treatment designed to promote the patient’s recovery through rapid stabilization, rehabilitation and return to the community. Derived from assessments, and utilizing patient strengths, the plan is the mechanism through which care and treatment needs are identified and goals and interventions planned to address each need. The plan is evaluated as the patient changes in response to care and treatment.
H. Visual Constant – The continuous one-on-one monitoring of a patient by a staff person who is not performing any other duties or activities and has no other assignments; is assigned to the patient on a one-on-one basis; and who maintains the patient within his/her eyesight. When a patient is secluded, this shall be performed by continuously visualizing the patient through the seclusion room window. When the patient is restrained, the staff person must be within sufficient physical proximity for intervention while affording personal space.

IV. Procedures:

A. General procedures

1. The treatment environment shall foster limited use of seclusion or restraint by using clinical processes that promote their prevention through:

   a. assessments that identify potential risk factors for dangerous behavior including triggers for escalation

   b. collaborative partnership with the patient, family and/or community care provider to develop individualized treatment objectives and interventions that utilize patient strengths and are designed to take into account patient preferences for strategies to include self calming and soothing strategies; and to prevent or manage dangerous behavior and offer alternatives to behavior that could lead to harm to self or others

   c. timely evaluation of factors that contributed to the use of seclusion or restraint

   d. consideration of how age, developmental level, cultural background, gender and history of physical or sexual abuse or other trauma may influence behavioral emergencies and affect the response to seclusion and restraint

   e. recognition of how a staff member’s culture, perceptions and experiences can influence his or her response to patient behavior

   f. prioritizing use of non-physical interventions

2. The use of restraint or seclusion shall not be based on a patient’s history or solely on a history of dangerous behavior.

3. The simultaneous use of seclusion and restraint is discouraged. Whenever both actions are implemented to provide safety to the patient or others, the attending/on-call physician and Nursing Unit Manager (NUM) or nursing supervisor must immediately collaborate about alternatives. If one of the
measures is not discontinued, the Medical Director and Chief Nurse Executive must be notified immediately for further consultation and collaboration regarding alternatives.

4. The use of the least restrictive method for the individual, including the method and minimum number of mechanical restraints, must be utilized for the shortest period of time necessary to assure the safety of the individual and others.

5. Under no circumstances may pain compliance techniques be used.

6. Under no circumstances may staff hold an individual’s jaw/chin closed or place something that could obstruct breathing over a patient’s nose or mouth.

7. Under no circumstances may staff lie on, straddle or apply pressure to a patient’s chest/trunk.

8. Seclusion is contraindicated for patients with uncontrollable self-abuse or self mutilation as well as patients who are at risk for suicide.

9. Seclusion or restraint shall never be used as punishment, retaliation, for staff convenience, as a substitute for treatment, or in a manner that causes undue physical discomfort or harm to the patient.

10. Physical or mechanical restraint may be contraindicated for individuals with known trauma histories including sexual or physical abuse or neglect.

11. Seclusion or restraint use shall be ordered by a physician after an individualized assessment. Standing or PRN seclusion or restraint orders are prohibited.

12. Careful assessment is required in order to distinguish patient behavior posing physical harm from behavior that irritates, annoys others or causes property destruction (without potential for physical harm). Likewise, when assessing patient readiness for release from seclusion or physical or mechanical restraint, it is important to distinguish behavior that represents continuing dangerousness if released from behavior that is occurring as a result of being secluded or restrained.

13. The Human Rights Advocate shall be notified of the patient name, reason for the seclusion or restraint, criteria for release, and length of time any patient is in seclusion or restraint.

14. If an emergency situation occurs while a patient is in transport and away from the hospital, he/she may be physically or mechanically restrained by the accompanying staff member(s). The staff member shall notify the charge nurse
or NUM/nursing supervisor immediately. The Registered Nurse (RN) shall immediately consult with a physician. When the staff returns to the hospital, he/she shall report to the RN or physician who shall assess the patient to determine continued need for restraint, assure documentation in the record and obtain or write an order for the restraint.

15. Unless the patient is in immediate danger, during drills or actual fires or disasters, the staff member designated to be on constant or visual constant observation with any secluded or restrained patient will remain with the patient until direction is given by a RN. In the event of an evacuation order, two staff members shall accompany and remain with the patient in the designated evacuation area.

