



## MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN

COMMONWEALTH OF PENNSYLVANIA \* DEPARTMENT OF PUBLIC WELFARE

DATE OF ISSUE  
June 1, 2001

EFFECTIVE DATE  
July 1, 2001

NUMBER: SMH-01-02

SUBJECT  
Use of Restraints, Seclusion and Exclusion  
in State Mental Hospitals and Restoration Center

BY:   
Deputy Secretary for Mental Health  
and Substance Abuse Services

### **SCOPE:**

State Mental Hospitals and Restoration Center

### **PURPOSE:**

To update and synthesize state wide policies and procedures for the use and monitoring of Restraint, Seclusion and Exclusion in OMHSAS operated facilities.

### **POLICY:**

State mental hospitals and South Mountain Restoration Center shall adopt and implement the attached procedures and practices relating to the use and monitoring of Seclusion/Restraint and Exclusion, and shall revise local policies and procedures, staff training requirements and monitoring practices accordingly.

### **BACKGROUND:**

It is the Office of Mental Health Substance and Abuse Services' belief that Seclusion and Restraint are not treatment but reflect treatment failure.

Since 1999, OMHSAS has become a recognized national leader in an emerging national movement to substantially reduce and ultimately eliminate these dangerous, emergency practices.

The attached policies reflect the substantial reduction in OMHSAS's use of these modalities since the first standardized policy was released in 1999, and take further steps toward the goal of ultimate elimination of their use.

This Bulletin synthesizes OMHSAS policies relating to seclusion and restraint developed since 1999, establishes additional controls on the use of restraint as a so-called protective device, integrates recent changes in HFCA and JCAHO requirements and adds evidence based best practices regarding seclusion and restraint safety and reduction.

**OBSOLETE BULLETINS:** OMHSAS 99-01 Use of Restraints, Seclusion and Exclusion in State Mental Hospitals; SMH-00-01 Use of Physical Restraint in State Mental Hospitals

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:  
The Medical Director's Office at 717-772-2351 or Bureau of Hospital Operations 705-8159

## **USE OF RESTRAINTS, SECLUSION, AND EXCLUSION IN STATE MENTAL HOSPITALS**

### **I. PHILOSOPHY OF CARE:**

The use of restraints, seclusion, and exclusion in a treatment setting must be directed by the values of the organization providing treatment. In order to affirm why and how restraint/seclusion/exclusion procedures are used, it is necessary to establish organizational values that guide and direct all administrative oversight and team involvement in providing treatment, while maintaining the safety of each individual patient.

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

- Restraint/seclusion/exclusion procedures may only be used as an intervention of last resort following a series of efforts by staff to promote less restrictive problem-solving by the patient and used only in emergency situations to prevent patients/residents from seriously harming themselves or others;
- Use of a restraint/seclusion/exclusion procedure is viewed as an exceptional or extreme practice for any patient;
- Once a restraint/seclusion/exclusion procedure is initiated, it shall be as limited in time as possible. Staff and the patients need to work together to lessen the incidence and duration of these procedures;
- All clinical staff with a role in implementation of restraint/seclusion/exclusion procedures must be trained and demonstrate competency in their prevention and proper and safe usage;
- Leaders of the hospital, leaders of clinical departments, and leaders of wards/units are held accountable at all times for the initiation, usage, and termination of restraint/seclusion/exclusion procedures. This accountability is demonstrated as a component of the hospital's Performance Improvement efforts and staff competency evaluations;
- The patient and family, as appropriate, are recognized members of the treatment team; as appropriate, family members shall be notified of each seclusion and restraint incident and of the department's policy regarding seclusion/restraint use.
- The Client Representative or Patient Advocate is recognized as a spokesperson for the patient and shall be involved in care and treatment, if the patient so desires (within the parameters of current law/regulation);
- The treatment plan shall address specific interventions to be used to avoid restraint/seclusion/exclusion procedures and shall address patient strengths and cultural issues;

- All decisions to initiate restraint/seclusion/exclusion procedures shall be based on assessment of the patient; assessments shall address history of sexual or physical abuse, violence history and medical/psychiatric issues that may be pertinent to seclusion or restraint practices.
- Patient/staff involvement in a post-procedure debriefing and discussion is essential to determine how future situations may be prevented or de-escalated by employing alternative problem-solving measures,
- Patient dignity shall be maintained to the extent possible during these procedures;
- Restraint/seclusion/exclusion procedures shall not be initiated or maintained as a substitute for treatment, as punishment, or for the convenience of staff;
- Restraint and seclusion are emergency safety interventions, not therapeutic techniques, but shall be implemented in a manner designed to protect the patient's safety, dignity and emotional well being.
- In administering restraints and seclusion, as well as in attempting to prevent its use and the necessity for subsequent/recurrent use, staff shall recognize and use the strengths of the patient, and remain sensitive to issues of cultural competence; and
- The commitment status of the patient requiring seclusion/restraint/exclusion shall be reviewed prior to initiating any of these procedures.
  1. Patients who are involuntarily committed may be placed in seclusion, restraint, or exclusion if indicated, but only when less restrictive measures and techniques have proven ineffective.
  2. If a patient in voluntary treatment (Legal Section 201) requires seclusion, restraint or exclusion, it is possible to utilize such measures if this has been agreed upon in the initial evaluation signed by the patient as part of the voluntary commitment procedure or via an advance directive. However, if the patient retracts or denies this agreement concerning possible restrictions and restraints, and refuses their use, an involuntary commitment must be obtained as soon as possible under the criteria, standards, and procedures of Legal Section 302 or 304C if seclusion, restraint or exclusion is ordered.
  3. Residents of the State Restoration Center are not subject to the provision of seclusion, restraints or exclusion. Should a resident require the use of one of these modalities for psychiatric reasons, commitment to a psychiatric treatment facility shall be initiated.
- The specific methods of implementing and monitoring these values are detailed in the following sections.

