pennsylvania
DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN

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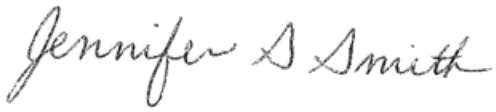
April 2, 2024	April 2, 2024	OMHSAS-24-01

SUBJECT:

Use of Restraints, Seclusion, and Exclusion at State Mental Hospitals

BY:



Jennifer Smith, Deputy Secretary
Office of Mental Health and Substance Abuse Services

SCOPE:

State Mental Hospitals:

Civil Sections
Regional Forensic Psychiatric Centers
Act 21 Sexual Responsibility and Treatment Program

The following are not addressed within the scope of this bulletin:

Use of seclusion and restraint at South Mountain Restoration Center, which is a licensed nursing home following Centers for Medicare & Medicaid Services (CMS) guidelines for standards of nursing home care, including those related to seclusion and restraint.

Use of mechanical restraint at the forensic centers for patients subject to the conditions of criminal detention, as defined and determined by the *Mental Health Procedures Act* (Act of Jul. 9, 1976, P.L. 817, No. 143); such restraints are instead subject to the governance in the *Mental Health Procedures Act* and Office of Mental Health and Substance Abuse Services (OMHSAS) Bulletin OMHSAS-16-08, *Security Guidelines for Regional Forensic Psychiatric Centers* when movement outside the facility occurs. Within the forensic buildings, the guidance within this bulletin applies.

PURPOSE:

This bulletin updates OMHSAS policies and procedures regarding approved and prohibited restraint, seclusion, and exclusion practices in state mental hospitals to further OMHSAS' efforts to reduce these practices in state mental hospitals.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
Office of Mental Health and Substance Abuse Services, Bureau of Policy, Planning and Program Development, P.O. Box 2675, Harrisburg, PA 17105. General Office Number: 717-772-7900
Email: RA-PWOMHSASBULLETINS@pa.gov

BACKGROUND:

OMHSAS has made great strides since 1999 in safely reducing the use of restraint, seclusion, and exclusion in state mental hospitals. The updates to this bulletin reflect OMHSAS' commitment to further reducing the use of these practices in state mental hospitals.

DISCUSSION:

State mental hospitals shall update their local policies and procedures to reflect the updated requirements in this bulletin. Language has been changed to remove the use of "manual hold" and now refers to "physical restraint." Additional changes have been made to clarify a number of definitions.

OBSOLETE BULLETIN:

This Bulletin obsoletes Bulletin OMHSAS-09-06, *Use of Restraints, Seclusion and Exclusion in State Mental Hospitals and Restoration Center*.

ATTACHMENT:

Use of Restraints, Seclusion, and Exclusion at State Mental Hospitals

Use of Restraints, Seclusion, and Exclusion at State Mental Hospitals

I. Philosophy of Care

Patients served at state mental hospitals are human beings who have the right to receive care in a setting that affords them dignity, respect, and physical safety. Accordingly, each patient has the right to be free from physical abuse, mental/emotional abuse, and corporal punishment, as well as any form of restraint, seclusion, and/or exclusion imposed as a means of coercion, discipline/punishment, substitute for treatment, the convenience of personnel, or retaliation by personnel.

Restraint types include physical restraint, mechanical restraint, and chemical restraint. The use of mechanical restraint, chemical restraint, seclusion, and exclusion are prohibited at state mental hospitals.

While permissible at state mental hospitals, use of Physical Restraint (PR) is subject to the governance in this bulletin. Personnel shall treat patients with respect during every interaction and, if application of a PR is required, personnel will make reasonable efforts to maintain the patient's dignity and privacy to the extent possible.

PR is not a therapeutic intervention and is instead a last-resort emergency safety intervention. The application of PR creates substantial risk for the involved patient and personnel and, thus, shall only be imposed to (1) prevent the immediate physical harm of the patient and/or another individual when therapeutic, less restrictive interventions have been determined to be ineffective to protect the patient and/or another individual from immediate physical harm or (2) in limited circumstances, to facilitate medically necessary medical treatment, shall be discontinued at the earliest possible time.

II. Definitions

Abuse – the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish; "willful" means that personnel acted deliberately, not that they intended to inflict injury or harm.

Chemical restraint – use of a drug or medication that is not a standard treatment or dosage for the patient's condition as a restriction to manage the patient's behavior or restrict the patient's freedom of movement.

- ❖ Chemical restraint is prohibited at all state mental hospitals.

Comprehensive, individualized patient assessment – a point-in-time assessment of the patient's current physical, mental, and emotional states and potential physiological causes of any behavioral changes the patient is exhibiting.

