PURPOSE

The purpose of this procedure is to set forth conditions and procedures for the use of seclusion and restraint in ASH/SFSH. The procedure addresses the use of seclusion and restraint for behavioral management purposes.

PHILOSOPHY

In this regard, the procedure reflects a shift in the focus of requirements governing the use of restraints. Historically, requirements focused on the type of device or restraint being used, and the setting in which it was being employed. Under current federal regulations and JCAHO standards, requirements are tailored to the function or purpose of the restraint, i.e., is the restraint being used for medical purposes or for behavioral management purposes?

For behavioral management purposes, seclusion and restraint are interventions to be used only in emergency situations, and also only as a measure of last resort, to avoid imminent injury to the person served or others. For the purpose of this policy “imminent danger” is defined as behavior that has reached a level that any observing person would clearly rate as having the potential to cause serious bodily harm or death to the individual themselves or others in the immediate facility. To meet this definition the person threatening the behavior must have the means and the intent to follow through in the judgment of the observing person. This definition does not include simple refusal to follow instructions, noncompliance with rules where there is no clear or immediate danger, or simple property destruction. It is the goal of ASH/SFSH to significantly reduce the incidence of emergency situations that necessitate the use of seclusion and restraint and to make the use of seclusion and restraint a rare occurrence or non-existent.

Among the hospital’s purposes and goals are the provision of a safe and therapeutic environment, the reduction of danger, and the prevention of violent behavior. Historically the consumer of service has been viewed as the initiator of the reason for the use of S/R. Recent literature and national experts now believe that many, if not most, antecedents to conflict or violence reside in the environment of care, namely in a lack of understanding of how life experiences of trauma affect persons behaviors, treatment of persons served that demonstrate a lack of respect or an understanding of mental illness, general facility attitudes, operational rules and regulations, cultures of control and coercion, and intolerance for individualized treatment needs. In addition, while it is clear that violent behavior may lead to seclusion and restraint, in other instances the initiation of compliance mechanisms such as forced time out or stat calls may incite or increase violent behavior. A such, staff need to be skilled in recognizing antecedents to conflict so prevention interventions can be immediately deployed. Statistically, seclusion and restraint are associated with increased risk of injury to both person served and staff. The hospital’s goal is to become restraint and seclusion free.

Seclusion and restraint also may have deleterious effects on persons served, including those who are survivors of sexual trauma, physical abuse, persons with hearing impairments who are unable to communicate without the use of their hands and people with medical or physical risk factors. All persons admitted to the facility need to be assessed for these risks and this information communicated to unit staff on a routine basis in shift report.
assessing the need to use these interventions the potential for any negative impact of the procedure on the particular person served shall be considered.

The use of seclusion and restraint can be reduced or eliminated through the development of a reduction plan that is based on prevention, quality improvement principles, trauma informed care, and recovery constructs that include the creation and maintenance of an environment that decreases risk for conflict, immediately addresses conflict when it occurs and rigorously analyzes every events in real time with feedback loops to senior leadership. In general the facility CEO will be responsible and accountable for the implementation of this procedure and the reduction plant. It is the goal of this procedure to encourage this result.
I. DEFINITIONS:

A. Clinical Director or designee means the individual in charge of clinical services at a psychiatric facility, or a physician designated by that individual to carry out the responsibilities of the head of the clinical staff.

B. Comfort Room is a time out area designed and furnished in a way to encourage rest and relaxation through comfortable furniture, lighting, music, etc.

C. Four-point restraint means leather straps, encasing the wrists and ankles of a person lying on a bed, which are secured to the bed frame.

D. Two-point restraint means leather straps encasing one wrist and one ankle on opposite extremities.

E. One-to-one constant observation means a situation in which a staff member is responsible for maintaining continuous watch of a single person served, keeping the person served in view at all times, and, if clinically appropriate, attempting to initiate dialogue with the person served. Does not include monitoring through AC equipment.

F. One-to-One supervision means a situation in which a staff member maintains constant supervision at arms-length with a person served.

G. Restraint means any manual method or physical or mechanical device that restricts freedom of movement or normal access to one's body, material, or equipment, attached or adjacent to the person served body that he or she cannot easily move.

H. Seclusion means the placement of an individual alone in a room or area from which he or she cannot leave at will or believes they cannot leave.

