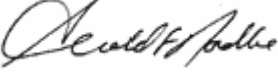
	<b>Mental Health and Substance Abuse Bulletin</b> <b>COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE</b>	
	<b>SUBJECT</b>  The Use of Seclusion and Restraint in Mental Health Facilities and Programs	<b>BY</b>   <b>Gerald F. Radke</b> Deputy Secretary for Mental Health and Substance Abuse Services
<b>NUMBER:</b>	OMHSAS-02-01	
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**SCOPE:**

This bulletin applies to the following mental health facilities and programs: Residential Treatment Facilities for Adults and Children, Adult Long Term Structured Residence Programs, Crisis Residential Services, Crisis Mobile Services, Crisis Walk-In Services, Community Residential Rehabilitation Programs, Psychiatric Units in General Hospitals, Private Psychiatric Hospitals, Partial Hospitalization Programs, Psychiatric Outpatient Clinics, Behavioral Health Rehabilitation Service Programs, Family Based Mental Health Services, Intensive Case Management, Resource Coordination Programs, Community Treatment Teams, Vocational Rehabilitation Services, Social Rehabilitation Services, Housing Support Services and Psychiatric Rehabilitation Programs. Because of the large scope of this bulletin the terms client, consumer, and individual will be used interchangeably to mean an adult with serious mental illness or a child/adolescent with serious emotional disturbance.

**PURPOSE:**

The purpose of this bulletin is to provide recommended practices on the use of seclusion and restraint with adults, children, and adolescents in mental health programs and facilities. This bulletin introduces ways to help create a positive and safe environment for the consumer, by encouraging that behavioral crises be anticipated and prevented, whenever possible, and addressed in the least restrictive manner, when it occurs. The use of restrictive procedures is justified only in situations of emergency as a safety measure, when there is imminent danger of bodily harm to the consumer or others, and when less restrictive interventions prove ineffective. The use of a restrictive procedure should match the need of the consumer, and should be properly and safely applied by trained staff that respect the dignity of the consumer and is attentive to the consumer's underlying needs and ability to regain control. The bulletin also provides uniform definitions for restrictive procedures, and explains the conditions under which seclusion or restraint should be employed. The bulletin describes information that should be included in the content of training, and introduces ideas for developing a quality improvement and risk management plan.

**BACKGROUND:**

It is the Office of Mental Health and Substance Abuse Services' belief that seclusion and restraint are not treatment but reflect treatment failure. This does not mean the treating professionals have failed, but that current circumstances have resulted in poor control of the symptoms of illness leading to use of a restrictive procedure as a safety measure.

In recent years, there has been a national movement toward the reduction in the use of seclusion and restraint in health care facilities. Risks associated with the use of seclusion and restraint include, but are not limited to: accidental death, injuries and emotional harm to both staff and consumer, continual disruption of the therapeutic relationship with consumer and family, and exposing the consumer and family to further trauma. While there are many risks associated with restrictive procedures, mental health staff should use sound professional judgment in situations to prevent a catastrophic tragedy.

Regulations have been promulgated by the Centers for Medicare & Medicaid Services (CMS) on reducing the use of restrictive procedures (Federal Register/Vol. 64, No. 127, Section C) in inpatient hospital settings and the Pennsylvania Office of Medical Assistance has issued a bulletin # 53-01-01 "The Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities (RTF)".

The Pennsylvania Office of Mental Health and Substance Abuse Services is in full support of the national trend toward the reduction in the use of restrictive procedures. In fact, Pennsylvania has become a national leader in establishing policy, procedures, and staff training resulting in reduction in the use of seclusion and restraints in the State Mental Hospital System. In furtherance of this effort, the Office of Mental Health and Substance Abuse Services is issuing this bulletin to establish consistent recommended practices for community based mental health service providers in order to facilitate their efforts to move toward restraint-free facilities.

The Office recognizes that movement toward restraint-free facilities involves major system change. Progress will require changes in values, beliefs, and practices, such as orientation for new employees, intensive staff training, as well as supervisory oversight and strong executive leadership.