## **II. FAMILY NOTIFICATION:**

On admission of the patient, the patient's family shall be informed of the hospital's policies/procedures regarding the use of seclusion, restraint and exclusion. With the patient's informed consent, as documented in the medical record, designated family

members shall be informed of their opportunity to be notified of each incident of seclusion/restraint within a time frame agreed to by the family and to participate in the patient debriefing, as appropriate..

### **III. STAFF TRAINING:**

It is the Office of Mental Health and Substance Abuse's philosophy and policy that restrictive interventions may only be used as a last resort to protect patients and other persons from physical injury. Consequently, staff training shall focus upon the development of skills and abilities needed to assess risk, identify escalating behaviors, and effectively assist patients to maintain control and learn safer ways of dealing with stress, anger, fear and frustration.

Training of staff shall focus upon identifying the earliest precipitant of aggression for patients with a known, suspected, or present history of aggressiveness, and on developing treatment strategies to prevent exacerbation or escalation of these behaviors. Patient involvement in the identification of precipitants is paramount.

Training shall encompass the primary importance of patient safety, at all times during the seclusion or restraint process. This shall include the time preceding the placement of a patient into seclusion or restraint as well as the time spent in seclusion or restraint.

Training shall be provided to all direct-care staff during employment orientation and on an annual basis.

Staff training in seclusion and restraint techniques and policies shall result in initial certification/demonstration of competency for each staff person who will be authorized to employ them. Retraining, re-certification and demonstration of competency in the use of physical restraint shall occur annually.

Training in safe physical intervention techniques shall be provided only by approval/certified instructors using methodologies approved by OMHSAS.

Specific training components shall include:

1. hospital and OMHSAS policies and procedures relating to the use of, documentation and monitoring of seclusion and restraint;
2. assessment skills needed to identify those persons who are at risk of violence to self or others;
3. treatment interventions that will reduce the risk of violence and increase the patient's capacity to benefit from psychosocial rehabilitation and educational programs;
4. skills in developing patient education programs that will assist patients in learning more adaptive ways of handling the stress, frustration or anger that precipitates aggressive behavior;
5. treatment planning skills that will enable staff to better plan and coordinate treatment activities that will reduce the incidence of assaultive behaviors;

6. conflict resolution, mediation, therapeutic communication, de-escalation, and verbal violence prevention skills that will assist staff to diffuse and safely resolve emerging crisis situations;
7. the nature and identification of the possible negative psychological effects these measures may have upon some individuals, and positive therapeutic strategies to combat such effects;
8. medical precipitants to aggressive behavior;
9. understanding of how age, gender, cultural background, history of abuse or trauma and other personal experiences may effect a patient's response to physical contact, holds, mechanical restraints, seclusion or exclusion.
10. use of verbal de-escalation and crisis management techniques;
11. identification and use of less restrictive alternatives;
12. first aid and CPR;
13. use of safe physical intervention techniques and restraint techniques and devises;
14. use of alternative adaptive support or assistive devises and care strategies in lieu of protective restraints for body positioning and falls prevention;
15. recognition and management of signs of patient physical and psychological distress during seclusion and restraint, and appropriate follow-up;.
16. recognition of the behavioral and psychological indicators that restraint/seclusion may be safely terminated;
17. participation in debriefings; and,
18. expectations for documentation in the patient's medical record, the SI-815 and other PI data collection systems.

#### **IV. PATIENT AND STAFF DEBRIEFING:**

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

1. assisting the patient to develop an understanding of the precipitants which may have evoked the behaviors necessitating the use of the restrictive technique.
2. assisting the patient to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations/emotions/thoughts present themselves again;

3. developing and documenting a specific plan of interventions for inclusion in the Comprehensive Individualized Treatment Plan, with the intent to avert future need for restrictive techniques; and,
4. evaluating whether alternate staff responses and interventions could be more effectively used in the future.

The team member shall document the debriefing process in the patient's medical record.

Findings from the staff debriefing and proposed administrative changes or strategies to prevent recurrence shall also be documented on the SI-815 incident report to facilitate hospital internal review.

The debriefing processes shall be initiated within 24 hours of the end of each incident of Seclusion, restraint or exclusion, unless further delay is clinically indicated.

## **V. CONTINUOUS PERFORMANCE IMPROVEMENT MONITORING:**

.The leadership staff of each state mental hospital shall maintain a performance improvement program designed to continuously review, monitor, and analyze the use of seclusion, restraint and exclusion and issues related to these processes. Ongoing efforts to reduce utilization of these measures shall be employed.

The facility Chief Executive Officer and Assistant Superintendent for Clinical Services of each state mental hospital are responsible for assuring that ongoing documentation and monitoring of patients placed in seclusion, restraint or exclusion are maintained. Monitoring shall consist of reviewing the necessity for use or continuation of these measures based upon documentation of unsuccessful, less restrictive alternatives, and appropriate rationale and justification. Patient "debriefing", health teaching, clinical response to seclusion, treatment plan revisions, and incidents where the physician involved does not see the patient within thirty (30) minutes of the initiation of seclusion shall also be monitored.

