



# MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN

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SUBJECT:

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

BY:

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**SCOPE:** State Mental Hospitals and Restoration Center

**PURPOSE:** To update and synthesize statewide policies and procedures for the use and monitoring of restraint, seclusion, and exclusion in OMHSAS-operated facilities.

**POLICY:** The 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.

**GOAL:** The Office of Mental Health and Substance Abuse Services (OMHSAS) has established the goal of eliminating the need for the use of Mechanical Restraint and Seclusion in State Mental Hospitals.

**BACKGROUND:** OMHSAS espouses the belief that seclusion and restraint are not treatment or clinical interventions and reflect treatment failure.

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

The attached policies reflect the substantial reduction in use by OMHSAS of these modalities since the first standardized policy was released in 1999, and take further steps toward the goal of ultimately eliminating the use of these interventions.

This Bulletin synthesizes OMHSAS policies relating to seclusion and restraint developed since 1999, establishes additional controls on the use of restraint as a protective device, integrates recent changes in Center for Medicare Services (CMS) and Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requirements, and adds evidence-based best practices regarding seclusion and restraint safety and reduction.

**OBSOLETE BULLETINS:** SMH-01-02 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 at 717-705-8152, P.O. Box 2675, Harrisburg, PA 17105.

# 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 person.

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 responses by the person served and used only in emergency situations to prevent people from seriously harming themselves or others.
- The application of floor restraint techniques is prohibited for use within the State Mental Hospitals and Restoration Center.
- The use of any restraint technique where the person served is in the prone (face-down) position is strictly prohibited.
- Use of a restraint/seclusion/exclusion procedure is viewed as an exceptional or extreme practice for any person.
- Once a restraint/seclusion/exclusion procedure is initiated, it shall be as limited in time as possible. Staff and persons served need to work together to reduce the incidence and duration of these procedures.
- All clinical staff with a role in implementing restraint/seclusion/exclusion procedures must be trained and demonstrate competency in their proper and safe use.
- Leaders of the hospital, of clinical departments, and of wards/units are held accountable at all times for the initiation, use, 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 person served and his/her 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 person served and shall be involved in care and treatment, if the individual so desires (within the parameters of current law/regulation).
- Mental Health or Psychiatric Advance Directives shall be referenced and used in the development of individualized plans to eliminate seclusion and restraints. The treatment plan shall address specific interventions to be used to avoid restraint/seclusion/exclusion procedures and shall address each individual's strengths and cultural issues.
- All decisions to initiate restraint/seclusion/exclusion procedures shall be based on assessment of the individual; assessments shall address history of sexual or physical abuse, violence history, and medical/psychiatric issues that may be pertinent to seclusion or restraint practices.
- Involvement of the person served and staff in a post-procedure debriefing and discussion is essential to determine how future situations may be prevented or de-escalated by employing alternative measures.
- An individual's 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, and shall be implemented in a manner designed to protect the individual'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 individual served, and remain sensitive to issues of cultural needs.
- The commitment status of the individual requiring seclusion/restraint/exclusion shall be reviewed prior to initiating any of these procedures.
  1. Individuals who are involuntarily committed may be placed in seclusion, restraint, or exclusion if indicated, and only when less restrictive measures and techniques have proven ineffective.
  2. If an individual in voluntary treatment (Legal Section 201) requires seclusion, restraint, or exclusion, it is possible to use such measures, if this has been agreed upon in the initial evaluation signed by the

individual as part of the voluntary commitment procedure or via an advance directive. However, if the individual 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 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.

## **II. FAMILY NOTIFICATION**

On admission of an individual, his/her family (as appropriate and approved by the individual) shall be informed of the hospital's policies/procedures regarding the use of seclusion, restraint, and exclusion. With the individual'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 post-incident debriefing, as appropriate.

## **III. STAFF TRAINING**

It is the philosophy and policy of OMHSAS that restrictive interventions may only be used as a last resort to protect individuals served and other persons from physical injury. Consequently, staff training shall focus upon the development of skills and abilities needed to assess risk, to identify escalating behaviors, and effectively to assist individuals 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 individuals with a known, suspected, or present history of aggressiveness, and on developing treatment strategies to prevent exacerbation or escalation of these behaviors. Involvement of individuals served in the identification of their precipitants is paramount.