Easily remove – the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by personnel, considering the patient's physical condition and ability.

Exclusion – the therapeutic removal of a patient from their immediate environment and the restriction of the patient to an unlocked (quiet) room with the door open for a period of time not to exceed 30 minutes, with the patient's consent and cooperation in order to assist the patient in regaining emotional control.

- ❖ Exclusion is prohibited at all state mental hospitals.

Immediate threat of physical harm – the patient's observed behavior credibly indicates that the patient imminently intends to, or is presently acting to, physically injure themselves and/or physically assault another individual.

Mechanical restraint – a type of physical restraint in which a device, material, or equipment immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely; Office of Mental Health and Substance Abuse Services (OMHSAS)-approved physical restraint excludes mechanical restraint.

- ❖ Mechanical restraint is prohibited at all state mental hospitals.

Medical Prescriber- refers to medical staff operating within the scope of their license, such as a Doctor of Medicine (MD) or a Doctor of Osteopathic Medicine (DO).

Medically necessary – services rendered and supplies furnished are proper and needed for the diagnosis or treatment of a patient's medical condition, are rendered for the diagnosis, direct care, and treatment of a patient's medical condition, meet the standards of good medical practice in the local area, and are not mainly for the convenience of the patient or the healthcare practitioner.

Neglect – a type of abuse in which there is a failure to provide the goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Patient's representative – as defined and determined by Centers for Medicare & Medicaid Services (CMS) Medicare State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Rev. 200, 02-21-2020, §482.13 (a)(1) *Condition of Participation: Patient's Rights, Notice of Rights.*

Personnel – commonwealth employees, annuitants, per diem/agency staff, and contract staff working at state mental hospitals.

Physical assist – physically assisting a patient in completing an activity of daily living (ADL), preventing an accidental injury to a patient, or receiving some type of care/treatment with the patient's consent and cooperation; if the patient verbally or physically resists, this is a physical restraint.

Some examples of physical assist include helping to steady a patient who has lost their balance, physically supporting a patient in standing up from a seated position and steadying a patient's shaking arm while they voluntarily undergo venipuncture for lab work.

Physical escort – using a light touch which the patient can easily remove to guide or redirect the patient to a desired location with the patient's consent and cooperation; if the patient verbally or physically resists and/or is unable to easily remove the touch, this is a physical restraint.

Physical restraint (physical hold, or "hands-on") – any manual method that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely; OMHSAS-approved physical restraint excludes mechanical restraint.

PR using OMHSAS-approved techniques and in compliance with regulatory requirements, and the requirement in this bulletin is a time-limited emergency safety intervention permitted to be used in state mental hospitals.

Positive attributes and experiences – assets such as strengths, activity interests, coping skills, past successes in handling challenges, achievements, supports, past successes in self-de-escalation, appropriate emotional outlets, and motivations.

Prescriber – A healthcare practitioner, including a physician, Certified Registered Nurse Practitioner (CRNP), who is Pennsylvania state-licensed, and hospital credentialed to provide medical or psychiatric services subject to the bylaws, rules, and regulations of the organized medical staff.

Psychiatric Prescriber- refers to medical staff operating within the scope of their license and as authorized by CMS, such as a psychiatrist or CRNP.

Restraint – any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely.

Seclusion – the involuntary confinement of a patient alone in a room/area from which the patient is physically prevented from leaving or has the perception that personnel will physically intervene if the patient attempts to leave the room/area.

- ❖ Seclusion is prohibited at all state mental hospitals.

Standard treatment or dosage – Criteria used to determine whether the use of one or more drugs/medications is a standard treatment or dosage for the patient's condition include all of the following:

(1) The drug/medication is used within the pharmaceutical parameters approved by the U.S. Food and Drug Administration and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters, and

(2) The use of the drug/medication follows national practice standards established or recognized by the medical community or professional medical associations/organizations, and

(3) The use of the drug/medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the prescriber's knowledge of that patient's expected and actual response to the drug/medication, and

(4) The overall effect of the drug/medication is that the patient can more effectively or appropriately function in the world around him/her than would be possible without the use of the drug/medication.

III. Patient Notification

Upon admission to a state mental hospital, patients and/or their representatives will be informed that mechanical restraint, chemical restraint, seclusion, and exclusion are prohibited; patients and/or their representatives will be informed of the state mental hospital's policy and procedures regarding PR, including patients' related rights. Patients' representatives will be notified of their right to be informed when the patient has undergone PR and to participate in the post-PR debriefing.