Seclusion or restraint incidents in excess of 12 continuous hours, or more than one seclusion /restraint incident within 12 hours, shall be reported to the ASCS or his/her designee. Thereafter, the leadership is notified every 24 hours if either of the above circumstances continues.

Events triggering notification of the ASCS noted in "c.", above, shall prompt ASCS review of the patient record, and consultation with the patient's psychiatrist and other treatment team members regarding alternatives to seclusion and restraint. All incidents of seclusion, exclusion and restraint, regardless of type, shall be documented on the State's Risk Management Incident Reporting form (SI-815).

## **VI. SECLUSION:**

### **A. DEFINITION:**

A brief, time limited placement of a patient into a safe, well ventilated, furniture-free, visually observable locked room for the purpose of assisting the individual to regain emotional and physical control over his/her dangerous, destructive behaviors.

**NOTE:** Seclusion is **not** a modality utilized in the State Restoration Center.

**B. INDICATIONS:** Prior to the use of seclusion, the following criteria must be met:

1. All less restrictive options/interventions, including changes in pharmacological interventions, have been considered and attempted and have failed to diminish the patient's immediate danger to self and/or others. Documentation of all such efforts shall be entered into the patient's medical record, in addition to rationale and justification of the need for seclusion;
2. Unless clinically contraindicated, prior to the use of seclusion the patient shall be given a choice of treatment options that may assist with limiting the environmental stimuli and their consequent effects on the patient's emotional status. The reason/justification for seclusion shall be communicated clearly to the patient. Treatment expectations and the outcomes which should occur within brief, time limited intervals shall be carefully explained.

**C. CONTRAINDICATIONS:**

Seclusion shall **not** be used for patients who exhibit suicidal or self-injurious behaviors or who have any known medical condition which precludes the safe application of this modality (such situations shall be determined by the attending/on-call physician on a case-by-case basis).

**D. PROCEDURES:**

1. Each patient shall be made aware of the specific behaviors that necessitated the use of seclusion and those behaviors and mental status components which will terminate seclusion;
2. Individual treatment plans shall have goals and interventions established to change the behaviors precipitating the need for seclusion.;
3. Seclusion shall be used **only** with a physician's order. In emergency situations, a registered nurse may initiate the use of seclusion for the protection of the patient and/or others. The physician on duty/on-call shall be contacted immediately, and a verbal order may be obtained. The physician's order shall not exceed one (1) hour. Orders shall specify "up to" one (1) hour, rather than a predetermined amount of time. The physician involved shall see the patient within thirty (30) minutes of the initiation of seclusion (barring extenuating circumstances), and then shall write/countersign the order for the seclusion and document his/her assessment of the patient in the medical record. Specific behavioral criteria written by the physician shall specify when the seclusion may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before seclusion can be reordered;

4. Patients in seclusion shall be continuously monitored, face to face, through the seclusion room window or in the room itself.
5. Patients are to be removed immediately from the seclusion room once the danger to self or others is no longer imminent;
6. During the seclusion process, each patient's dignity and need for physical care shall be carefully monitored and addressed. Each patient's safety is of paramount concern and, as such, potentially dangerous clothing and objects shall be removed from the patient and the seclusion area. This, however, does not prohibit the use of appropriate non-dangerous attire or such things as may be therapeutically indicated (i.e., soft inanimate objects, magazines, etc.);
7. Patient physical needs shall be met promptly. Opportunity for personal care, including fluids, bathroom use, exercise, meals and hygiene, shall be provided, and the patient's physical condition assessed and documented at no less than 15 minute intervals during the seclusion incident.

## **VII. RESTRAINT:**

### **A. RESTRAINT FOR EMERGENCY BEHAVIOR CONTROL**

1. **DEFINITION:** use of manual holds or mechanical devices used to restrict movement of all or part of a patient's body in emergency situations in which the patient's violent behavior presents an immediate risk of physical harm to self or others, and less restrictive interventions have failed.
2. **EXPECTATIONS**
  - a. All members of the treatment planning team shall be involved in preventing and reducing the need for restraints by resolving the underlying problem which necessitates restraint.
  - b. Prior to the use of physical or mechanical restraint for aggressive behavior which presents an immediate danger to self and/or others, the patient (unless clinically contraindicated) will be given a choice of treatment options to enable him/her to regain self-control over the injurious behavior. The reason for restraint shall be communicated clearly to the patient. Behavioral expectations shall be clearly explained as conditions for release from restraint. Restraint shall never be used as substitute for treatment, as punishment, or for convenience of staff.
  - c. Only restraint devices and techniques approved by OMHSAS may be used according to manufacturers instructions and for the purpose intended. See Attachment #A.

- d. Staff shall demonstrate competence in recognizing signs of escalating behavior that could potentially lead to physically aggressive behavior, by intervening in a therapeutic manner to prevent escalation, and to assisting persons to learn alternative ways of dealing with stress and/or anger.
- e. The patient's Comprehensive Individualized Treatment Plan shall describe the therapeutic interventions to be used by staff when a patient's behavior is starting to escalate.
- f. Behaviors necessitating the use of restraints must be addressed on the patient's treatment plan. The overall goal is to eliminate the use of restrictive interventions. In doing so, it is essential that the patient's treatment plan clearly describe the dangerous behaviors necessitating treatment, identify the antecedents or causes of such behavior and prescribe coordinated and integrated treatment approaches that reduce or eliminate the dangerous behaviors. The treatment plan should also include treatment goals for the patient that will provide positive alternatives to behavior that is physically harmful to self or others.
- g.. Individual treatment plans shall have goals and interventions written to eliminate the need for restraints. Plans shall also include behavioral indicators of impending violent behavior and positive, constructive crisis interventions.