Training shall encompass the primary importance of individual and staff safety at all times during the seclusion or restraint process. This shall include the time preceding the placement of a person 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 a quarterly basis.

Training in safe physical intervention techniques shall be provided only by approved/certified instructors using methodologies approved by OMHSAS. The specific methodologies approved for use are:

- Response Training Programs  
708 Wendell Road  
Shutesbury, MA 01072  
413-367-2485  
[www.ResponseTrainings.com](http://www.ResponseTrainings.com) email: [info@responsetrainings.com](mailto:info@responsetrainings.com)
- Crisis Prevention Institute, Inc.  
3315-K North 124<sup>th</sup> Street  
Brookfield, WI 53005  
1-800-558-8976  
[www.crisisprevention.com](http://www.crisisprevention.com) email: [info@crisisprevention.com](mailto:info@crisisprevention.com)
- Comprehensive Crisis Management  
Western Psychiatric Institute and Clinic  
Office of Education and Regional Programming  
3811 O'Hara Street  
Pittsburgh, PA 15213

**Note:** These training vendors will be maintained until a single vendor is identified for the State Mental Hospitals and Restoration Center.

Specific training components shall include:

1. Hospital and OMHSAS policies and procedures relating to the use, 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 individual's capacity to benefit from psychosocial rehabilitation and educational programs.
4. Skills in developing education programs that will assist individuals in learning more adaptive ways of handling the stress, frustration, or anger that precipitates their aggressive behavior.
5. Treatment planning skills that will better enable staff to 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 how age, gender, cultural background, history of abuse or trauma, and other personal experiences may affect an individual'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. Use of safe physical intervention techniques and restraint techniques and devices.
13. Use of alternative adaptive support or assistive devices and care strategies in lieu of protective restraints for body positioning and prevention of falls.
14. Recognition and management of signs of a person's physical and psychological distress during seclusion and restraint, and appropriate follow-up.
15. Recognition of the behavioral and psychological indicators that restraint/seclusion may be safely terminated.
16. Participation in debriefings.
17. Expectations for documentation in the individual's medical record, the SI-815, and other PI data collection systems.

#### **IV. INDIVIDUAL 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 individual for the purpose of:

1. Assisting the individual to identify the precipitants that may have evoked the behaviors necessitating the use of the restrictive technique.
2. Assisting the individual to develop appropriate coping mechanisms or alternative behaviors that could be effectively used 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.
4. Evaluating whether alternative staff responses and interventions could be more effectively used in the future.

A team member shall document the debriefing process in the individual'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.

The hospital clinical leadership staff shall review every incident of seclusion, restraint, or exclusion and the debriefing results.

## **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 use of these measures shall be employed.

The facility Chief Executive Officer (CEO) and Chief Medical Officer (CMO) of each State Mental Hospital are responsible for assuring that ongoing documentation and monitoring of individuals 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. "Debriefing" of persons served, health teaching, clinical response to seclusion, treatment plan revisions, and incidents where the physician involved does not see the individual within thirty (30) minutes of the initiation of seclusion shall also be monitored.

Seclusion or restraint incidents in excess of two (2) continuous hours, or more than one seclusion/restraint incident within 12 hours, shall be reported to the CMO or his/her designee. Thereafter, the leadership is notified every 24 hours if either of the above circumstances continues.

Events triggering notification of the CMO, noted above, shall prompt a CMO review of the individual's record, and consultation with the person'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 an individual into a safe, well-ventilated, furniture-free, visually observable locked room for the purpose of assisting the person to regain emotional and physical control over his/her dangerous, destructive behaviors.

**NOTE:** Seclusion is not a modality used in the 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 individual's immediate danger to self and/or others. Documentation of all such efforts shall be entered into the person'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 individual shall be given a choice of treatment options that may assist with limiting the environmental stimuli and their consequent effects on the person's emotional status. The reason/justification for seclusion shall be communicated clearly to the individual. 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 persons 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). The treatment teams shall develop

a list of “do not seclude” individuals as a component of the ongoing safety efforts for individuals served. The list is to be reviewed and updated on an ongoing basis, but no less than every thirty (30) days.