## **PHILOSOPHY OF CARE:**

The use of seclusion and restraint in any treatment setting must be directed by the values of the organization and its staff. This requires a change in the "culture of care" within the organization. Facilities that have been successful in reducing and eliminating the use of these procedures have recognized and addressed this cultural change as the first step in accomplishing the goal. The individual responsible for leading this change is the director of the organization whose role is to establish the goal, eliminate administrative barriers, and support the staff as they work to reduce the use of restrictive procedures.

The use of seclusion and restraint is often a reflection of a limited model and culture of care that is based on the erroneous belief that restrictive procedures are therapeutic in nature. The use of restrictive procedures is decreased when a broad range of information is obtained, therapeutic alliances with consumer and family are developed and maintained, and active treatment is maximized. Under these circumstances, restrictive procedures are reserved only for those emergencies where the use of less restrictive interventions prove unsuccessful.

This is a very different way to look at restraint and seclusion when, less than 100 years ago, it was the primary mechanism to maintain safety in a mental hospital. Overcoming this cultural acceptance of the use of seclusion and restraint as part of the treatment process can be the biggest obstacle an organization faces in reducing the use of these procedures.

The following value statements illustrate the core values important in this effort:

- Restraint and seclusion are emergency safety interventions, not therapeutic techniques, and should be implemented in a manner designed to protect the individual's safety, dignity and well-being.
- Restraint and seclusion should not be used as a substitute for treatment, as punishment, or for the convenience of staff.
- Restraint and seclusion should only be used as an intervention of last resort in situations where harm may come to the individual or others, and only after appropriate less restrictive therapeutic interventions have proven ineffective.
- Use of restraint or seclusion is viewed as an exceptional or extreme practice for any individual.
- The consumer's dignity should be maintained during the use of restrictive procedures.
- Once a seclusion or restraint procedure is initiated, it should be as limited in time as possible. The staff and individual need to work together to lessen the duration of each episode.
- All clinical staff with a role in implementation of restraint and seclusion procedures should be trained and demonstrate competency in the safe use of seclusion and restraint practices. Staff should demonstrate competency in using less restrictive alternatives in order to prevent the use of seclusion and restraint.
- Leaders of the agency, clinical departments and units/wards are held accountable at all times for the initiation, usage and termination of restraint and seclusion procedures.
- The consumer and family members, as appropriate, are recognized members of the treatment team. Family can be instrumental in developing prevention strategies in many circumstances.
- A risk assessment used for the identification of specific behavior that could lead to the use of restraint or seclusion is critical in prevention efforts and should be done on admission to the treatment program. Strategies to prevent loss of control by the consumer should be addressed in the initial treatment plan for high-risk individuals, accentuating the strengths of the individual and cultural factors. Simply asking the individual what can be done to help them de-escalate when agitated can often lead to a plan of prevention.
- Staff needs to recognize and understand client-specific factors relevant to the use of seclusion and restraint. For example, some individuals with a history of abuse can be re-traumatized by the use of restraint.
- Client and staff involvement in a post-procedure debriefing and discussion is essential to determine how future situations may be prevented or de-escalated by employing alternative problem-solving measures outlined in the treatment plan.

## **DEFINITIONS:**

**Seclusion** is restricting a child/adolescent/adult in a locked room, and isolating the person from any personal contact. The term "locked room" includes any type of door locking device such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door closed, preventing the individual from leaving the room. Seclusion does not include the use of a time-out room. Locking an individual in a bedroom during sleeping hours is considered seclusion.

**Time-out room** is an unlocked room used to remove an individual from the individual's immediate environment to reduce stimulation and assist the individual to regain self-control. Use of a time-out room constitutes a potential alternative to the use of seclusion and restraint.