### 3. **PROCEDURES FOR THE USE OF MECHANICAL RESTRAINT DEVICES**

- a. Restraints are prescription devices and shall be used only with a physician's order. In emergency situations, a registered nurse may initiate the use of restraints for the protection of the patient and/or others. The physician on duty/on-call shall be contacted immediately and a verbal order may be obtained. The physician's order shall not exceed one (1) hour. Orders shall specify "up to" one (1) hour, rather than a pre-determined amount of time. The physician involved shall see the patient within thirty (30) minutes of the initiation of the restraints (barring extenuating circumstances), and then shall write/countersign the order for the restraints and document his/her assessment of the patient in the medical record. Specific behavioral criteria written by the physician shall specify under what conditions the restraints may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before restraints can be reordered;
- b. Patients in mechanical restraint devices shall be placed on constant 1:1 observation (at arm's length), and this action is to be documented by attending staff;
- c. Physical needs shall be met promptly. The patient's physical condition shall be assessed, and the opportunity for personal care, including fluids, bathroom use, exercise, meals and hygiene, shall be provided and

documented throughout each restraint incident at no less than 15 minute intervals.

#### **4. PROCEDURES GOVERNING THE USE OF PHYSICAL RESTRAINT/HUMAN HOLDS**

- a. Physical Restraint(PR) will only be used in situations where the person's behavior presents a clear threat of harm to self or others and it is necessary to use approved physical restraint techniques to prevent injury to self or others; this includes restraint necessary to apprehend an involuntary patient attempting to go AWOL. Staff shall always attempt to assist the person to regain control without the use of physical restraint or any other restrictive intervention.
- b. PR may only be used as long as absolutely necessary to protect the patient from injuring self or others" However, use of PR shall not exceed 10 minutes. If the patient has not gained control within this time period, the patient shall be transitioned to seclusion or mechanical restraint.
- c. The deliberate use of floor restraint techniques shall be avoided whenever possible. However, if floor techniques are used either inadvertently or by necessity, a minimum of two staff shall be involved in the restraint application, with a third staff person observing the patient for duress throughout the use of floor restraint. If insufficient staff are available to meet this condition, staff shall attempt to disengage from the floor hold, and wait for the patient to rise before reapplying restraint, if physical restraint continues to be needed.
- d. Use of physical restraint requires a physician's order. Physician's orders for physical restraint shall not exceed 10 minutes. The physician shall conduct a face to face evaluation of the patient within 30 minutes of initiation.
- e. Whenever physical restraint is used on a living area, or any area under the supervision of nursing staff, the Registered Nurse in charge of the patient's living area shall ensure that a Registered Nurse assesses the patient's mental and physical status within 10 minutes of PR initiation, the physician is notified, and a physician's order obtained.
- f. If the incident necessitating PR occurs on grounds, in an area not under the direct supervision of nursing staff, the following procedures are to be followed:

It is the responsibility of the supervisor of the staff who utilized PR to ensure that:

- the nursing supervisor responsible for the patient's ward is immediately notified and provided with the following information:
  - a description of what happened and why it was necessary to employ PR;
  - any injuries to the patient or staff involved;

- the current physical and behavioral status of the patient;
- the immediate need for additional staff assistance, if indicated.

- The incident is properly documented and the SI-815 is initiated by the person applying or observing the application of the restraint;
- The patient is safely returned to the ward, as soon as possible after the incident;
- Debriefing is provided to all staff involved in the incident.

It is the Nursing Supervisor's responsibility to ensure that:

- a Registered Nurse notifies the physician and obtains a verbal order.
- a Registered Nurse is promptly dispatched to the site of the restraint to assess and monitor the patient and determine next steps, and,
- additional staff are sent to the site to ensure staff and patient safety and to assist in the patient's safe return to the ward, if necessary.
- Physical restraint use may continue only so long as is needed to return the patient to his living area.

- g. If an incident requiring the use of physical restraint occurs off grounds, and a Registered Nurse is unavailable, the person applying or observing application of the restraint shall:

- attempt to ensure the safety of the patient, staff and the public in a manner affording the patient the most privacy and dignity possible;
- contact the hospital nursing department for assistance and direction, following local policy and procedure, as soon as it is safe to do so;
- provide the hospital contact person with the following information:
  - a description of what happened and why it was necessary to employ PR;
  - any injuries to the patient or staff involved;
  - the current physical and behavioral status of the patient;
  - the immediate need for additional staff assistance, if indicated.

The Nursing Supervisor shall:

- designate a nurse assigned to the patient's ward to assess the emotional and physical status of the patient immediately upon return to the hospital.
  - ensure that the attending psychiatrist or on-site physician is notified and a physician's verbal order for use of the restraint is obtained.
- h. A physician's order for any use of physical restraint must be obtained and the physician shall examine the patient within 30 minutes. If the incident occurs off grounds, the Registered Nurse shall notify the physician promptly when the patient is returned to the hospital and the physician examination shall occur within 30 minutes of the patient's return.