Patients capable of giving informed consent have the right to elect that individuals important to them are notified if they undergo PR and are invited to participate in the post-PR debriefing. Upon admission to a state mental hospital, patients capable of giving informed consent shall be asked if there are individuals they would like to be notified of a PR and invited to participate in the post-PR debriefing. Such elections will be documented in the patient's medical record. Patients capable of giving informed consent may change their elections at any time and changes shall be documented in the patient's medical record.

If, in the medical opinion of a psychiatric prescriber, notification to an individual elected by the patient would cause severe mental or emotional injury, the psychiatric prescriber may determine that notification should be withheld from the elected individual. This determination must be made after every incidence of PR and the psychiatric prescriber shall document their decision and rationale in the patient's medical record.

Upon admission to a state mental hospital, patients with court-appointed guardians of person shall be informed that the guardian(s) of person will be notified of each PR and will be

invited to attend the post-PR debriefing. Notification of court-appointed guardians is not at the discretion of psychiatric prescribers.

IV. Treatment Planning to Prevent PR

Successful reduction of PR relies on a coordinated effort by the personnel treating the patient to develop and execute an individualized, comprehensive treatment plan which effectively addresses the patient's needs.

Assessment and treatment planning begin upon admission and are ongoing processes that include identifying the patient's triggers, stimuli, pattern of behavior, signs of escalation, and factors contributing to and/or causing the patient to engage in self-injurious behavior and/or physical assault of other individuals, as well as the patient's positive attributes and experiences—as defined above—which can be employed in identifying effective alternatives to PR. Input from the patient is critical during this process and allows personnel to craft individualized therapeutic interventions for the patient.

Each patient's treatment plan shall describe the therapeutic interventions to be employed by treating personnel when the patient's behavior is starting to escalate, in order to prevent the need for PR. The treatment plan shall specifically describe the patient's behaviors that present an immediate threat of physical harm to the patient and/or another individual, identify the underlying causes of such behavior, and prescribe specific therapeutic interventions aimed at immediately reducing or eliminating the behavior without the use of PR.

V. Comprehensive, Individualized Patient Assessment

The decision to use a PR shall be driven solely by a comprehensive, individualized patient assessment and not factors such as the patient's diagnosis, a request by the patient or the patient's family for a PR, or the convenience of personnel.

Components of a comprehensive, individualized patient assessment shall minimally include:

A. Assessment of the patient's physical condition to identify whether physical symptoms are causing or contributing to any present negative behavioral changes. Some examples of symptoms/conditions which may cause or contribute to behavioral changes include hypoxia, pain, drug interactions, infection, electrolyte imbalances, hunger, and dehydration.

B. Assessment of the patient's mental and emotional conditions to identify any factors causing or contributing the patient's present negative behavioral changes, as well as any underlying causes of the factors. Some examples of factors which may cause or contribute to behavioral changes include anxiety, anger, experiencing internal stimuli, and depressed mood. Identifying underlying causes will inform the identification of appropriate therapeutic interventions. For example, the patient may be angry because

they had a verbal disagreement with their spouse on the phone or the patient may be experiencing internal stimuli which is making them agitated, or because the efficacy of their medication has decreased.

C. Assessment of environmental factors causing or contributing to any present negative behavioral changes. Two examples of environmental factors include ambient temperature of the immediate area and excessive stimuli, such as noise, activity level, or close proximity of other individuals, in the immediate area.

D. Assessment of the patient's needs, strengths, weaknesses, and preferences, along with how this information will inform the development of therapeutic interventions for effectively managing the patient's condition.

E. Determination of the most appropriate and least restrictive interventions for effectively managing the patient's condition/symptoms and rationale for why the chosen interventions were the most appropriate and least restrictive, i.e., would provide the most benefit to the patient with the least risk.

F. Assessment of whether the risks associated with the use of PR reasonably outweigh the risk of immediate physical harm to the patient and/or another individual.

VI. Therapeutic Intervention with an Escalating Patient

The following guidelines provide general guidance for personnel attempting to de-escalate a patient who reasonably appears to be escalating toward self-injurious behavior and/or physical assault of another individual. Personnel should always take into account their direct observation of the patient's point-in-time behavior, as well as their clinical training and their specific knowledge of the patient, when determining which interventions are appropriate for an individualized response to the present situation. For example, a specific technique may serve to de-escalate one patient but, in a similar situation with a different patient, the same technique would serve as a trigger to further escalate that patient.

Interacting with the patient in an authentic, respectful, and therapeutic, not punitive, manner is paramount in partnering with the patient toward de-escalation.

- Attempt to establish a rapport with the patient through positive interaction—be authentic in demonstrating an interest in connecting with the patient.