**Restraint** is any **chemical, mechanical, or manual** technique used for the purpose of restricting movement.

1. A **chemical restraint** (federal term: "drug used as a restraint") is a medication used to control acute, episodic behavior that is not the standard treatment for the consumer's medical or psychiatric condition, and is intended to significantly lower the individual's level of consciousness and restricts the movement of a consumer. A medication ordered by a physician as part of the ongoing individualized treatment plan for treating the symptoms of mental, emotional, or behavioral disorders is not a chemical restraint.
2. A **mechanical restraint** is a device used to control acute, episodic behavior that restricts movement or function of a consumer or portion of a consumer's body. Examples of mechanical restraints are handcuffs that are locked around the wrists, elbow restraints, foot restraints, cloth harnesses applied to any portion of the body, and blanket wraps. Mechanical restraints do not include measures to promote body positioning to protect the consumer and others from injury, or to prevent the worsening of a physical condition. Devices also used for medical treatment such as helmets for prevention of injury during seizure activity, mitts, and muffs to prevent self-injury are not considered restraints.
3. A **manual restraint** is a physical hands-on technique that restricts the movement or function of the consumer's body or portion of the consumer's body. Prompting, escorting or guiding a consumer who does not resist to assist in the activities of daily living is not a manual restraint.

## Recommended Practices:

The Office of Mental Health and Substance Abuse Services is issuing the following recommended practices regarding the use of seclusion and restraint in all programs covered under the scope of this bulletin.

### A. Seclusion

1. The use of seclusion is not permitted by regulation in 55 Pa. Code, Chapter 3800, Child Residential and Day Treatment Facilities, §3800.206 (with the exception of secure care as stated in, §3800.273), and in 55 Pa. Code, Chapter 5320, Long Term Structured Residence, §5320.54 (a). Seclusion should not be used in adult residential treatment facilities, crisis residential services, crisis mobile services, crisis walk-in services, community residential rehabilitation programs, partial hospitalization programs, psychiatric outpatient clinics, behavioral health rehabilitation service programs, family based mental health services, intensive case management, resource coordination programs, and psychiatric rehabilitation programs.
2. The use of seclusion should be used in private psychiatric hospitals and in psychiatric units in general hospitals only in an emergency as a safety measure, when there is an imminent danger of bodily harm to the consumer or others. Seclusion should only be used after appropriate less restrictive behavioral techniques have been tried and a physician has determined that continuation of less restrictive interventions poses a greater threat/risk to the consumer's health and safety than does the use of seclusion. Less restrictive behavioral and physical interventions include the use of de-escalation techniques by trained staff, such as reducing environmental stimuli, escorting the consumer to a quiet room, and permitting time for the consumer to verbalize his/her concerns.
3. When seclusion is used in community psychiatric hospitals/units, the following recommended practices should be followed:
  - Seclusion should only be used pursuant to a licensed physician's order. In emergency situations, if a physician is not present, a registered nurse is permitted to initiate the use of seclusion for the protection of the consumer and/or others, and the registered nurse must immediately contact the physician on duty/on call and obtain a verbal order.
  - A physician should see the individual within one hour after the initiation of seclusion for adults and children. The licensed physician should write/countersign the order for seclusion and document his/her assessment of the individual in the medical record.
  - An order for seclusion should not exceed one hour for adults and children.

- A registered nurse may determine that an individual may be released from seclusion based on the clinical status of the individual anytime following the initiation of the order.
- As early as feasible in the seclusion process, staff should inform the individual of the behavioral criteria required for the seclusion to be discontinued. The seclusion should be discontinued when the individual meets the behavioral criteria.
- A staff person trained in the use of emergency safety interventions should continuously assess the individual in seclusion.
- A registered nurse should perform a face-to-face assessment every fifteen minutes, to ensure that the physical and emotional needs of the consumer are being met (food, water, personal hygiene, etc.).
- If seclusion is reordered, a licensed physician should perform a face-to-face reassessment of the consumer and write a new order. Each new order should not exceed one hour for adults and children. However, if a licensed physician is not available due to extenuating circumstances, a registered nurse is permitted to initiate the use of seclusion for the protection of the consumer and/or others, and the registered nurse must immediately contact the physician on duty/on call and obtain a verbal order.
- Seclusion should not be used for consumers who have any known medical condition that precludes the use of seclusion.
- Seclusion should not be used for consumers who exhibit suicidal or self-injurious behaviors. These individuals should be placed on constant 1:1 observation for suicide prevention. The purpose of 1:1 observation for suicide prevention is to protect the consumer from self-injury or death, to increase the consumer's control of self-destructive impulses, and to provide an opportunity for the consumer to verbalize his/her thoughts and feelings. Staff needs to be trained on crisis intervention in order to skillfully intervene 1:1 with the consumer, reassuring the consumer that he/she will not be left alone.
- Seclusion and restraints should not be used simultaneously.
- PRN (Pro re nata-as required, whenever necessary) orders for seclusion should not be used.