II. GENERAL PRINCIPLES

A. The health and safety of the person served are the primary concerns of ASH/SFSH at all times. Therefore, whenever a person served demonstrates a need for serious medical attention in the course of an episode of seclusion or restraint, medical priorities shall supersede psychiatric priorities, including the immediate discontinuation of the use of restraint or seclusion.

B. Seclusion or restraint for safety purposes shall be employed only in emergency situations when necessary to prevent a person served from seriously injuring self or others, and less restrictive techniques have been tried and failed, or if it has been clinically determined that the persons served danger is of such immediacy that less restrictive techniques cannot be safely applied.

C. Seclusion or restraint for safety is not a treatment intervention and will not appear on a treatment plan as such. When S/R events occur, this indicates the need for an immediate post-event debriefing by the staff involved in the procedure, and, a formal causal analysis by the treatment team on the next working day using the JCAHO sentinel event process.

D. Seclusion or restraint shall not be used as punishment, for the convenience of staff, or as a substitute for quality and effective treatment programming. Staff who show a pattern or propensity to use S/R shall receive further training so that they can develop alternative practice strategies.

E. The criterion for release of a person served from seclusion or restraint for behavior management is achievement of the objective - i.e., that the person served no longer represents an imminent danger to
self or others, rather than the passage of a period of time or some behavior, verbal or physical, by the person in restraint.

F. Seclusion and restraint shall never be used simultaneously.

G. Seclusion or restraint use shall not be based on the individual's seclusion or restraint history or solely on a history of dangerous behavior.

H. It is against ASH/SFSH procedure to place objects on or over a person served face during restraint procedures. In situations in which precautions need to be taken to protect staff against biting and spitting during restraint episodes, the Senior Clinical Staff recommends that staff wear gloves, masks or clear face shields when possible for purposes of infection control. In no circumstances shall a person's face or mouth be covered during this procedure.

I. Mitts and helmets do not impair movement and therefore shall not be considered mechanical restraints. They shall be used only to prevent self-harm and/or self-injury as part of an individual treatment plan pursuant to a physician's order.

J. Manual restraint of an adult person served is against ASH/SFSH policy.

K. Notwithstanding section J above, manual restraint may be used for the limited purpose of facilitating the placement of a person served in mechanical restraints, secluding a person served, or administering court ordered treatment or emergency medication over objection following Crisis Prevention Institute techniques sanctioned by ASH/SFSH. In these situations all holds are considered restraint under this policy as per CMS Conditions of Participation.

L. All clinical staff shall demonstrate competence in alternatives to, and the appropriate application of, seclusion and restraint prior to participating in the restraint or seclusion of a person served. Techniques sanctioned and taught by ASH/SFSH staff must be employed. Excessive force shall not be used in initiating the use of seclusion or restraint. To enable staff to check the person served airway, care shall be taken to assure that persons served are not restrained in a face and chest down position at any time unless a specific medical reason exists with a accompanying physician order directing the same. In some take down situations it may be necessary for a person to be in a face down position temporarily. In general this situation will never last over one minute.

M. In the case of persons served who are known or reasonably believed to have a history of physical or sexual abuse, or in the case of persons served with hearing impairments who would be unable to communicate without the use of their hands, an explanation of why restraint is the most appropriate intervention under the circumstances shall be included in the persons medical record when an order for the use of restraint is written.

N. The standard forms of mechanical restraint are the two-point restraint, and four-point restraint.

O. In choosing among the permissible forms of intervention, staff shall utilize the least restrictive type that is appropriate and effective under the circumstances.

P. The facility shall convey the intention to make the use of restraint a rare occurrence, and to continue efforts to reduce the rate of such rare occurrences to zero occurrences, to persons served and to those families who are involved in the persons served treatment-planning process.

III. PROCEDURES
Seclusion or Restraint for Behavioral Management Purposes

1. Advance Preferences

   a) In determining the appropriate intervention for a specific person served in response to an emergency situation that may warrant seclusion or restraint, any preferences or recommendations provided by the person served must be considered and documented in the medical record. Toward this goal, the nursing assessment, which is completed on all admissions identifies techniques, methods or tools that would help the person served control his/her behavior, pre-existing conditions or physical disabilities and limitations that would place the person served at greater risk during restraint or seclusion and any history of sexual or physical abuse that would place the person served at greater psychological risk during restraint or seclusion. This information is obtained from the person served and family member if possible on admission. In addition, staff should help such persons served understand what factors contribute to the exacerbation of their dangerous behavior and what steps may be helpful to reduce such behavior. The de-escalation preference form is also completed for the persons served on the behavioral units due to the higher risk of use of seclusion and restraint on these units. The development of safety or crisis plans are recommended.