- Speak to the patient in a low, calm and steady voice.

- Acknowledge the patient's observed behavior, statements, and/or expressed emotions and offer to listen to what they have to say.

- Employ active listening skills to garner an understanding of the patient's needs and show the patient genuine interest in helping them.

- Therapeutically prompt the patient to employ their coping skills.

- Seek agreement from the patient about how they would prefer to proceed; offer the patient-specific, individualized, positive options for de-escalating with the goal of focusing the patient away from whatever is stimulating them in the moment.

- Support and positively reinforce the patient's efforts at maintaining self-control.

- Notify the patient's registered nurse (RN) and psychiatric prescriber, or, as applicable, the on-call prescriber, of the situation.

    - Upon being notified, the RN shall clinically assess the situation and determine an appropriate course of action, including whether to initiate an emergency increase in level of treatment to a continuous/constant visual observation (CVO) or 1:1 until the prescriber arrives at the scene. The RN initiating the emergency observation shall instruct the observing personnel in the specific interventions/treatment modalities to employ.

    - Upon being notified, the prescriber shall clinically evaluate the situation and determine an appropriate course of action, including whether to maintain emergency observation initiated by an RN or to initiate emergency observation if none has been initiated. The prescriber ordering the emergency observation shall instruct the RN in the specific interventions/treatment modalities to employ.

    - See CMS Medicare State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Rev. 200, 02-21-2020, §482.13 (c)(2) *Condition of Participation: Patient's Rights, Patient Safety* and OMHSAS Policy SMH-P-07-01 *Observation Levels of Intensive Treatment* for requirements regarding levels of intensive treatment.

If therapeutic intervention does not result in the patient beginning to de-escalate, promptly summon additional personnel to the area to help manage the situation.

- The ultimate goal is the safety of all individuals. Patient behavior escalating toward self-injury and/or physical assault of another individual is an emergency. Needing to summon additional personnel does not represent a failure and instead is a critical step in attempting to avoid PR of the patient while supporting the safety of all individuals. The focus of intervention at this point is to safely reverse the escalation as soon as possible using the least restrictive therapeutic interventions possible.

- Safely guide all individuals who do not need to be present for the intervention, such as visitors and other patients, out of the immediate area and prevent individuals who do not need to be present for the intervention from entering the area.

- Organize therapeutic intervention to address the patient's escalating behavior using the additional personnel present, in consideration of how the specific patient would reasonably be expected to respond to a larger presence of personnel.

- Employ safety techniques, such as maintaining a safe distance from the patient and never turning away from the patient, to help prevent physical injury to personnel while attempting to stop the patient's escalation.

- If the therapeutic intervention does not stop the escalation and the patient presents an immediate physical threat of harm to themselves and/or another individual, apply PR in accordance with the following guidance.

VII. Clinical Contraindications to the Use of PR

Prescribers shall document the rationale for their clinical determinations in patients' medical records when determining that application of PR is expected, with a reasonable degree of medical certainty, to:

A. endanger the patient's life due to the patient's known medical/physical conditions, as determined by the patient's medical prescriber,

B. exacerbate the patient's known medical/physical conditions, as determined by the patient's medical prescriber, or

C. severely mentally and/or emotionally injure the patient, as determined by the patient's psychiatric prescriber. The psychiatric prescriber shall consider factors such as the patient's history of inflicted trauma(s) when making this determination.

VIII. Patients in Voluntary Inpatient Psychiatric Treatment at State Mental Hospitals

If a patient is in voluntary inpatient psychiatric treatment at a state mental hospital under Article II. Section 201 of the Mental Health Procedures Act, *Voluntary Examination and Treatment, Persons Who May Authorize Voluntary Treatment* and the application of PR has been ordered by a prescriber because the patient presents an immediate threat of physical harm to themselves and/or another individual, the patient's social worker shall immediately file a petition for involuntary inpatient psychiatric treatment under Article III. of the Mental Health Procedures Act, *Involuntary Examination and Treatment*.

IX. Prohibited Types of PR

These prohibitions are mentioned in the context of applying PR in order to respond to an immediate threat of physical harm by the patient toward him/herself and/or another individual. Nothing in this section is intended to limit standard medical practice by a licensed healthcare practitioner fulfilling medically necessary duties within his/her scope of practice, such as a medical prescriber tapping a patient's patella with a reflex hammer to evaluate the patient's reflex response or an RN applying noxious stimulus during the graded assessment of an unconscious patient.

Prohibited PR includes any technique that:

A. Forces the patient to the floor or maintains the patient on the floor, regardless of position, e.g., prone, supine, sitting, lateral/side-lying, etc.