## B. Mechanical Restraints

1. The use of mechanical restraints is not permitted by regulation in 55 Pa. Code, Chapter 3800, Child Residential and Day Treatment Facilities, §3800.210 (with the exception of secure care as stated in, §3800.273), and in 55 Pa. Code, Chapter 5320, Long Term Structured Residence, §5320.54 (b). Mechanical restraints should not be used in adult residential treatment facilities, crisis residential services, crisis mobile services, crisis walk-in services, community residential rehabilitation programs, partial hospitalization programs, psychiatric outpatient clinics, behavioral health rehabilitation service programs, family based mental health services, intensive case management, resource coordination programs, and psychiatric rehabilitation programs.
2. The use of mechanical restraints should be used in private psychiatric hospitals and in psychiatric units in general hospitals only in an emergency as a safety measure, when there is an imminent danger of bodily harm to the consumer or others. Mechanical restraints should be used only after less restrictive behavioral techniques have been tried and a physician has determined that continuation of less restrictive interventions poses a greater threat/risk to the consumer's health and safety than does the use of mechanical restraints. Less restrictive behavioral and physical interventions include the use of de-escalation techniques by trained staff, such as reducing the environmental stimuli, escorting the consumer to a quiet room, and permitting time for the consumer to verbalize his/her concerns.
3. When mechanical restraints are used in community psychiatric hospitals/units in an emergency situation, we recommend the following practice(s):
  - Mechanical restraints should only be used pursuant to a licensed physician's order. In emergency situations, a registered nurse may initiate the use of mechanical restraints for the protection of the patient and/or others. The physician on duty/on call should be contacted immediately, and a verbal order obtained.
  - A consumer's history should be taken into consideration when a clinical decision is made to use mechanical restraints. Extra caution and individualized consideration should be used for an adolescent/adult with a history of Posttraumatic stress disorder, physical or sexual abuse.

- As early as feasible in the restraint process, staff should inform the individual of the behavioral criteria required for the restraint to be discontinued. The restraint should be discontinued when the individual meets the behavioral criteria.
- A licensed physician should see the individual within one hour after the initiation of mechanical restraint for adults and children. The licensed physician should write/countersign the order for the mechanical restraint and documents his/her assessment of the individual in the medical record.
- A licensed physician's order should not exceed one hour for adults and children.
- A staff person trained in the use of emergency safety interventions should continuously assess the consumer in mechanical restraints, to ensure that their physical and psychological needs are being met.
- A registered nurse should assess the consumer's blood pressure, heart rate, respirations, and observe skin areas for irritation every fifteen minutes, or more frequently, unless the frequency is raised or lowered by the licensed physician.
- If a mechanical restraint is reordered, a licensed physician should perform a face-to-face reassessment of the consumer and write a new order. Each new order should not exceed one hour for adults and children. However if a licensed physician is not available due to extenuating circumstances, a registered nurse may initiate the use of mechanical restraints for the protection of the patient and/or others. The physician on duty/on call should be contacted immediately, and a verbal order obtained.
- Mechanical restraints should not be used for consumers who have any known medical condition that precludes the use of such restraints.
- Mechanical restraints should not be used simultaneously with seclusion, or manual restraints.
- PRN (Pro re nata-as required, whenever necessary) orders for mechanical restraints should not be used.