- i. Physical restraint shall only be used by staff with demonstrated competency in its use.
- j. Physical restraint used in an off grounds emergency may be used only so long as necessary to return the patient to his hospital living area.
- k. It is recognized that there may be emergency situations that require an individual to act quickly to prevent harm to the patient or others. Individual staff members should refrain from attempting to use physical management techniques alone unless absolutely essential. The following guidelines should be followed in a psychiatric emergency that involves violent behavior or the potential for violent behavior:
  - Attempt to establish rapport with the patient. Speak to the person in a calm manner. Acknowledge the patient's emotions and offer to help.
  - the first sign of escalating behavior, staff shall immediately summon help
  - If other patients or visitors could be placed in danger due to the escalating behavior, remove them from the area as soon as possible. Keep other patients from entering to the area.
  - Unless absolutely necessary to protect the patient, self or others, do not attempt to employ PR techniques alone. Wait for help to arrive.
  - If physical restraints are essential, only approved interventions in which the employee has demonstrated competency, may be employed.
  - Before and during use of any physical restraint technique, staff applying or observing the technique shall explain to the patient what is happening, why the restraint is being used, and what the patient must do to obtain release.
- l. Documentation requirements:
  - At least one staff person directly involved in the administration or observation of the physical restraint episode must document the incident in the patient's medical record;
  - The RN who assessed the patient must also record the findings of the assessment, along with any follow-up actions recommended.
  - The physician order and assessment shall all be documented in the medical record, as well as any ordered or recommended treatment changes.
- m. Documentation shall provide at least the following information:
  - when and where the incident occurred;
  - a clear description of the behaviors that necessitated use of PR;
  - a description of prior interventions tried and patient response;
  - a description of the PR techniques used and their duration;
  - a description of the patient's physical and emotional response during and subsequent to the restraint episode;
  - a description of how the patient's physical and emotional response was monitored during the incident;
  - a description of any injuries observed or suspected by staff, or reported by the patient;

- the time and location of the nursing assessment;
- the name of the physician notified , time of notification, name/title of employee notified, and any instructions or orders received from the physician upon notification;
- the time of physician examination and physician findings and orders.

## **B. PROTECTIVE RESTRAINT**

### **1. DEFINITION**

The use of restraint devices to restrict the movement of a person with a medical condition to prevent falls, achieve maximum body functioning, or promote normal body positioning, when the patient is unable to remove the restraining device without assistance.

### **2. INDICATIONS**

Protective restraint involving the use of gerichairs, chairs with trays, bed rails, straps or cloth devices used to position the patient, restrict freedom of movement or access to one's body, prevent falls, maintain posture and for other medical purposes shall only be used as a last resort, when:

- a. adaptive or assistive devices or environmental changes have failed to prevent patient injury,
- b. assessment of the patient's history and condition indicates the strong probability that substantial harm to the patient will occur in absence of temporary restraint;
- c. the risks of potential injury exceeds the known risks of injury and death associated with use of protective restraint.

### **3. EXPECTATIONS**

- a. As with restraint used for behavioral control in emergency situations, it is the goal of the OMHSAS to ultimately eliminate the use of protective restraint.
- b. Use of alternative interventions shall be added to the treatment plan to reduce the need for protective restraint. Such alternatives include physical therapy, ambulatory assertive devises, recliner chairs, alarms, perimeter beds, non-slip cushions or shoes, beds with shortened legs and safety belts removable by the patient.
- c. Use of protective restraint requires the written time limited order of the physician.
- d. The patient in protective restraint must be continually monitored and reassessed and the restraint removed as soon as the alternative measures for safety are feasible.

### **4. PROCEDURES FOR THE USE OF PROTECTIVE RESTRAINT**

- a. Restraints are prescription devices and shall be used only with a physician's order. In emergency situations, a registered nurse may initiate the use of restraints for the protection of the patient and/or others. The physician on duty/on-call shall be contacted immediately and a verbal order may be obtained. The physician's order shall not exceed one (1) hour. Orders shall specify "up to" one (1) hour, rather than a predetermined amount of time. The physician involved shall see the patient within thirty (30) minutes of the initiation of the restraints (barring extenuating circumstances), and then shall write/countersign the order for the restraints and document his/her assessment of the patient in the medical record. Specific behavioral criteria written by the physician shall specify under what conditions the restraints may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before restraints can be ordered;
- b. Patients in restraint devices shall be placed on constant 1:1 observation (at arm's length), and this action is to be documented by attending staff;
- c. Physical needs shall be met promptly. The patient's physical condition shall be assessed, and the opportunity for personal care, including fluids, bathroom use, exercise, meals and hygiene, shall be provided and documented throughout each restraint incident at no less than 15 minute intervals.

**5. PROTECTIVE RESTRAINT DOES NOT INCLUDE:**

- a. use of adaptive, assistive or positioning devices that can be moved or removed by the patient;
  - b. helmets used to prevent head injury;
  - c. wheelchairs, gerichairs or trays, safety belts, postural supports, orthopedic devices, or bed rails, if the patient can remove these devices, and,
  - d. alarmed chairs, beds or doorways.
6. Family notification, patient/staff debriefing, continuous quality improvement and staff training requirements contained in sections II through V of this bulletin shall also be applicable to the use of protective restraint.