    1. The use of an item or material to soften the floor's surface, such as a mat or blanket, does not create an exception.

    2. If the patient reaches the floor during a PR, such as falling, personnel shall immediately release the PR and reassess the patient's mental and emotional states. If the patient no longer presents an immediate threat of physical harm to him/herself and/or another individual, an RN shall immediately assess the patient's physical condition and facilitate treatment of any injuries.

B. Forces the patient to a prone position or maintains a patient in a prone position, regardless of the surface type, e.g., floor, bed, table, etc.

C. Is likely to restrict or obstruct the patient's breathing or blood circulation, e.g., choking any body part, pinching the patient's nose shut, covering the patient's nose or mouth in any way, applying any pressure to the patient's throat, etc.

D. Is for the purpose of causing physical pain or physical injury, e.g., use of trigger points or pressure points, pinching, poking with a finger or an item, biting, flicking, twisting the patient's arm, hair pulling, jabbing, slamming fingers in a door, poking or pushing into any part of the patient's face, mouth, or throat, etc.

E. Forces the patient to a surface, regardless of whether the surface is hard or soft, e.g., the floor, a wall, a chair, a bed, a table, etc.

F. Involves striking any part of the patient's body in any way, e.g., kicking, punching, pushing, shoving, hitting, body slamming, slapping, elbowing, kneeing, spanking, stomping, etc.

G. Forces or maintains the patient off balance, e.g., tripping, jostling, sweeping the patient's feet out from under him/her, etc.

H. Puts any pressure on the patient's torso, except for the lower abdomen.

I. Involves sitting, standing, or lying on any part of the patient's body.

J. Involves covering any part of the patient's body with material or with an item.

K. Absent the existence of an emergency or immediate extreme hazard, involves lifting or carrying a patient who is struggling against the hold.

L. Risks hyperextending any part of the patient's body, e.g., pulling the patient's arms behind his/her back, jerking the patient's neck, pushing the patient's fingers or wrist back, etc.

M. Reasonably involves a substantial risk of physical injury to the patient.

X. Application of PR

PR is not a therapeutic intervention and is instead a last-resort emergency safety intervention. The application of PR creates substantial risk for the involved patient and personnel and, thus, shall only be imposed to prevent the immediate physical harm of the patient and/or another individual when therapeutic, less restrictive interventions have been determined to be ineffective in protecting the patient and/or another individual being from immediate physical harm. PR shall be discontinued at the earliest possible time.

The ultimate goal is the safety of all individuals. Unless the patient is actively injuring themselves and/or physically assaulting another individual, personnel shall not apply PR when they are the lone personnel present. Instead, they shall summon immediate help from additional personnel and reassess the situation once additional personnel arrives.

If lone personnel need to act immediately because a patient is actively injuring themselves and/or physically assaulting another individual, they shall summon additional personnel at the first opportunity to assist in de-escalating the patient, safely applying the PR, monitoring the PR, safely guiding all individuals who do not need to be present for the intervention, such as visitors and other patients, out of the immediate area, and preventing individuals who do not need to be present for the intervention from entering the area.

Personnel shall only apply PR, which are OMHSAS-approved techniques on which they were trained and on which they demonstrated competency.

While applying the PR, personnel applying or monitoring the PR shall calmly and clearly communicate to the patient why the PR is being used and what behavior the patient must demonstrate to achieve discontinuation of the PR. Personnel shall document this communication in the patient's medical record.

Application of and prescribers' orders for PR shall not exceed three (3) minutes; however, the PR must be discontinued once the threat abates, regardless of whether the order authorizes PR for a longer period of time. When personnel discontinue the PR at the three-minute mark, they shall reassess the situation to determine if the patient still presents an immediate threat of physical harm to him/herself and/or another individual.

An RN shall promptly notify the prescriber responsible for the immediate care of the patient at the time of the restraint and assess the patient's physical, mental, and emotional status. The prescriber shall promptly evaluate the patient following notification of the PR. The results of the assessment and the evaluation shall be documented in the patient's medical record. If the PR occurred by state mental hospital personnel off-grounds, the RN shall promptly notify the prescriber and assess the patient upon his/her return to the state mental hospital.

XI. PR to Facilitate Medically Necessary Medical Treatment

With limited exception, patients have the right to make informed decisions regarding their care, including participating in their treatment planning and refusing treatment.