### C. Chemical Restraints

1. The administration of chemical restraints is not permitted by regulation in 55 Pa. Code, Chapter 5320, Long Term Structured Residence, §5320.54 (b). Although chemical restraints are not specifically prohibited by regulation in Residential Treatment Facilities and inpatient facilities they should be strongly discouraged by the clinical leadership. Chemical restraints should not be used in crisis residential services, crisis mobile services, crisis walk-in services, community residential rehabilitation programs, partial hospitalization programs, psychiatric outpatient clinics, behavioral health rehabilitation service programs, family based mental health services, intensive case management, resource coordination programs, and psychiatric rehabilitation programs. Significant risks are attached to the use of medication with the intent to immobilize an individual. Immobilization of an individual may result in the person being defenseless against aggressive behavior from peers and may also increase the individual's risk of accidental falls and other physical injuries. If a chemical restraint is utilized, the individual must be under close observation to protect them from these and other problematic events. Chemical restraints should only be ordered by a licensed physician and administered by a qualified registered nurse or physician.
2. When used, chemical restraints should only be used in an emergency as a safety measure, when there is imminent danger of bodily harm to the consumer or others, and only after less restrictive behavioral techniques have been tried. Less restrictive behavioral and physical interventions include the use of de-escalation techniques by trained staff, such as reducing environmental stimuli, escorting the consumer to a quiet room, and permitting time for the consumer to verbalize his/her concerns.
3. Medication administered on a regular basis, or PRN, 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 consumer in gaining progressive self-control over his/her impulses, are not considered chemical restraints, since they are used for treatment purposes and not for behavioral control.
4. PRN (Pro re nata-as required, whenever necessary) orders for chemical restraints should not be used.

### D. Manual Restraints

1. The **use of manual restraints is not permitted** by regulation in 55 Pa. Code, Chapter 5320, Long Term Structured Residence, §5320.54 (b). The use of manual restraints that apply pressure or weight on the

child/adolescents' respiratory system is not permitted by regulation in 55 Pa. Code, Chapter 3800, §3800.211 (b). The application of the prone position manual restraints for females who are pregnant is not permitted in regulation, §3800.211 (c).

2. Manual restraints should only be used in an emergency as a safety measure, when there is imminent danger of bodily harm to the consumer or others, and only after appropriate less restrictive behavioral techniques have been tried, in community residential rehabilitation facilities, adult, children/adolescents residential treatment facilities, crisis residential facilities, crisis mobile services, crisis walk-in services, partial hospitalization programs, psychiatric inpatient facilities, psychiatric outpatient clinics, behavioral health rehabilitation service programs, family based mental health services, intensive case management, resource coordination programs, and psychiatric rehabilitation programs. Less restrictive behavioral and physical interventions include the use of de-escalation techniques by trained staff, such as reducing environmental stimuli, escorting the consumer to a quiet room, and permitting time for the consumer to verbalize his/her concerns.
3. Since only one, or in some cases, two staff persons deliver mobile services such as family based mental health services, intensive case management, resource coordination, and behavioral health rehabilitation services (to include therapeutic staff support (TSS), mobile therapy (MT) and behavior specialist consultant (BSC), it is expected that staff of these programs will not implement manual restraints.
4. When manual restraints are used in an emergency situation, the following practices should be followed:
  - Manual restraint should not be applied without an order based upon the presenting situation. A physician preferably orders manual restraint. However, if a physician is not available, a certified registered nurse practitioner (CRNP) or physician assistant (PA), licensed psychologist or a licensed social worker (LSW) may order a manual restraint. The resident's treatment team physician must be contacted and informed about the use of restraint, unless the ordering licensed professional is also the resident's treatment team physician.
  - In emergency situations, a registered nurse (RN), practical nurse (LPN), licensed occupational therapist (OT), or physical therapist (PT) is permitted to initiate the use of an emergency safety intervention for the protection of the consumer and/or others, and must immediately contact the physician on duty/on call and obtain a verbal order.
  - When applying a manual restraint, at least two staff trained in the use of manual restrictive procedures should be involved in any intervention that would immobilize a consumer. A third trained staff who is not involved with applying the restraint should continuously observe the physical and emotional condition of the individual and document the observation at least every 10 minutes during the time the manual restraint is applied. The staff observing the restraint may order a cessation of the restraint if he or she feels it necessary or advisable to ensure the individual's physical well being, or if continuation of the restraint is no longer necessary.
  - At no time should a staff person apply his/her weight on any portion of the consumer's respiratory system.
  - As early as feasible in the restraint process, staff should inform the individual of the behavioral criteria required for the restraint to be discontinued. The restraint should be discontinued when the individual meets the behavioral criteria.
  - Staff must use clinically approved restraints that they have been trained to use and that are applied appropriately, so the safety of the individual is maximized.
  - The position of the manual restraint should be changed at least every ten minutes after application begins.
  - Trained staff should take a consumer's history into consideration when a decision is made to use manual restraints. For example, a child/adult may have a history of posttraumatic stress disorder (PTSD), physical or sexual abuse, and the use of restraints could cause further trauma.
  - Manual restraints should not be used on consumers who have medical or physical conditions where there is reason to believe that such use would endanger their lives or exacerbate a medical condition, such as fractures and back injury.
  - Manual restraints should never be used simultaneously with seclusion or mechanical restraints.