16. NVMHI does not use pharmacological restraint. In the unusual event that such an intervention may be required it must be approved by the Medical Director and comply with DMHMRSAS criteria for definition and appropriateness.

B. Training

1. All facility staff shall participate in training in the Department approved behavioral interaction and crisis management techniques per NVMHI Policy A-50, Staff Education and Competency. Only individuals who are certified as being competent to perform activities designated in this policy may do so.

2. All clinical staff, including leadership, will be trained in the Department approved behavioral interaction and crisis management techniques, including non-physical interventions, approved physical holding techniques and restraint training. The training and determination of competency must occur during the staff member’s orientation period and annually thereafter.

3. Only staff with current competency in the facility approved training may apply physical restraints.

4. Staff approved by the facility to apply mechanical restraints or initiate seclusion must have completed additional competency-based training and may implement these measures only under supervision of a RN.

5. Designated facility trainers will assure that the seclusion and restraint training includes at a minimum: application and removal of mechanical restraints; transporting patients in restraints; transporting patients into seclusion; recognizing how staff culture, bias or counter transference may influence their response to a behavioral emergency; understanding how staff behavior may escalate a potentially volatile situation.
6. Nursing will assure that RNs who perform 15 minute assessments of secluded or restrained patients will be trained and demonstrate orientation and annual competence in assessing psychological and physiological status including:

   a. determining the need for taking vital signs and recognizing readings that require notification of a physician
   b. recognizing and addressing nutritional/hydration needs, hygiene, elimination and comfort needs
   c. recognizing when circulation in and range of motion of the extremities must be addressed
   d. recognizing and addressing untoward reactions to seclusion or restraint including symptoms of trauma
   e. recognizing readiness for discontinuation of seclusion or restraint
   f. recognizing when to contact a physician or emergency services
   g. determining that the room being used has adequate lighting, is free of any safety hazards, is a comfortable temperature and is adequately ventilated

7. In addition to the training listed above, RN’s who in the absence of a physician are authorized to initiate restraint or seclusion in an emergency and perform evaluations/reevaluations of patients, are educated and demonstrate orientation and annual competence in the following:

   a. recognizing the effect of age, developmental level, gender, ethnicity, and a history of sexual or physical abuse or other trauma on the patient’s reaction to physical contact
   b. accurately assessing the patient to initiate the appropriate intervention using the crisis model
   c. using behavioral criteria for discontinuing seclusion or physical or mechanical restraint and assisting patients to meet these criteria; and
   d. using de-escalation techniques, problem solving and collaboration with patients to formulate less restrictive interventions

C. Admission Assessment and Patient/Family Involvement:
1. The primary care physician performing the history and physical shall determine and document any pre-existing medical conditions, physical disabilities or limitations that may place the patient at greater risk during seclusion or restraint.

2. The admitting physician and RN shall assess the patient’s risk factors for behavioral emergency, ascertain any history of sexual or physical abuse or other trauma and ask the patient if he or she has an advance directive with respect to behavioral health care.

3. During admission, or as soon as feasible thereafter, the RN and physician shall discuss with the patient the Institute philosophy regarding seclusion or restraint use and involve the patient in identifying past successful strategies for preventing or managing dangerous behavior. The discussion shall be documented. The RN shall assist the patient to complete his/her Partnership for Safety plan (Appendix A), identifying, in addition to strategies for self-management, the patient’s preferences for emergency interventions if needed and identification of individuals the patient wishes to be notified if emergency behavioral interventions are needed. The Partnership for Safety Plan shall be incorporated into the patient’s Treatment Plan.

4. When authorized by the patient, the social worker shall discuss the Institute’s philosophy regarding seclusion or restraint use with the patient’s emergency contact, (family or significant others) and shall ascertain alternatives or strategies that have been effective in the past to prevent or manage behavioral emergencies. In addition, the social worker will ascertain if and when the emergency contact wishes to be notified of seclusion or restraint use. Whenever the patient has an authorized decision maker, that individual shall be involved in these discussions. Identified strategies, as well as desires for notification, shall be documented in the patient’s Treatment Plan.