PR may be applied in order to administer medically necessary psychotropic medications to patients over their objection in circumstances delineated in Mental Health Bulletin 99-85-10 *Administration of Psychotropic Medication to Protesting Patients.*

PR may be applied in order to facilitate medically necessary medical treatment of protesting patients if the patient has been adjudicated incompetent to make his/her own healthcare decisions by a court of law and a substitute decision maker has authorized the treatment in accordance with the requirements in Mental Health Bulletin 99-83-26 *Informed Consent to Non-Psychiatric Health Care at State Mental Hospitals.*

The PR will be applied only for the period of time necessary to successfully administer the medically necessary psychotropic medications or complete the medically necessary medical treatment.

All requirements contained elsewhere in this bulletin regarding PR apply to PR for the purpose of facilitating medically necessary medical treatment. When the non-immediate conditions specified in Mental Health Bulletin 99-85-10 *Administration of Psychotropic Medication to Protesting Patients* have been met, the prescriber's order for the PR and the updates to the patient's treatment plan shall be issued in advance of application of the PR.

XII. Prescribers' Orders for PR

Since PR is not a therapeutic intervention and is instead a last-resort emergency safety intervention, the application of PR is prohibited from being used as a routine intervention.

The use of PR shall always be in accordance with an order from the prescriber responsible for the immediate care of the patient at the time of the PR. PR is prohibited from being ordered as a standing order or a PRN ("pro re nata"; as needed/as circumstances require) order. Each episode of PR requires a new order; once a PR/Manual Hold is discontinued, a PR cannot be applied again under the same order.

The prescriber's order for a PR shall not exceed three (3) minutes.

The prescriber's order must be written, at the latest, immediately following the application of the PR. For this specific requirement, CMS considers "immediately" to mean "within a few minutes". If an order is not written within a few minutes following the application of the PR, the patient is considered to have been restrained without an order, which would be considered patient neglect or abuse. Each facility will also maintain local policies regarding PR and appropriate after-action steps.

The PR must be discontinued once the threat abates, regardless of whether the order authorizes PR for a longer period of time.

XIII. Debriefing after Each PR

Unless clinically contraindicated, the treatment team—including the patient—shall assemble no later than the regular business day following the end of the PR to initiate the debriefing process led by the patient's psychiatric prescriber.

If the personnel who interacted with the patient immediately before and at initiation of the PR anticipate they will not be on duty for the debriefing, they shall, through a detailed note in the persons record, provide a detailed account of the event, including a clear description of the patient's observable behavior necessitating the PR, the rationale for why they determined, prior to the application of PR, that therapeutic, less restrictive interventions were ineffective to protect the patient and/or another individual from immediate physical harm, identification of specific therapeutic interventions attempted and the outcome of each, and a description of the specific PR used and the duration of the PR.

Individuals delineated in the notification section above shall be invited, with reasonable notice, to participate in the debriefing, and, to the extent possible, reasonable efforts shall be made to accommodate individuals' availability and/or inability to attend in person. For example, if an individual is not able to attend in person, the treatment team shall arrange their participation by telephone or, if available, video conferencing. Individuals unable to attend even by telephone shall be afforded an opportunity to provide input for the treatment team to discuss at the debriefing.

Efforts to engage the individuals delineated in the notification section shall be documented in the patient's medical record, including identification of the names of those invited, the date and time of notification, the individual's response to the notification, efforts to accommodate the individual's availability and/or inability to attend in person, and, if the individual was unable to attend even by telephone, the individual's provided input.

If delaying the post-PR debriefing is necessary because the patient is not present at the state mental hospital, e.g., has been hospitalized at a community hospital, or because a delay is clinically indicated, the psychiatric prescriber shall document in the patient's medical record the rationale for the delay and, if the patient is present at the state hospital, what intervention was occurring to address the patient's immediate mental and emotional needs. If completing the debriefing over the course of multiple sessions is clinically indicated, the psychiatric prescriber shall document in the patient's medical record the rationale for each pause and what intervention was occurring to address the patient's immediate mental and emotional needs.

XIV. Purpose of Debriefing

A. The purpose of conducting debriefing after an incident of PR is to identify how to prevent future recurrence of PR for the patient.

B. Debriefings shall minimally include specific information addressing the following topics:

1. Identifying factors that contributed to and/or caused the patient's behavior which necessitated PR. The input of both the patient and the personnel initiating the PR is critical.

2. Identifying the patient's positive attributes and experiences, as defined in the definitions above, which can be employed in identifying effective alternatives to be used in similar situations in the future. The input of both the patient and the personnel treating the patient is critical.

3. Identifying specific effective alternatives to PR to be used in similar situations in the future. The input of both the patient and the personnel treating the patient is critical.