**C. RESTRAINT FOR THE PURPOSE OF ADMINISTERING NECESSARY MEDICATION OR MEDICAL TREATMENT**

**1. INDICATIONS:**

Physical or mechanical restraints may be applied briefly to enable clinical staff to administer necessary medication or medical treatment consistent with established protocol in the following situations:

- a. To facilitate necessary medical treatment of a resisting or uncooperative patient who is adjudicated to be incompetent to make informed decisions about medical care, when a substitute decision-maker has given permission for the necessary treatment, under the provisions of Mental Health Bulletin 99-83-26;

- b. To permit administration of prescribed psychoactive medication or facilitate veni-puncture for laboratory studies required by the use of psychoactive medication to a physically resisting patient, in accord with Mental Health Bulletin 99-85-10;

2. **EXPECTATIONS:**

- a. Every effort to gain patient cooperation for essential medical procedures has occurred but failed.
- b. The restraint will be used only so long as is necessary to successfully complete the procedure.
- c. A time-limited physician's order for the restraint procedure is obtained reflecting the anticipated length of the procedure. PRN's and standing orders may not be used.
- d. The treatment plan shall be modified to address the patient's need for restraint.
- e. Provisions for patient debriefing, staff training, and continuous quality improvement contained in this bulletin are met.
- f. Procedures for mechanical or physical restraint use described in this bulletin are followed, depending on the type of restraint used. (Section VII, A3 or Section VII 4d).

**D. CONTRAINDICATIONS AND CONDITIONS FOR USE OF PHYSICAL HOLDS AND MECHANICAL RESTRAINTS**

- 1. Physical restraint may not be used on persons who have known medical or physical conditions where there is reason to believe that such use would endanger their lives or exacerbate a medical condition, e.g. fractures, back injury, pregnancy, etc. See Attachment B.
- 2. Choice of mechanical restraint devices and positioning of the body within shall be designated by a physician based on assessment of the patient's physical and psychiatric condition. See Attachment B.

**E. HUMAN HOLDS OR MECHANICAL DEVICES USED TO RESTRICT MOVEMENT OF ALL OR PART OF THE PATIENT'S BODY DO NOT CONSTITUTE RESTRAINT UNDER THE FOLLOWING CIRCUMSTANCES:**

- 1. Physical prompting, escorting or guiding of a person to assist in development or use of ADL's;
- 2. Physically holding a cooperative person in a manner that is necessary to administer needed medical, dental or nursing care;

3. Physically redirecting a nonresistant person to avoid a physical confrontation with another person;
4. Locked areas or wards for security or safety purposes;
5. Use of mechanical restraints for security purposes on forensic patients subject to criminal detention, outside of the forensic center's secure perimeter or in security emergencies, as required by law and Bulletin SMH 97-04.

## **F. CHEMICAL RESTRAINT**

### **1. DEFINITION:**

Chemical restraint shall mean the use of drugs or chemicals for the specific and exclusive purpose of controlling aggressive patient behavior, which restricts the patient's freedom of movement by rendering the patient semi-stuporous or unable to attend to personal needs.

Drugs administered on a regular basis, as part of the individualized treatment plan, and for the purpose of treating the symptoms of mental, emotional or behavioral disorders, and for assisting the patient in gaining progressive self control over his/her impulses, are not considered chemical restraints.

### **2. POLICY:**

It shall be the policy of the Department of Public Welfare and the Office of Mental Health and Substance Abuse Services that chemical restraints are not utilized at any state mental hospital or the Restoration Center.

### **3. CONTINUOUS PERFORMANCE IMPROVEMENT MONITORING:**

Chief Executive Officer of each state mental hospital and the Restoration Center, in conjunction with the Medical Staff, is responsible for assuring that ongoing drug utilization monitoring of patients/residents is maintained to ensure that chemical restraints are not prescribed. Leadership staff (including Nursing, Pharmacy, and Quality Improvement) and the facility Pharmacy and Therapeutics Committee shall maintain compliance with the provisions of this policy through the institution of performance improvement programs designed to continuously review, monitor, and analyze drug utilization.

## **VIII. EXCLUSION**

### **A. DEFINITION:**

The therapeutic removal of a patient from his/her immediate environment and the restriction of this individual to an unlocked (quiet) room for a brief, time limited period not to exceed 30 minutes, for the purpose of assisting the individual to regain emotional control. Exclusion involves the patient's cooperation in leaving the immediate environment and in remaining in another, specified area (e.g., unlocked seclusion room) with the door open and unlocked for a specified period of time. Each facility shall designate rooms/areas to be utilized for exclusion.

**B. THE FOLLOWING EVENTS ARE NOT CONSIDERED EXCLUSION:**

1. A patient's request to spend time in a private, unlocked room is not considered exclusion and should be granted where feasible and not clinically or therapeutically contraindicated;
2. Quarantine or other preventive health measures are not considered exclusion; and Exclusion is not a modality utilized in the State Restoration Center.

**C. INDICATIONS:**

Prior to the use of exclusion, the following criteria must be met:

1. All lesser restrictive treatment options/interventions, including the use of alternative pharmaceutical interventions have been considered and attempted and have failed to diminish the patient's escalating behavior. Documentation of all such efforts shall be entered into the patient's medical record as well as the necessary rationale and justification of the exclusion need;
2. Unless clinically contraindicated, prior to the use of exclusion the patient shall be given a choice of treatment options that may assist with limiting the environmental stimuli and their consequent effects on the patient's emotional status. The reason/justification for exclusion shall be communicated clearly to the patient. Treatment expectations shall be carefully explained, including the outcomes which should occur within brief, time limited intervals; and
3. Exclusion is an adjunct to treatment with defined clinical parameters of expected care and, therefore, shall never be used in a punitive or otherwise non-therapeutic manner.