   Part of the de-escalation preference survey assessment procedure for persons served shall be an interview in which the following inquiries are made, as clinically indicated:

   1) What behaviors, situations or circumstances upset you?

   2) What techniques, methods or tools help you control your behavior and thus prevent crisis situations, and what methods help you regain control when you are experiencing loss of control? For example, would you like your family to play a role when you are having trouble controlling your behavior?

   3) What can staff do to assist you? What should staff not do?

   4) As a last resort in a crisis situation, do you have a preference for seclusion or a particular form of restraint?

   5) If seclusion or restraint is used as a last resort, do you want us to notify your family or an advocate of your choice?

   b) The information obtained from the nursing assessment and de-escalation preference form will ensure awareness of circumstances and actions that may serve as triggers for person served violent behavior and the measures that may help to prevent them.

   c) Any preferences expressed by the person served regarding the gender of the observing staff person shall be honored when practical and clinically appropriate.

2. Initiating Seclusion or Restraint

   a) The implementation of seclusion or restraint shall only be pursuant to a physician's written order, based on the results of a documented personal examination of the person served by the physician. Seclusion or restraint may be initiated prior to a physician’s written order as in section J below.
b) The examination of the person served, in one hour, conducted by the physician shall include an assessment of his/her mental status and physical condition, as well as a review of the clinical record for any pre-existing medical diagnosis and/or physical condition which may contraindicate the use of seclusion and/or restraint.

1) The mental status assessment shall include an assessment of the person served behavior, thought content, actual dangerousness to self or others, level of consciousness, and any other assessments which are clinically necessary. NOTE: The only reason that can justify the use of seclusion or restraint is imminent danger to self or others.

2) The physical assessment shall include an assessment of the persons served general condition and vital signs, and any other examinations that are clinically necessary.

3) The results of the examination shall be documented in the person served record, along with the inadequacies of less restrictive interventions and the specific behaviors that necessitated seclusion or restraint.

4) Whenever any elements of the examination cannot be performed due to the condition of the person served, an explanation for the omission and the physician's clinical observations of the person served shall be recorded.

5) Any prior medical diagnoses, conditions, or behaviors which may serve as relative contraindications to the use of seclusion or restraint, including but not limited to a history of physical or sexual abuse or hearing impairment, should be documented, as well as the physician's rationale for ordering such an intervention at this time.

c) The physician shall review the persons served existing medication orders and shall assess the need for modifying such orders during the period of restraint or seclusion. Documentation of this medication review shall be included in the persons served record.

d) The physician must document the time at which he or she personally examined the person served in the person served record.

e) The physician's written order shall:

1) be written on the Order Sheet and included in the person served record.

2) specify the facts and behaviors justifying the intervention and set forth the time of initiation and expiration of the authorization.

3) Include criteria for release.

4) specify the type of intervention to be used. If a physician orders the use of restraint, the written order shall specify the type of restraint to be used.

5) include any special care or monitoring instructions.
f) The maximum time period of orders of seclusion or restraint shall be four hours.

g) Seclusion shall not be used with persons with a sole diagnosis of mental retardation or a sole diagnosis of any other developmental disability. However, emergency seclusion shall be permitted for persons with a dual diagnosis of mental illness and mental retardation or any other developmental disability.

h) PRN orders shall not be used to authorize the use of seclusion or restraint.

i) The use of seclusion or restraint beyond a continuous 4-hour period requires written approval by the clinical director or his/her designee.

j) Seclusion or restraint may be initiated in the absence of a physician's written order if a person served presents an immediate danger to self or others and a physician is not immediately available to examine the person served. The procedure shall be employed in accordance with the following directives:

1) The procedure shall be initiated at the direction of a registered nurse, or ARNP.

2) A physician must be called immediately to conduct a personal examination of the person served. The registered nurse or ARNP shall note in the person served record the time of the call and the name of the physician contacted. All actions taken must be recorded on the Restraint or Seclusion Monitoring Form.

3) As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, the registered nurse or ARNP will obtain an order (verbal or written) from the physician and the physician will personally examine the person served as described above in 2b.

4) In no event shall seclusion or restraint be applied for longer than 60 minutes without the written order and personal evaluation of the person served by a physician.