4. Identifying the personnel-provided therapeutic interventions that will be added to the patient's treatment plan to support the patient in developing the skills necessary to avoid PR in the future.

5. Evaluating the efficacy of personnel's therapeutic interventions occurring prior to the application of PR, i.e., what worked well, what could have been better, and the plan for how to respond more effectively in the future.

6. A designated treatment team member shall promptly document the following regarding the debriefing in the patient's medical record: date of debriefing, time of debriefing, names of the attendees, (for personnel) job titles of the attendees, and specific responses to the aforementioned minimally required topics. Personnel contacting the individuals delineated in the notification section above shall document the aforementioned efforts to accommodate such individuals.

XV. Documentation Required in the Patient's Medical Record

A. Identification of the patient's representative, as applicable.

B. The notifications made at the time of admission, as delineated in the notification section above.

C. Assessments and a treatment plan addressing the items delineated in the treatment planning section above.

D. Documentation by the relevant prescriber identifying clinical contraindications to PR and the corresponding rationale, as applicable.

E. The date, time, and location of each PR.

F. The required components of the comprehensive, individualized patient assessment(s) conducted prior to the application of any PR.

G. A clear description of the patient's observable behavior necessitating the PR.

H. Communication to the patient, at application, explaining why the PR was being applied and what behavior the patient needed to demonstrate to achieve discontinuation of the PR.

I. Rationale for why personnel determined, prior to the application of PR, that therapeutic, less restrictive interventions were ineffective to protect the patient and/or another individual from immediate physical harm, including identification of specific therapeutic interventions attempted and the outcome of each.

J. A description of the specific PR used and the duration of the PR.

K. An order for the PR from the prescriber responsible for the immediate care of the patient at the time of the PR.

L. A description the impact the PR had on the patient's behavior which necessitated the PR.

M. A description of how the patient's physical and emotional responses were monitored during and after the PR.

N. A detailed assessment of the patient's physical and emotional responses during and after the PR.

O. A detailed description, including measured dimensions, of any injuries observed by personnel after the PR and the corresponding actions taken regarding the injuries.

P. Assessment of any injuries reported by the patient after the PR, a detailed description of any subsequent assessment/evaluation findings, and the corresponding actions taken.

Q. The notifications made subsequent to a PR as delineated in the notification section above.

R. Input provided by individuals important to the patient who were invited to the post-PR debriefing but were unable to attend even by telephone.

S. The date of debriefing, time of debriefing, names of the attendees, (for personnel) job titles of the attendees, and specific responses to the aforementioned minimally required topics.

T. If delaying or pausing the post-PR debriefing is clinically indicated, documentation by the psychiatric prescriber explaining the rationale for the delay and what intervention was occurring to address the patient's immediate mental and emotional needs.

U. Written updates to the treatment plan after application of PR to reflect the process of assessment, intervention, and evaluation used in the PR event.

In cases where an individual has required the use of PR more than three times within a seven- day period, the Chief Medical Officer, or designee, shall review the case and provide recommendations for care and document follow-up to reduce the use of PR.

XVI. Incident Reporting regarding PR

Application of PR is a reportable incident and, thus, shall be documented on a State Hospital Incident Report (SI-815) by personnel who initiated a PR. Personnel completing the SI-815 shall document all the pertinent information regarding the PR as requested in the relevant fields on the SI-815.

XVII. Personnel Education and Training

Personnel shall be trained and shall demonstrate competency prior to conducting PR, monitoring/assessing a patient in a PR or caring for a patient in a PR. Training regarding PR shall be provided only by approved instructors using a methodology explicitly approved by OMHSAS.

Personnel who have any contact with patients shall be trained initially during the employment orientation process and retrained each year, no more than 13 months from their previous training. Additionally, personnel providing direct care to patients shall be refreshed on nonphysical intervention, prohibited types of PR, and techniques for approved PR on a quarterly basis. Personnel who have only limited/minimal contact with patients shall complete an abbreviated training each year after completing the initial training.

Trainers conducting personnel training regarding PR shall be qualified to do so as evidenced by education, training, and experience in identifying and treating behaviors in the patient population served. Trainers conducting personnel training regarding PR shall be able to demonstrate a high level of knowledge about the requirements related to PR, including OMHSAS' and the state mental hospital's associated policies and procedures.

XVIII. Training Documentation

The personnel file of each trainer conducting personnel training regarding PR shall contain documentation of how the trainer is qualified by education, training, and experience to train personnel regarding PR.

Personnel records shall contain documentation that personnel were trained, refreshed, and demonstrated competency in PR at the aforementioned frequency.