## **Recommended Procedures:**

## A. Prevention

The first commitment of facilities and staff involves efforts to prevent the need for restrictive procedures. Prevention can be promoted in many ways. These include: developing a collaborative relationship with the consumer and family starting at the time of admission, developing and utilizing comprehensive evaluations and ongoing assessments, addressing the consumer's unique strengths and needs within an individualized treatment plan, recognizing verbal and non-verbal signs of distress or change in a consumer's functioning as part of a strategy of anticipation, using a range of verbal de-escalation and conflict resolution techniques, enlisting the cooperation of the consumer in resolving the problem prior to the development of a crisis, and using interventions less intrusive than seclusion and restraint, whenever possible.

Efforts to de-escalate and enlist the cooperation of the consumer should continue, to the extent feasible, even when a restrictive procedure becomes necessary and is implemented. It should be understood that seclusion and restraint should never be used as treatment or a substitute for treatment, nor should these procedures be used for punitive purposes, discipline, retaliation, or coercion, for the control of the environment, or to prevent the disruption of the therapeutic milieu, or in lieu of inappropriate numbers of staff.

## B. Assessment

A comprehensive assessment should include a physical examination or receipt of documentation of a current physical examination upon admission, to determine any pre-existing medical problems. The physician and all members of the treatment planning team should be knowledgeable concerning any pre-existing medical problems an individual may have that preclude the use of seclusion or restraint.

A comprehensive assessment should also evaluate aggressive behaviors and triggers, a history of physical or sexual abuse, any history of drug or alcohol abuse, as well as a review of family history. Ongoing assessment should be performed to determine the appropriateness of restraints, and consideration given to using alternatives.

## C. Treatment Plans

Individual treatment plans should have goals and interventions jointly developed by the consumer, family, and other members of the treatment team, to eliminate the need for seclusion or restraints. Alternative interventions should be added to the treatment plan to reduce the need for seclusion or restraint. Examples of alternative interventions would be providing 1:1 care for the consumer when the consumer is experiencing increased agitation. Another example would be escorting the consumer to a time-out room before aggression is increased or out of control, and giving the consumer time to verbalize his/her feelings and concerns.

## D. Debriefing and Review Of Incident

The following procedures should be followed after any use of seclusion or restraint. All are intended to decrease the likelihood of the consumer needing restrictive procedures in the future.

- **Review of incident between consumer and primary therapist or treating psychiatrist:** A review of the incident leading to the seclusion or restraint should occur, within 24 hours of the termination of the restrictive procedure, between the consumer and the consumer's primary therapist and/or treating psychiatrist, and under most circumstances the involved mental health staff unless their presence jeopardizes the well being of the consumer. Such review should seek to understand the incident within the framework of the consumer's life history and primary mental health issues, and should help the consumer identify and expand effective coping mechanisms to avoid future need for restrictive procedures. This review with the primary therapist or treating psychiatrist, or a subsequent review, may also include the consumer's family members as appropriate, and may at times involve a change in the consumer's treatment plan. The nature and outcomes of this review between consumer and primary therapist, or treating psychiatrist should be documented in the consumer's record.
- **Review of the incident between involved staff and supervisor:** A one-on-one review between staff involved in the restrictive procedure and the supervisor should occur within 24 hours after any use of seclusion or restraint. This review should address the circumstances leading to the restrictive procedure, the nature of prior de-escalation efforts attempted, the staff response to the incident, and ways to effectively support the consumer's constructive coping in the future and avoid the need for future seclusion or restraint. The nature and outcomes of this review between involved staff and supervisor should be documented by the facility, for purposes of continuous performance improvement and monitoring.

It is also expected that appropriate staff contact the consumer's family within 24 hours of the use on a restrictive procedure. To the extent that notification of family members requires the individual consent, the notifying staff must ensure that appropriate consent is obtained.