5. In specific instances in which participation by the emergency contact or family may have a deleterious effect on the patient or his rights, the rationale for not discussing seclusion or restraint or contacting the family when seclusion or restraint is initiated must be clearly documented in the medical record by the social worker.

D. Early Intervention:

1. Consistent with the requirement for least restrictive interventions, whenever a patient begins to act in a manner that could indicate potential to escalate to becoming dangerous to self or others, clinical staff shall implement the interventions contained in the patient’s treatment plan or interventions appropriate to that crisis level.
2. Medications that are consistent with the patient’s treatment needs and are standard treatment for the patient’s medical or psychiatric condition may be utilized to support self management through targeting the symptoms associated with the behavioral dyscontrol.

3. If the interventions described in the treatment plan are not applicable to the current situation or are ineffective, clinical staff shall collaborate with the patient to identify and consider other less restrictive verbal, behavioral, recreational, self-soothing or diversionary interventions as well as environmental modifications to reduce stimulation.

4. Consideration must be given to patient preferences, utilizing interventions that have been previously effective for the individual patient as well as avoiding those that the patient and/or staff have identified as not being effective unless the assessment factors have changed.

5. In situations when less restrictive interventions are not feasible prior to initiating seclusion or restraint, staff must clearly document in the clinical record the immediacy of the threat, which lesser restrictive interventions were considered and why they were not utilized.

E. Initiation of Seclusion or Restraint

1. If the interventions described above cannot be safely implemented, are not feasible due to the immediacy of the risk, or are not effective in decreasing the likelihood of harm to self or others, then the patient shall be assessed by a Registered Nurse or Physician, and the assessment documented in advance, to determine the appropriateness of implementing seclusion or restraint on an emergency basis.

2. In an emergency, a staff person certified in the Department-approved behavioral interaction and crisis management techniques and who has met competency for application and removal of restraints may initiate a physical restraint. The staff member(s) shall use the least restrictive form of physical restraint needed to ensure the safety of individual patients and others. Under no circumstances may staff hold an individual’s jaw/chin closed or place something that could obstruct breathing over a patient’s nose or mouth. Under no circumstances may staff lie on, straddle or apply pressure to a patient’s chest/trunk while restraining the patient. An RN or physician must be immediately notified when a physical restraint is initiated.

3. Once a physical restraint is applied, a physician or an RN must personally:

   a. assess the patient within ten (10) minutes of his/her being physically restrained
b. identify the least restrictive measure, considering alternatives and patient preferences

c. make a determination of the need for continued physical restraint, mechanical restraint or seclusion

d. check the patient’s record for contraindications to seclusion or restraint use

e. check for the correct application of physical restraint and signs or reports of pain or injury

f. release the patient if alternatives are identified

g. initiate required mechanical restraint or seclusion and

h. inform the patient of the behaviors that he or she must demonstrate for release or for a reduction in restraint.

4. An RN must be present when seclusion or mechanical restraint is initiated. When implementing seclusion or restraint, staff shall assure the patient’s personal dignity and privacy by providing a protected environment, occurring away from other patients if possible.

5. Observing seclusion/restraint can be traumatizing for other patients. Staff members not involved in working with the individual patient will assist other patients away from the area of the seclusion or restraint and remain with them providing reassurance and support as needed.

6. Prior to placing a patient in seclusion or restraint, the reason for the procedure shall be explained to the patient by the RN or physician along with specific behavioral criteria for release. In rare situations where seclusion or restraint must be initiated prior to such an explanation, the reason for the procedure shall be explained to the patient as soon as the patient has regained sufficient control of his behavior to allow such an explanation to be given.

7. Prior to placing a patient in seclusion or mechanical restraint, the patient must be checked for any objects that might be used to injure him-or herself (i.e., shoes, matches, lighters, belts, jewelry, glass, sharp or potential breakable objects, etc.). These objects shall be removed and stored in a safe place for return to the patient when appropriate.