**D. CONTRAINDICATIONS:**

Exclusion shall not be utilized for patients who exhibit suicidal or self-injurious behaviors for who have a known seizure disorder or any other medical condition, which precludes the safe application of this modality (such situations shall be determined by the attending/on-call physician on a case-by-case basis).

**E. PROCEDURES:**

1. Each patient shall be made aware of the specific behaviors that necessitated the use of exclusion and those behaviors and mental status components which will terminate the exclusion;
2. Individual treatment plans shall have goals and interventions established to eliminate the need for exclusion;
3. Exclusion shall be used only with a physician's order. In emergency situations, a registered nurse may initiate the use of exclusion. Immediately the physician on duty/on-call shall be contacted and a verbal order may be obtained. The physician's order shall not exceed 30 minutes. Orders shall specify "up to" thirty (30) minutes,

rather than a predetermined amount of time. The physician involved shall see the patient within thirty (30) minutes of the initiation of exclusion (barring extenuating circumstances) and then shall write/countersign the order for the exclusion, and document his/her assessment of the patient in the medical record. Specific behavioral criteria written by the physician shall specify when the exclusion may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before exclusion can be reordered;

4. Patients in exclusion shall be monitored/checked at routine intervals not to exceed fifteen (15) minutes;
5. Exclusion shall not affect the rights of an individual to basic sustenance, clothing, or communication with appropriate or responsible persons (i.e., family, attorneys, physicians, patient advocates, or clergy); however, any person wishing to visit the patient in exclusion must gain authorization from the attending/on-call physician;
6. Patient physical needs shall be met promptly. Opportunity for personal care, including fluids, bathroom use.

**COMMONWEALTH OF PENNSYLVANIA**  
**DEPARTMENT OF PUBLIC WELFARE**  
**OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**  
**February 3, 1999**

**SUBJECT:** Guidelines for the use of physical management and mechanical restraint techniques

**TO:** CEOs, State Mental Health Facilities and Assistant Superintendents for Clinical Services

**FROM:** Steven Karp, D.O.  
Medical Director

In recent months national attention has been directed toward the techniques used to restrain and physically contain persons hospitalized for psychiatric treatment, living in residential treatment settings, residing in nursing homes and even those who are incarcerated, during crisis in which their behavior poses a danger of harm to self or others. Following press reports of the death of persons subject to physical or mechanical restraint, the National Alliance for the Mentally Ill called upon the federal government to investigate and provide oversight into patient deaths in restraint. Pennsylvania Protection and Advocacy has requested we officially ban restraint practices which may have adverse medical consequences, and JCAHO had published a summary and analysis of sentinel event restraint death root causes, with recommendations for safer practice.

We have subsequently affirmed that each hospital's use of physical and mechanical restraint application techniques is based on a variety of private sector training and certification programs. These programs usually include verbal and nonverbal crisis de-escalation techniques, self-defense and physical containment strategies to promote safe physical management of the patient. Training in these certified programs is required at the time of employment, usually for all staff in patient contact assignments, and annually for all direct care staff engaged in actual physical management of patients (i.e. nursing). Internal hospital policies were subsequently developed to require use of the techniques taught in these programs.

Safe physical management technique training was originally mandated for all direct care staff in state mental hospitals over 15 years ago, using a copyrighted training program provided by OMH through a private vendor. During subsequent years, some hospitals have updated the curricula, or contracted with new vendors for this service.

Consequently, the systems in place across the state are no longer consistent. Although none of these systems appears to teach techniques that are now known to increase risk of harm during the physical management or restraint of patients, they may not explicitly prohibit the methods and techniques that are more likely to incur a risk to patient safety nor describe the reasons for such risk.

The purpose of this memorandum is to apprise all Superintendents and Assistance Superintendents for Clinical Services of the following risk factors and guidelines for the prevention of restraint deaths. They shall ensure that hospital policy and direct care staff training reflect these guidelines.

A. Factors contributing to risk of asphyxia during physical management and restraint:

- Cocaine induced excited delirium (impaired thinking, disorientation, visual hallucinations, etc.) may increase the heart rate to a critical level when the patient is being restrained or is confined to restraints.
- Drug or alcohol intoxication reduce respiratory drive, diminishing the individual's realization that suffocation is occurring.
- The patient who engages in extreme violent activity and struggles may be more vulnerable to subsequent respiratory failure during physical intervention and restraint.
- Sudden unresponsiveness or limpness during or immediately after a struggle may indicate cardiopulmonary events that warrant immediate medical attention.
- Pre-existing risk factors combined with body position can compound the risk of sudden death, particularly following a struggle. These risk factors include:
  - Obesity
  - Alcohol and drug use
  - An enlarged heart (stress and low blood oxygen enhance the susceptibility to cardiac arrest)
  - Smoking
  - Deformities that preclude proper restraint positioning
  - Emphysema, bronchitis, asthma, colds and other respiratory conditions enhance risk, especially if the patient is placed face down.