## E. Documentation

Documentation in the consumer's record of an incident of seclusion or restraint should include the following information:

- The time, date and location where the incident occurred.
- The precipitating event and circumstances giving rise to need for restrictive procedure.
- Identification of less restrictive interventions attempted first.
- Any circumstances that precluded other, less restrictive interventions from being implemented.
- The specific restrictive procedure used and duration of use.
- The rationale for the specific restrictive procedure used.
- Record of vital signs obtained and of consumer's emotional and physical condition, during the procedure.
- Any injuries or medical care required following the procedure.
- Summary of the debriefing of consumer with staff following the restrictive procedure.
- Any other actual or planned follow up actions.

## F. Training

- Prior to working unsupervised with consumers, staff should receive at least **10 hours of training** on less restrictive alternatives to the use of seclusion or restraints. Facilities and programs whose policies allow for the use of any type of restraint should provide training on the proper application of restraints.
- Staff should receive training that includes the following:
  - Listening skills
  - Communication skills
  - Relationship building with consumer and family
  - De-escalation techniques
  - Conflict resolution
  - Violence prevention
  - Psychosis (command hallucinations directing the consumer to become violent)
  - Risk assessment
  - Debriefing techniques
  - Possible negative psychological effects of seclusion and restraint
  - Understanding of how age, gender, cultural background, history of abuse or trauma may effect an individual's response to seclusion and restraint
  - The proper application of manual restraints appropriate to the age, weight, and diagnosis of the consumer served.
  - The developmental stages of children/adolescents/adults and the vulnerabilities of individuals to assess when seclusion or restraints are appropriate.
  - Individuals with posttraumatic stress disorder (PTSD) and those with a history of sexual/physical abuse.
  - Appropriate documentation to be included in the consumer's records.
  - The removal of restraints and how to monitor individuals in restraint or seclusion.
- Staff should be able to verbalize understanding of the training, and successfully demonstrate their skills and knowledge through a written exam. If a facility's/program's policies and procedures allow the use of restraint, staff should demonstrate the appropriate application of those restraints the facility/program has approved for use.
- Staff should regularly receive training and refresher courses in alternative non-intrusive behavior modification techniques. If a facility/program allows the use of restraint or seclusion, staff should also receive ongoing education and training in the safe and appropriate use of restraint or seclusion.
- A record of training should be kept which included the person trained, date, source, content, and the length of each course.

## Continuous Performance Improvement and Monitoring:

Each facility should employ ongoing efforts directed toward the goal of reducing and eliminating the use of seclusion and restraints. A performance improvement and monitoring program designed to continuously review, assess, and analyze the facility's use of seclusion and restraints should be in place. Facilities should clearly document the attempt and failure of less restrictive alternatives and include justification for the use of seclusion or restraint. Consumer debriefing and clinical response to the use of seclusion or restraints should be documented in the consumer's medical record.

Any facility that uses seclusion or restraint should develop a comprehensive performance and risk management program to reduce the use of restrictive procedures and to minimize incidents that result in harm to persons in the facility. The performance and risk management plan should include:



- A plan to address the prevention, detection, evaluation and correction of any environmental triggers that may lead to the use of seclusion and restraints.
- A plan to track the type and number of occurrences, and the duration of each occurrence, in which seclusion and restraint were used.
- A system to report, investigate, analyze, monitor, and track incidents resulting in injuries or death related to the use of seclusion and restraints.
- A requirement to file a formal written incident report within 24 hours from the time a seclusion or restraint is used. The report should include the name and diagnosis of the person, the time, date and place where the incident occurred, staff members involved, any other individuals involved, and any medical care administered, and follow-up. Follow-up should include notification of the physician and family (with proper consent when necessary). And a copy on the written incident report should be given to the new facility if the resident needs to be transferred. The treatment team leader should sign the report and facility senior management should review all incident reports.
- A system to monitor improvement in the decline of seclusion and restraints. Aggregate data, as well as patterns of seclusion and restraints, should be reviewed by the quality management program, with the objective of reducing and ultimately eliminating the use of seclusion and restraints.

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

Bureau of Policy and Program Development (717) 772-7900

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