8. If an RN authorized the initiation of seclusion or physical or mechanical restraint, he/she will immediately contact a physician to obtain verbal or telephone order. The order shall meet the requirements outlined in F-5 (below) and the RN shall document in the clinical record the:
a. circumstances that led to the use of seclusion or restraint

b. names of staff who participated in applying the intervention

c. position (right arm, legs, etc.) that each staff person was assigned in the intervention

d. time, location, and antecedent behaviors and circumstances

e. less restrictive interventions attempted or why they were not attempted

f. behavioral criteria for release and that the patient was informed of criteria; or the patient behavioral changes that have occurred since initiation of physical restraint that enabled the patient to be released

g. name of physician contacted and time.

F. Physician Evaluation:

1. A physician’s face-to-face evaluation shall occur within 1 hour after the initiation of seclusion or restraint.

2. Prior to the face-to-face evaluation, the physician shall review with the RN the precipitating circumstances and less restrictive interventions utilized, review the documentation of risks for use, and review patient preferences or advance directives.

3. The face-to-face evaluation must include:
   
a. a review of the physical and psychological status of the patient

b. an evaluation of the patient’s response to seclusion or restraint

b. a determination of whether restraint or seclusion should be continued or terminated and

d. a discussion with staff of alternatives to facilitate release or a written order to release the patient.

4. The physician shall conduct the face-to-face evaluation within one hour even if the patient was released from seclusion or restraint in less than one hour.

5. The physician’s order for seclusion or restraint must include the following:
   
a. Descriptive of specific behaviors requiring seclusion or restraint
b. type of restraint selected

c. the maximum duration of the order, not to exceed 4 hours from initiation of the seclusion or restraint

d. specific measures for meeting the special needs of patients, (i.e., eyeglasses, hearing aides to remain with patient)

e. level of staff monitoring, if different from procedures described in this policy

f. descriptive behavioral criteria for release that reflect relationship to behaviors that led to need for seclusion or restraint; and

g. signature, date, and time.

6. The physician’s documentation in the clinical record must include:

a. the results of the physician’s one hour face-to-face evaluation

b. justification for use of seclusion or restraint

c. if contraindications exist, why the use of the procedure outweighs the known risks.

d. Signature, date, and time of face-to-face-evaluation

7. If the attending physician is not the physician who ordered the seclusion or restraint, the patient’s attending or covering physician will promptly be consulted regarding the seclusion or restraint use.

G. Assessment, Interventions, Care, and Monitoring During Seclusion or Restraint

1. The physician or RN shall notify the patient’s Social Worker that seclusion or restraint has been initiated. When authorized by the patient and desired by the family or emergency contact, the Social Worker shall notify the patient’s Emergency Contact (or others as indicated) of the need for seclusion or restraint. This dialog with the family/AR shall include exploration of his/her knowledge of patient triggers for escalation, identification of additional alternatives strategies to manage the current emergency as well as strategies that might help prevent future behavioral emergencies. Whenever the patient has an authorized decision maker, that individual shall be notified. The Nursing Supervisor shall perform this function from 4:45 p.m. to 8:00 a.m. weekdays and at all times on weekends and holidays.
2. When a patient is secluded or restrained, additional treatment measures to promote recovery of self-management and expedite release from seclusion or restraint shall be considered and implemented. Such consideration should include medications and verbal or behavioral strategies that may be useful to the clinical situation. The patient shall be involved in formulating strategies to promote release.

3. Care and monitoring of patients in seclusion or restraint, as well as the application and removal of restraints, shall be performed by individuals who have completed the designated training and have current competency. Specific procedures for the implementation of seclusion and the application of restraint, as well as for maintaining restraints, are contained in the NVMHI Nursing Procedures.

4. All staff providing assessments, care and monitoring shall assure patient privacy and dignity. In addition, staff shall observe for any signs of changing level of consciousness, as well as verbal expressions of pain or discomfort. If signs of pain or discomfort are observed or at any time a patient verbalizes discomfort, an RN shall be notified immediately to assess the patient.