5) If, based on the results of the physician's examination, the physician determines that the use of seclusion or restraint was and/or continues to be indicated, he or she shall write an order for the procedure consistent with the requirements. The order shall commence from the time at which the person served was initially placed in seclusion or restraints. The combined duration of the period specified in the physician's written order and the period of seclusion or restraint initiated by the registered nurse or ARNP shall not exceed 4 hours.

6) If, based on the physician's examination, it is determined that seclusion or restraint are not needed, the physician shall document his rationale in a progress note. This should not be interpreted as a reflection of the registered nurse's or ARNPs judgment, as the crisis may have passed.

k) Prior to placing a person served in seclusion or restraints, he or she shall be searched for potentially dangerous objects, and such objects shall be removed. In no event shall a person served be placed in seclusion in a nude or semi-nude state.

l) Implementation of the seclusion or restraint order shall be consistent with the Crisis Prevention Institute techniques sanctioned and taught by the hospital.
m) To enable staff to check the person served airway, care shall be taken to assure that persons served are not placed in a face and chest down position.

n) Immediately after the application of the seclusion or restraint, a physician or registered nurse shall conduct an assessment of the person served to ensure that the intervention was safely and correctly applied without undue harm or pain to the person served.

o) If the person served has granted permission for notification of his/her family and/or an advocate of the initiation of seclusion or restraint, a professional staff member shall promptly make such notification. If the seclusion or restraint is applied during the night, such notification shall occur the following morning. If a family has submitted a written request not to be notified of instances of seclusion and restraint, the facility shall honor this request.

p) If, at any time after application of seclusion or restraint, clinical assessment indicates that the person served no longer represents an imminent danger to self or others, release shall be immediate. This includes sleeping.

3. Monitoring Persons in Seclusion or Restraint

a) A person served in seclusion or restraint shall be monitored to ensure that his or her physical needs, comfort and safety are properly cared for. Such a person served shall receive one-to-one constant observation by a staff member who is trained and competent in hospital policies and procedures regarding seclusion and restraint, with demonstrated skills in minimizing the use of seclusion and restraint, assisting person served in meeting behavior criteria for the discontinuation of seclusion or restraint, assisting person served in meeting their physical needs (e.g., hydration, use of bathroom), assessing physical and psychological signs of distress of person served who are in seclusion or restraint, and recognizing readiness for the discontinuation of these interventions.

b) Although audiovisual monitoring may be useful for time-out, one-to-one observation shall be used to monitor persons in seclusion. 1:1 (arms length) supervision will be maintained for persons served in restraints.

c) A written assessment of the need for seclusion or restraint and of the general comfort and condition of the person served shall be done at the time of the initial application of the seclusion or restraint and every 15 minutes thereafter, or at more frequent intervals as directed by the physician. The assessment shall be recorded on the Restraint and Seclusion Monitoring Form.

d) In order to reduce the possibility of choking, in those rare occasions when the person served remains in restraint at mealtime, the person served shall be fed in an upright position and assisted with eating and hydration.

e) In order to assess the person served physical status during the use of seclusion or restraint, vital signs, consisting of blood pressure, temperature, pulse and respiratory rate shall be taken and recorded on the Restraint and Seclusion Monitoring Form according to the following guidelines:
1) For person served in restraint, vital signs should be taken immediately after application of restraint, hourly thereafter, and upon release, or more frequently as ordered by the physician.

2) For person served in seclusion, vital signs should be taken immediately after placement in seclusion and every two hours thereafter and upon release, or more frequently as specified by the physician.

3) If vital signs of a person served in seclusion or restraint cannot be taken safely at the frequency required, the reason for each omission shall be documented in the person served record.

f) Time limited orders do not mean that restraint or seclusion must be applied for the entire length of time for which the order is written. A person served shall be released from seclusion or restraint as soon as he or she no longer appears to be a continued imminent danger to self or others and meets the behavioral criteria for its discontinuation.

g) If restraint or seclusion needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from the physician and a personal evaluation is conducted by the physician. The Clinical Director and the Hospital Administrator will be notified of all repeating orders.

h) When restraint or seclusion is terminated before the time-limited order expires, that original order can be used to reapply the restraint or seclusion if the person served is at imminent risk of physically harming himself/herself or others and non-physical interventions are not effective.

i) It is the responsibility of the physician who has ordered seclusion or restraint to be accessible to staff in the event of an emergency. Accordingly, the physician shall advise appropriate staff how to contact him or her, or a relief physician, during the period of the order.