#### **D. PROCEDURES:**

1. Each person 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. The physician on duty/on-call shall be contacted immediately. The attending (on-site/on-call) physician shall be responsible to review the documentation of attempted prior interventions with Nursing before writing an order for the use of seclusion. The attending (on-site/on-call) physician shall be responsible to interact with and assess the individual before writing an order for the use of seclusion. When extenuating circumstances bar the immediate presence of the physician, he/she may give a verbal/telephone order for the initiation of seclusion. Seclusion may not be initiated by Nursing staff without the presence of a written or verbal/telephone order from the physician. The physician’s order shall not exceed thirty (30) minutes. Orders shall specify “up to” 30 minutes, rather than a pre-determined amount of time. The physician involved shall see the individual within thirty (30) minutes of the initiation of seclusion (barring extenuating circumstances), and then shall write/ countersign the order for seclusion and document his/her assessment of the individual in the medical record. Specific behavioral criteria written by the physician shall specify under what conditions seclusion may be discontinued, to insure minimum use. When a physician’s order has expired, the individual must be seen by a physician and his/her assessment of the person documented before seclusion can be reordered. Verbal/ telephone orders for continuation shall only be permitted in the event of extenuating circumstances where the physician cannot be present.
4. Individuals in seclusion shall be continuously monitored, face to face, through the seclusion room window.
5. Individuals 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 person’s dignity and need for physical care shall be carefully monitored and addressed. Each person’s safety is of paramount concern and, as such, potentially dangerous clothing and objects shall be removed from the individual and the seclusion area.
7. An individual’s physical needs shall be met promptly. Nursing staff shall provide an opportunity for personal care, including fluids, bathroom use, exercise, meals, and hygiene, and the person’s physical condition assessed by the Registered Nurse and documented at 15-minute intervals during the seclusion incident.
8. The treatment team shall be required to meet with the hospital’s Executive Staff/Council on the next working day following the seclusion use to discuss the incident and their plans to reduce and eliminate the need for this intervention.

## **VII. RESTRAINT**

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

#### **1. DEFINITION:**

Any method of restricting a person’s freedom of movement, physical activity, or normal access to his/her body. For the purpose of this bulletin, permissible restraints shall include mechanical devices and physical/manual holds. Either method shall only be utilized in emergency situations where an individual’s behavior presents an immediate risk of physical harm to self or others, less restrictive interventions have failed, and the specific technique is prescribed by a physician.

## 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 individual (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 person. 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 the convenience of staff.
- c. Only restraint devices and techniques approved by OMHSAS may be used according to manufacturers' instructions and for the purpose intended. Permitted devices are: two-point soft Velcro and four-point soft Velcro restraints. Any mechanical restraint not included in the list of approved devices above is prohibited.
- 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 individual's Comprehensive Individualized Treatment Plan shall describe the therapeutic interventions to be used by staff when a person's behavior is starting to escalate.
- f. Behaviors necessitating the use of restraints must be addressed on the individual's treatment plan. The overall goal is to eliminate the use of restrictive interventions. In doing so, it is essential that the person'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 person 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

**Storage:** Where mechanical restraints shall be maintained.

- Storage of mechanical restraints shall be limited to the central nursing office or another central area designated by the Chief Executive Officer.
- Storage shall consist of at least one full set (Velcro only) of mechanical restraints.

**Cleaning:** Each facility shall have a written procedure for the cleaning of mechanical restraints as a component of the Infection Control Program.

**Access:** How staff are to access the mechanical restraints.

- The individual's Mental Health or Psychiatric Advance Directive and/or ITP shall be accessed by staff prior to the use of the mechanical restraints.
- Staff are required to document all attempted prior interventions.
- The Nursing Supervisor or Nursing Manager is responsible to sign out and sign in the mechanical restraints.
- The Nursing Supervisor or Nursing Manager is responsible to review the documentation of attempted prior interventions.