5. Monitoring and interventions shall be performed by as follows:

   a. Patients in any type of mechanical restraint outside of seclusion shall be on constant observation or visual constant observation. A second staff member will check on both the staff member who is performing this level of special observation as well as the patient every 15 minutes and document as directed in the nursing procedure.

   b. Patients in seclusion shall be on visual constant observation. A staff member shall be stationed outside the seclusion room door, observing the patient continuously through the window. A second staff member will check the staff member and patient every 15 minutes and document as directed in the nursing procedure. A patient in both seclusion and restraint shall be on visual constant observation.

   c. Vital signs shall be taken and documented as least hourly.

   d. Patients in any type of restraints shall have the opportunity to exercise restrained limbs every 2 hours at a minimum or as the patient requires.

   e. Patients in seclusion or restraint shall be offered food at regularly scheduled dining hours and shall be offered fluids every hour while awake.
f. Special attention must be paid to the condition of skin area and limbs involved in restraint, to patients with unstable medical conditions requiring close monitoring and to the patient’s vulnerability to continued or reduced sensory input.

g. During the period of seclusion or restraint, verbal interaction shall be consistent with the treatment plan and directed toward assessment, monitoring, evaluating, the patient condition and supporting the patient to meet criteria for release. This should be accomplished in a manner consistent with the patient’s need for rest or stimulation. Staff shall discuss with the patient the behavior that must be demonstrated for release from seclusion or restraint and strategies to meet the behavioral expectations.

h. The patient shall have access to toilet facilities according to his/her needs or a minimum of every two (2) hours.

i. Any patient in seclusion or restraint for 24 consecutive hours shall be provided the opportunity to bathe at least once every 24 hours or more frequently if needed. Assistance shall be provided consistent with the patient’s condition.

j. Staff shall observe the patient for behaviors that demonstrate that the release criteria are met. In those situations where the patient is not demonstrating the identified release criteria but is demonstrating other types of behavior that indicate readiness for release, the physician shall be consulted to discuss revision of the release criteria order to include alternative behaviors.

6. Staff who monitor the patient will be alert to adequate lighting in the room, as well as adequate ventilation and comfortable temperatures.

7. Assessment by an RN shall be performed and documented every fifteen minutes unless more frequently ordered by the physician or determined by the RN. This assessment is directed toward determining the patient’s mental and physiologic status as well as response to seclusion or restraint. The assessment shall be performed through direct observation and interaction and must determine and respond to:

a. the patient’s need for exercise, hygiene, elimination, and nutrition/hydration

b. the patient’s need for circulation and range of motion in extremities

c. the need to measure vital signs
d. signs of injury or illness such as skin color, complaints of discomfort and level of consciousness

e. the physical and psychological status and comfort needs of the patient; and

f. readiness for discontinuation of restraint or seclusion

8. RN assessment every fifteen minutes may be conducted through the seclusion room window provided all aspects of the assessment can be accurately determined.

9. An RN shall conduct and document an in-person, face-to-face assessment of the patient’s physical and psychological status at least hourly.

10. An RN shall conduct an immediate in-person, face-to-face assessment of the patient’s physical and psychological status and document the assessment:

   a. Whenever there is a change in the patient’s level of consciousness or responsiveness (e.g., sleep, drowsiness)
   b. Whenever vital signs signal a change in physical status
   c. Whenever patient verbalizes distress or complains of pain
   d. In response to concerns raised by other staff monitoring the patient.

11. The RN shall evaluate the patient’s response to other interventions designed to promote release and engage the patient in formulating plans to promote safety, comfort, and expedite release.

12. Special attention should be directed toward patients whose cultural or functional needs or history of trauma may require individualized support and intervention.

H. Re-evaluation, Continuation and Release:

1. Unless otherwise ordered by the physician, patients in seclusion or restraint shall be released when sleeping.

2. When a patient exhibits the release criteria described in the written order, an RN or physician shall be notified immediately. The RN or a physician shall evaluate the patient to determine patient readiness for release. If the determination is made that a patient is exhibiting the behaviors indicated in the order but the patient is still not ready for release, the justification to
continue the seclusion/restraint must be documented in the clinical record and a new physician order obtained with alternative release criteria.

3. If a patient in seclusion or restraint for four (4) hours continues to exhibit behavior that poses danger to self or others, the physician or RN shall perform a face-to-face re-evaluation and consult with the Medical Director and Chief Nurse Executive. This consultation shall include consideration of interventions that would expedite release. If it is determined that the seclusion or restraint must continue, the following actions are required:

   a. Facility Director must be notified
   b. A new physician’s order shall be written
   c. Documentation completed to reflect the results of the re-evaluation and consultation with the Medical Director and CNE including continued need for seclusion and restraint, alternatives considered and rejected, and planned approaches and interventions to support expediting release, including possible alternative release criteria.