XIX. Required Training Content

Training shall be targeted to the specific needs of the patient population served and approved by OMHSAS in advance of being delivered to state hospital personnel. Training content will be reviewed periodically by OMHSAS to determine whether the training content requires updating due to changed needs.

Training shall minimally address the following topics:

A. OMHSAS and state mental hospital policies and procedures regarding preventing, applying, documenting, reporting, and debriefing PR.

B. Requirements of a comprehensive, individualized patient assessment and clinical techniques to make the assessment based on observing the patient's condition and therapeutically eliciting information from the patient.

C. Recognizing the signs and phases of the crisis cycle, signs of each phase, the impact of each phase on the patient's ability to effectively mentally process information and control their behavior, and the types of interventions that are indicated at each phase.

D. Emphasis on the skilled use of nonphysical intervention, including calling additional personnel to the scene to assist in de-escalation, to effectively prevent escalations by redirecting patients, engaging patients in constructive activities, and supporting patients in maintaining self-control.

E. Types of therapeutic interventions appropriate for the specific patient population, ranging from least restrictive to most restrictive.

F. Providing for the safety of the patient and all other individuals while attempting to de-escalate the patient and prevent PR.

G. If a PR/ is required for reasons delineated in this bulletin, preventing immediate physical harm to the patient and/or another individual, providing for the safety of the patient and all other individuals while applying PR and while transitioning through the immediate post-PR period.

H. Identifying personal factors that may impact how a patient experiences and responds to a PR.

I. How to safely apply PR, including how to promptly recognize and respond to signs of physical and psychological distress.

1. How to monitor the physical and psychological well-being of the patient during the PR, including, but not limited to, respiratory status, circulatory status, skin integrity, and vital signs.

2. Using first aid and cardiopulmonary resuscitation to render aid to a patient who is in distress and/or injured during a PR, including identifying the most likely scenarios for distress and injury in the state mental hospital's patient population from PR.

J. Signs that the immediate threat of physical harm no longer exists, and the PR must end.

K. Requirements of the post-PR debriefing process.

L. Requirements for documenting PR in the patient's medical record and on the State Hospital Incident Report (SI-815).

XX. Performance Improvement and Risk Management

State mental hospitals shall incorporate efforts to reduce their use of PR/ into the hospital wide performance improvement programs that are required by 42 CFR 482.13 (c)(2) CMS *Conditions of Participation for Hospitals, Quality Assessment and Performance Improvement Program* and into the risk management programs that are required by OMHSAS Bulletin SMH-10-01 *Management of Incident: SI-815 Incident Reporting and Risk Management Policy and Procedural Change*.

XXI. References

42 CFR 482.13 (a)(1) CMS *Conditions of Participation for Hospitals, Patient's Rights, Notice of Rights*

- CMS Medicare State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Rev. 200, 02-21-2020, §482.13 (a)(1) *Condition of Participation: Patient's Rights, Notice of Rights*

42 CFR 482.13 (c)(2) CMS *Conditions of Participation for Hospitals, Patient's Rights, Patient Safety*

- CMS Medicare State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Rev. 200, 02-21-2020, §482.13 (c)(2) *Condition of Participation: Patient's Rights, Patient Safety*

42 CFR 482.13 (e) through (g) CMS *Conditions of Participation for Hospitals, Patient's Rights, Restraint or Seclusion*

- CMS Medicare State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Rev. 200, 02-21-2020, §482.13 (e) through (g) *Condition of Participation: Patient's Rights, Restraint or Seclusion*

42 CFR 482.21 CMS *Conditions of Participation for Hospitals, Condition of Participation: Quality Assessment and Performance Improvement Program*

Mental Health Procedures Act (Act of Jul. 9, 1976, P.L. 817, No. 143)

Mental Health Procedures Act, Article II. *Voluntary Examination and Treatment, Section 201. Persons Who May Authorize Voluntary Treatment*

Mental Health Procedures Act, Article III. *Involuntary Examination and Treatment*

Mental Health Bulletin 99-83-26 *Informed Consent to Non-Psychiatric Health Care at State Mental Hospitals*

Mental Health Bulletin 99-85-10 *Administration of Psychotropic Medication to Protesting Patients*

Mental Health and Substance Abuse Services Policy SMH-P-07-01 *Observation Levels of Intensive Treatment*

Office of Mental Health and Substance Abuse Services Bulletin SMH-10-01 *Management of Incident: SI-815 Incident Reporting and Risk Management Policy and Procedural Change*

Office of Mental Health and Substance Abuse Services Bulletin OMHSAS-16-08 *Security Guidelines for Regional Forensic Psychiatric Centers*