### **Conditions:**

- a. Restraints shall be used only with a physician's order. The physician on duty/on-call shall be contacted immediately. The attending (on-site/on-call) physician shall be responsible to review the documentation of attempted prior interventions with Nursing before writing an order for the use of mechanical restraints. The attending (on-site/on-call) physician shall be responsible to interact with and assess the individual before writing an order for the use of mechanical restraints. When extenuating circumstances bar the immediate presence of the physician, he/she may give a verbal/telephone order for the initiation of the mechanical restraints. Mechanical restraints are prohibited to be applied by Nursing staff without the presence of a written or verbal/telephone order from the physician. The physician's order shall not exceed thirty (30) minutes. Orders shall specify "up to" 30 minutes, rather than a pre-determined amount of time. The physician involved shall see the person within thirty (30) minutes of the initiation of the restraints (barring extenuating circumstances, e.g., on-site physician is involved in a medical emergency on another ward), and then shall write/countersign the order for the restraints and document his/her assessment of the individual 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 individual must be seen by a physician and his/her assessment of the person documented before restraints can be reordered. Verbal/ telephone orders for continuation shall only be permitted in the event of extenuating circumstances where the physician cannot be present.
  - b. Staff shall provide for an individual's privacy for all mechanical restraint use. Persons in mechanical restraint devices shall be placed on constant 1:1 observation (in accordance with the hospital procedure), and this action is to be documented by attending staff.
  - c. The treatment team shall be required to meet with the hospital's Executive Staff/Council on the next working day following the mechanical restraint use to discuss the incident and their plans to reduce and eliminate the need for this intervention.
  - d. The treatment teams shall develop and maintain a list of consumers who have a prior history of trauma and/or physical/psychological conditions. The lists shall be forwarded to the hospital's central Nursing Office for distribution to all physicians and the Chief Executive Officer (or designee). The CEO and CMO will develop and maintain a list of "do not restrain" individuals as a component of the ongoing safety efforts for individuals served. The list is to be reviewed and updated on an ongoing basis, but no less than every thirty (30) days.
  - e. Treatment plans shall include a comprehensive plan for the reduction and elimination of mechanical restraints. The treatment team shall be required to review, revise, and document the ITP within 24 hours of the incident, or the next routine working day.
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 PR techniques to prevent injury to self or others. Staff shall always attempt to assist the person to regain control without the use of PR or any other restrictive intervention.
  - b. PR may only be used as long as absolutely necessary to protect the person from injuring self or others. However, use of PR shall not exceed ten (10) minutes. If the individual has not gained control within this time period, staff are to disengage the hold, reassess the situation and need for further intervention, including an additional application of PR, or transitioning to seclusion or mechanical restraint.
  - c. The application of floor restraint techniques is prohibited for use within the State Mental Hospitals and Restoration Center. In the event the individual reaches the floor during the physical restraint period, staff shall disengage the PR technique.

- d. Use of physical restraint requires a physician's order. Physician's orders for physical restraint shall not exceed ten (10) minutes. The physician shall conduct a face to face evaluation of the individual within thirty (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 person's living area shall ensure that a Registered Nurse assesses the individual's mental and physical status within ten (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 person'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 individual or staff involved;
  - . the current physical and behavioral status of the individual;
  - . 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 individual 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 person and determine next steps.
- Additional staff are sent to the site to ensure the safety of the individual and staff and to assist in the individual's safe return to the ward, if necessary.
- Physical restraint use may continue only as long as is needed to return the person to his/her 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 individual, staff, and the public in a manner affording the person 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. The nursing department may solicit the assistance of the hospital's security department.
  - 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 individual or staff involved;
    - . the current physical and behavioral status of the individual;
    - . the immediate need for additional staff assistance, if indicated.

The Nursing Supervisor shall:

- Be responsible to go to the area and assess the situation.
- Designate a nurse assigned to the person's ward to assess the emotional and physical status of the individual 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 individual within thirty (30) minutes. If the incident occurs off grounds, the Registered Nurse shall notify the physician promptly when the person is returned to the hospital, and the physician examination shall occur within thirty (30) minutes of the person's return.