4. Verbal or telephone orders shall be accepted only by a RN, who will:

   a. Write the order on the physician’s order form in the clinical record consistent with expectations in F.5 of this policy
   b. Read it back to the physician for verification
   c. Note the date and time of the order, that it was a verbal or telephone order and that it was read back for clarification and confirmation
   d. Sign the order with the name of the physician giving the order and the RN receiving the order.

5. If the patient remains in seclusion or restraint for 8 hours, a physician shall perform a face-to-face re-evaluation and follow policy as set forth in F-3, a-d above.

6. Staff shall facilitate the patient’s re-entry into the treatment milieu following release from seclusion or restraint. This will include:

   a. Observation consistent with patient needs or physician order
   b. Transitional support such as quiet time or diversionary activities, according to the patient’s individual needs
c. Opportunities to discuss the experience privately with staff who will listen and clarify patient perceptions

7. When the patient is released from seclusion or restraint, the nurse, physician, patient and others shall participate in a debriefing within 24 hours after each episode. The debriefing shall include the patient, the family if appropriate and available staff who were involved in the episode. The debriefing involves:

a. Discussing the behaviors requiring seclusion or restraint, what led to the incident, how the patient’s behavior met the criteria for release and alternatives to avoid future seclusion or restraint, including changes to the patient’s Partnership for Safety Plan.

b. Determining if the patient’s physical and psychological needs and right to privacy were addressed during seclusion or restraint and advising the patient of the opportunity to discuss issues with the Human Rights Advocate.

c. Discussing and clarifying any possible misperceptions the patient may have concerning the incident.

d. Addressing any trauma that may have occurred as a result of the incident.

e. Modifying the patient’s treatment plan when indicated.

8. When the patient has been in restraint or seclusion the attending or covering physician shall assure that the use of seclusion or restraint is reviewed by the Treatment Team no later than 5 pm on the next weekday to develop a clinical strategy, including considering behavioral and pharmacological components to reduce the need for seclusion or restraint. This review shall include review of seclusion/restraint documentation and exploration of triggers, including milieu issues that may have contributed to the behavioral emergency. The treatment team shall make additions or revisions to the treatment plan that reflect any information learned from the patient debriefing and team review of the incident and document the team review in the patient record.

I. Documentation:

1. The patient’s attending physician or the MD covering for that physician shall review each episode of seclusion or restraint, including ensuring that the procedure was discontinued when the patient met the criteria for removal. He or she shall document this review by signing and dating all nursing documentation relating to seclusion or restraint. Additional relevant
observations and/or interventions should be documented by a physician progress note and adjustments to the treatment plan.

2. Nursing staff shall document patient behavior, lesser restrictive nursing interventions prior to seclusion or restraint and the patient response to lesser restrictive interventions according to directives in the NVMHI Nursing Procedures.

3. Other disciplines shall document patient behavior and relevant discipline specific interventions prior to or during the application of seclusion or restraint in the Interdisciplinary Notes.

4. Nursing staff shall make entries on ID Notes for Special Observations (Form #IDN-E-2) and on the ID Notes of RN Assessment While in Seclusion or Restraint (Form # IDN-5d) indicating the RN assessment every fifteen (15) minutes and describing patient behavior and staff interventions during visual or constant observation. Documentation shall include information on verbal and physical behaviors indicative of readiness for release from seclusion or restraint.

5. The RN shall review and sign or co-sign the flow sheets and document the RN assessment at 15-minutes intervals. Other aspects of nursing documentation shall follow Nursing procedures.

J. Reporting and Performance Improvement:

1. The Medical Director and Chief Nurse Executive shall monitor the use of seclusion or restraint on an ongoing basis in order to identify opportunities to improve care.

2. Quality monitor data for each seclusion/restraint event shall be reported to the Clinical Management Team (CMT) and will be reviewed by the CMT using pre-established quality criteria.