4) Reviewing the Use of Seclusion or Restraint

a) Upon the person served release, the registered nurse or ARNP shall conduct an in-person re-evaluation of the person served and write a progress note that includes a description of the person served response to the use of seclusion or restraint.

b) As soon as possible, but not longer than 24-hours following the episode of seclusion or restraint, the staff involved in the procedure, shall conduct and document a post-event debriefing to review what precipitated the episode and whether there are opportunities to avoid and/or manage future crisis situations with this person served and whether procedures were followed.

c) On the next working day following the use of seclusion or restraint, the treatment team and appropriate supervisory staff shall meet to review the episode with the person served if possible, and, if desired by the person served, an advocate and/or a family member to:

- identify what led to the incident and what could have been handled differently;
- explore with the person served what occurred from their perspective and what might have avoided this incident. Consumer advocates are recommended for person served interviews post restraint and to represent them at the debriefing if they do not wish to participate or cannot
- ascertain whether or not the individual's physical well-being, psychological comfort, and right to privacy were addressed;
- review whether or not the person served advance preferences were followed;
- assess the effectiveness of the strategies utilized to regain control;
- identify any alternative solutions for addressing or preventing future emergency situations;
- determine whether or not the person served suffered any traumas as a result of the incident and, if so,
- ensure that the person served is offered support and subsequent counseling, as clinically appropriate; and
- when indicated, modify the individual's treatment plan.

Any recommended solutions or intervention preferences offered by the person served shall be noted in the person served record. Such information shall be considered in future situations, and implemented whenever clinically appropriate.

d) It shall be part of the unit psychiatrist's responsibilities upon coming on duty to review the clinical record of any persons served for whom he or she is responsible who have been in seclusion or restraint since he/she was last on duty, and to ascertain their current status.

e) A report which indicates the utilization of seclusion or restraint shall be sent to the clinical director or designee on a daily basis. The report shall, at a minimum, include:

1) the person served name and unit;
2) the type of seclusion or restraint used;
3) the length of time that the person served was in seclusion or restraint for each written order;
4) the behaviors necessitating the intervention; and
5) any less restrictive techniques attempted and a statement of why they were found inadequate.

f) The clinical director or designee shall review the use of seclusion and/or restraint daily, and shall immediately investigate unusual or unwarranted patterns of utilization.

g) Multiple episodes of seclusion or restraint with an individual person served shall be reviewed by the person served treatment team and the clinical director or his or her designee. At a minimum, such reviews, which shall include a review of the person served treatment plan, shall be conducted whenever three or more orders are written for a given person served every 30 days. The review team shall include a senior psychiatrist and, if available, at least one peer advocate.

h) As part of the facility's performance improvement program, the incidence of violent behavior and the associated use of seclusion and/or restraint shall be monitored. Data regarding each order of seclusion and/or restraint shall be collected, analyzed, and reported to the Risk Management Office. These data shall be integrated into hospital performance improvement activities.
i) Injuries and deaths related to the use of seclusion and/or restraint shall be reported as incidents pursuant to the mandates of hospital policy and JCAHO standards. Staff injuries shall also be reported, pursuant to employee accident reporting policies.

j) The hospital shall report to CMS/JCAHO any death or serious injury that occurs while a patient is secluded and/or restrained, or in which it is reasonable to assume that the death is a result of seclusion and/or restraint. This notification will be made by the Hospital Administrator or his/her designee. Other notifications will also be made as per the law including the local P & A representatives

5) Training

a) The facility shall assure that clinical staff, including professional staff, as well as any staff that may be involved in seclusion and restraint, receive orientation and instruction in alternatives to both seclusion and restraint, the techniques of applying both seclusion and restraint, and the laws, regulations, policies and procedures governing the use of seclusion and restraint. The training shall also address the sensitization of staff regarding the use of seclusion and restraint and the viewpoints of persons who have experienced seclusion or restraint shall be presented using written or audiovisual material. A written record of training shall be maintained.

b) Such training must be provided, at a minimum, annually, with refresher courses provided on an annual basis.

c) Staff must initially demonstrate competency in all of the training areas identified in this procedure prior to their participation in the seclusion or restraint of a person served, and shall further be required to demonstrate such competence on an annual basis.