- i. Physical restraint used in an off grounds emergency may be used only so long as necessary to return the individual to his/her hospital living area.
- j. It is recognized that there may be emergency situations that require an individual to act quickly to prevent harm to the person 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 individual. Speak to the person in a calm manner. Acknowledge the person's emotions and offer to help.
  - At the first sign of escalating behavior, staff shall immediately summon help.
  - If other people under care or visitors could be placed in danger due to the escalating behavior, remove them from the area as soon as possible. Keep other individuals from entering the area.
  - Unless absolutely necessary to protect the individual, 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 PR technique, staff applying or observing the technique shall explain to the individual what is happening, why the restraint is being used, and what the person must do to obtain release.
- k. Documentation requirements:
  - At least one staff person directly involved in the administration or observation of the PR episode must document the incident in the person's medical record;
  - The RN who assessed the person must also record the findings of the assessment, along with any follow-up actions recommended.
  - The physician's order and assessment shall all be documented in the medical record, as well as any ordered or recommended treatment changes.
- l. 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 the person's response.
  - A description of the PR techniques used and their duration.
  - A description of the person's physical and emotional response during and subsequent to the restraint episode.
  - A description of how the individual's physical and emotional response was monitored during the incident.
  - A description of any injuries observed or suspected by staff, or reported by the individual.
  - 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 person 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 individual, 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 injury to the person.
- b. assessment of the individual's history and condition indicates the strong probability that substantial harm to the person will occur in absence of temporary restraint.
- c. the risks of potential injury exceed 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 ultimately to 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 assistive devices, recliner chairs, alarms, perimeter beds, non-slip cushions or shoes, beds with shortened legs, and safety belts removable by the individual.
- c. Use of protective restraint requires the written time limited order (up to one [1] hour) of the physician.
- d. The individual in protective restraint must be continually monitored and reassessed and the restraint removed as soon as the alternative measures for safety are feasible.

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

- a. use of adaptive, assistive, or positioning devices that can be moved or removed by the individual.
- b. helmets used to prevent head injury.
- c. wheelchairs, gerichairs or trays, safety belts, postural supports, orthopedic devices, or bed rails, if the person can remove these devices.
- d. alarmed chairs, beds, or doorways.

**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 individual 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 venipuncture for laboratory studies required by the use of psychoactive medication to a physically resisting person, in accord with Mental Health Bulletin 99-85-10;

**2. EXPECTATIONS:**

- a. Every effort to gain an individual's 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 person's need for restraint.
- e. Provisions for the individual's 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.
- 2. Choice of mechanical restraint devices and positioning of the body within shall be designated by a physician based on assessment of the person's physical and psychiatric condition.

**E. HUMAN HOLDS OR MECHANICAL DEVICES USED TO RESTRICT MOVEMENT OF ALL OR PART OF A PERSON'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 people 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 behavior of an individual, which restricts the person's freedom of movement by rendering the person 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 person 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 used at any State Mental Hospital or the Restoration Center.

**3. CONTINUOUS PERFORMANCE IMPROVEMENT MONITORING:**

The 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 use monitoring of individuals/residents is maintained to ensure that chemical restraints are not prescribed. Leadership staff (including Nursing, Pharmacy, and Performance 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 use.

## **VIII. EXCLUSION**

### **A. DEFINITION**

The therapeutic removal of an individual 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 thirty (30) minutes, for the purpose of assisting the individual to regain emotional control. Exclusion involves the person'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 used for exclusion.

**Note:** exclusion is not a modality used in the State Restoration Center.

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

1. A person'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.

### **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 person's escalating behavior. Documentation of all such efforts shall be entered into the individual's medical record as well as the necessary rationale and justification of the need for exclusion.
2. Unless clinically contraindicated, prior to the use of exclusion the individual shall be given a choice of treatment options that may assist with limiting the environmental stimuli and their consequent effects on the person's emotional status. The reason/justification for exclusion shall be communicated clearly to the person. Treatment expectations shall be carefully explained, including the outcomes which should occur within brief, time-limited intervals.
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 individuals who exhibit suicidal or self-injurious behaviors or 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 person shall be made aware of the specific behaviors that necessitated the use of exclusion and those behaviors/mental status components which will terminate the exclusion. In the event the individual is not cooperative to this intervention, the exclusion shall be terminated.
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 individual 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 individual in the medical record. Specific behavioral criteria written by the physician shall specify when the exclusion may be discontinued, to insure minimum use. When a physician's order has expired, the person must be seen by a physician and his/her assessment of the person documented before exclusion can be reordered.

4. Individuals 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 individual in exclusion must gain authorization from the attending/on-call physician.
6. An individual's physical needs shall be met promptly and shall include opportunities for personal care, including fluids and bathroom use.