3. When the following thresholds are met, the attending or covering physician shall take actions as indicated below:

   a. When a patient has been in seclusion or restraint for 4 hours and an MD order to continue the seclusion/restraint has been obtained, the physician shall perform a face-to-face evaluation and consult with the Medical Director and Chief Nurse Executive to strategize interventions to support discontinuation of seclusion or restraint, to include a review of the criteria for release, options for less restrictive measures and the need for continuation.
b. When a patient has been in seclusion or mechanical restraint twice within a three day period, the head of the treatment team will request and document in the medical record a clinical review by a non-treating psychiatrist by the next weekday following the second seclusion or mechanical restraint event. The reviewing physician’s report will be documented in the clinical record within 24 hours of the request. This review shall include, but need not be limited to:

(1) a medication review for potential adverse effects manifesting as behavioral dyscontrol, ineffective or inappropriate dosage, toxic reaction drug-drug interactions and whether the chosen medication regimen is indicated for current diagnosis and

(2) review factors which precipitate, sustain or reinforce dangerous behavior including review of the treatment plan in relation to these factors.

c. If the same patient has 2 or more events of seclusion or restraint within the following 3 days the Medical Director and Chief Nurse Executive shall complete a review.

4. When a patient has been in seclusion or restraint for more than 96 hours in a seven (7) day period, the Medical Director will notify the DMHMRSAS Medical Director by the next weekday to request a medical or behavioral treatment peer review. This notification will be documented in the clinical record by the Medical Director.

5. Aggregate monthly seclusion or restraint data shall be analyzed by the Patient Safety and Risk Management Committee (PSRMC) on a monthly basis as part of their performance improvement activities. Minimum data sets shall include:

a. number of episodes

b. number of patients involved

c. number of hours

d. average number of hours per patient in seclusion or restraint

e. number and severity or patient and staff injuries

f. rates calculated per 1000 patient hours.
6. Based on trends identified by the above analysis the PSRMC may drill down data that would allow them to:

   a. Examine patterns or trends of seclusion or restraint use, e.g., that may be associated with patient, or staff characteristics, hospital location, times of day

   b. Identify opportunities to reduce the rate and improve the safety of restraint and seclusion use; and

   c. Identify any need to redesign care processes.

7. The Chair of the Patient Safety and Risk Management Committee shall report analysis of the seclusion and restraint data to the MEC on a monthly basis.

8. The Senior Management Team, in daily morning report, will receive reports of episodes of seclusion or restraint provided via CNE to assure that restraint and seclusion is limited to behavioral emergencies.

9. The Director of Quality and Risk Management will assure that all required data is reported to DMHMRSAS Quality Management Office as required.

10. All deaths and injuries associated with the use of seclusion or restraint will be reported by the Director of Quality and Risk Management/designee to the:

    a. Senior Management Team

    b. Central Office, Office of Risk Management

    c. Center for Medicaid Medicare Services

    d. Office of the Inspector General

    e. Virginia Office of Protection and Advocacy, and

    f. other external agencies, consistent with applicable law and regulation

11. DMHMRSAS will be notified if a regulatory or accreditation agency or third party payee identifies problems or noncompliance with seclusion or restraint standards.

12. All episodes of seclusion or restraint that do not conform to the Human Rights regulations or an approved variance will be reported to the assigned Human Rights Advocate and the patient’s Authorized Representative if applicable.
K. Maintaining the Seclusion Room or Restraint Devices

1. All restraint devices must be approved by the Medical Executive Committee prior to use. A list of all approved types of restraints and criteria for use shall be maintained by the Medical Director and the Chief Nurse Executive. The Chief Nurse Executive is responsible for overseeing the maintenance and cleanliness of restraints and for requesting new ones when necessary. All requests for replacement restraints must be submitted to the Chief Nurse Executive.

2. The physical safety, temperature, lighting, ventilation and cleanliness of the seclusion rooms are the responsibility for the Facility Administrator and his or her staff.

V. References:

1. Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services, September 2007

2. Psychiatric Uses of Seclusion, APA Press;


4. NVMHI Nursing Procedure II-21, Seclusion and Restraint

5. Therapeutic Options of Virginia (TOVA), Participant Manual

6. DI 211 (RTS) 00, Use of Seclusion and Restraint in DMHMRSAS Hospitals.