B. Procedural factors that increase risk during the restraint process:

- All of the above pre-existing risk factors are exacerbated when the patient is placed in a face down position and/or when "hands are held behind the back" holds or restraints are employed.
- When the patient is held or restrained in a face down (prone) position, lungs are compressed and breathing may become labored. The more pressure that is applied to the person's torso, the more compression is increased.
- Restraint in a supine (face up) position may predispose the patient to aspiration.
- Inadequate numbers of staff to safely manage mechanical restraint application may increase the likelihood that staff will place their body weight across the patient's back, or use her unsafe practices which enhance the danger of patient injury.
- Failure to search the patient for contraband when placed in mechanical restraints can result in fire from attempted use smoking materials, or other self-harm.
- Placing a pillow, blanket or other item under or over the patient's face as part of a restraint or holding process, especially when the patient is in a prone position may result in suffocation.
- Use of high neck vests are blamed for strangulation deaths in geriatric patients, as are use of unprotected split side bed rails.
- Incorrect application of a mechanical restraint device enhances strangulation potential.
- Techniques which pull the patient's or employee's arms across the neck contribute to risk of asphyxiation.
- Leaving a patient in mechanical restraints without continuous staff observation precluded timely corrective action in response to physical distress.

C. Guidelines for safe physical management and restraint.

Effective immediately, the following practices shall be adopted and incorporated into staff training curricula:

1. No fewer than 3 staff persons shall be present to apply mechanical restraints. If insufficient staff are available to safely control and restrain a patient in a psychiatric crisis, staff should remove others from harm's way and get help before attempting physical management or restraint.
2. At no time is pressure to be placed upon the patient's back while the patient is in the prone position in a floor control situation. Patient arms, shoulders, and legs are to be immobilized. Staff body weight is not to be applied to the torso or above the upper thighs.
3. Patients in restraints must be placed under a physician's order for constant staff observation for the duration of the restraint.
4. Patients placed in seclusion or restraint must always be promptly searched for contraband.
5. High neck vests or waist restraints are not to be used for body positioning in geriatric or long term care settings, nor is any patient to be restrained to a bed with unprotected split side rails.
6. Never place a towel, bag, blanket or other cover over a patient's face during the physical management process.
7. If a patient is placed under floor control in a prone position for the purpose of administering an injection or application of mechanical restraint, the patient shall be rolled/turned to the supine (face up) position as soon as the procedure is completed, unless the risk or act of vomiting is present.
8. When restraining patients in a supine position, ensure that the head is free to rotate. The head of the bed should be elevated to minimize the risk of aspiration, unless clinically contraindicated.
9. Physicians writing initial and renewed orders for restraint shall assess, consider and document the patient's pre-existing physical condition when ordering the body position, number and manner of mechanical restraints.

Deviation from the above guidelines for clinical reasons in individual cases must be documented and approved by the Assistant Superintendent for Clinical Services.

In the coming months, I will be reviewing available physical management technologies and training programs with the Assistant Superintendent for Clinical Services and the Statewide Risk Management Committee to select a statewide training curriculum. Until then, please be sure that your staff are made aware of the aforementioned risk factors and policy guidelines.

cc: Mr. Curie  
Mr. Kopchick  
Ms. Hardenstine

**COMMONWEALTH OF PENNSYLVANIA**  
**DEPARTMENT OF PUBLIC WELFARE**  
**OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**  
May 15, 2000

**SUBJECT:** Mechanical Restraint Devices

**TO:** CEOs, State Mental Health Facilities

**FROM:** Steven Karp, D.O  
Medical Director, OMHSAS

And

George A. Kopchick, Jr., Director  
Bureau of Hospital Operations

The purpose of this memorandum is to revise OMHSAS 99-01, specifically the section entitled Restraints: Treatment Expectations, Section B, located on p.8 of that Bulletin, which describes the mechanical restraint devices which are acceptable for use for psychiatric purposes in the state mental hospital system. This memorandum is also intended to delete obsolete devices currently listed in the ERPS Manual, Appendix B.

Effective immediately, restraint devices which can be legitimately used for psychiatric purposes are limited to those found in the following list. The two-letter code adjacent to the device is the ERPS code for the device, which will be incorporated into the SI-815 in the very near future.

**Permitted Devices:**

**Soft Velcro**

a a one point  
a b two point  
a c three point  
a d four point  
a f soft mitts

**Leather Restraint**

b c two point  
b i three point  
b i four point

All body restraints listed in the OMHS 99-01 and/or the ERPS Bulletin, Appendix B are henceforth prohibited for psychiatric purposes. The category of "Psychological Restraint" coded on Appendix B, code sheet 3, of the E/R/P/S Manual is also abolished.

Items (c b) helmets and (d b) geri chair may continue to be used as "protective or adaptive devices" under the conditions listed on p. 7 of OMHSAS 99-01, under the section entitled "Excluded from the Definition of Restraint," but are not to be used as restraint devices to control acute or episodic aggressive behavior.

Metal restraints may be used only in forensic units, for security purposes, and only during the transport of such patients outside of the forensic unit's secure perimeter as described in Bulletin SMH-95-02. Metal restraints may not be used to control acute or episodic aggressive behavior or as a substitute for other restraint devices for any purpose described in Bulletin OMHSAS-99-01.

Any mechanical restraint not included in the list of approved devices listed above is prohibited.

Requests to introduce new or additional devices to the above list must be approved in writing by the OMHSAS Chief of Clinical Services and the Director, Bureau of Hospital Operations.

cc: Mr. Curie  
Assistant Superintendents for Clinical Services  
Performance Improvement Directors  
Assistant Superintendents for Nursing Services