Standards for Seclusion/Restraint for Behavioral Management: May 2000

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| **Application:** | Rules related to restraint/seclusion concern their use in two situations: respectively, standard (e), use of restraint in medical and post-surgical care; and standard (f), emergency use of restraints/seclusion in behavior management. For both situations, it is important to note that these requirements **are not specific to any treatment setting**, but to the situation the restraint is being used to address. | **Application:** The behavioral health care standards for restraint/seclusion apply to any use of restraint and seclusion for behavioral health care reasons. Standards TX.7.1 through TX.7.1.16 apply to all behavioral health care settings in which restraint or seclusion is used. Selected standards TX.7.1.4.1, TX.7.1.5, TX.7.1.6 through TX.7.1.8 and Standards TX.7.1.10 and TX.7.1.11 apply to non-behavioral health care settings in which restraint or seclusion is used for behavioral health reasons:  
- acute care hospital that does not have a psychiatric unit;  
- acute care hospital to receive medical or surgical services;  
- emergency department for assessment, stabilization, treatment or awaiting transfer to a psychiatric hospital/unit;  
- awaiting transfer from a non-psychiatric bed to a psychiatric bed/unit after receiving medical/surgical care | |

**Definition of Restraint:** placement of a patient in a posey vest and/or soft wrist/ankle restraints.

**Definition of Seclusion:** placement of a patient in a locked security room.

**Restraint:** any manual method or physical or mechanical device that restricts freedom of movement or normal access to one’s body, material, or equipment, attached or adjacent to the patient’s body that he or she cannot easily remove. (Any object may be a restraint by functional definition: e.g., tucking sheets, side rails, geri chair, etc.).

**Drug Used as a Restraint:** a medication used to restrict the patient’s freedom of movement in medical-post surgical situations or for the emergency control of behavior, and is not a standard treatment for the patient’s medical or psychiatric condition.

**Seclusion:** involuntarily confining an individual alone to a room or an area where he/she is physically prevented from leaving.

**Time Out:** restriction of a patient for any period of time to a designated area from which the patient is not physically prevented from leaving and for the purpose of providing the patient an opportunity to regain self-control.

**Restraint:** the direct application of physical force to an individual, without the individual’s permission, to restrict his/her freedom of movement.

**Seclusion:** the involuntary confinement of a person in a locked room.

**Time-out:** a procedure used to assist the individual to regain emotional control by removing the individual from his/her immediate environment and restricting the individual to a quiet area or unlocked quiet room.
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<td><strong>When is restraint/seclusion used:</strong></td>
<td>Seclusion or restraint can only be used in emergency situations if needed to ensure the patient’s physical safety and less restrictive interventions have been determined to be ineffective. Emergency is defined as a situation where the patient’s behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff or others.</td>
<td>Restraint and seclusion are used only in an emergency, when there is an imminent risk of an individual physically harming himself or herself or others, including staff. Non-physical interventions are the preferred intervention, unless safety issues demand an immediate physical response. <strong>Definition of Emergency:</strong> when there is imminent risk of an individual physically harming himself or herself, staff or others; when non-physical interventions are not viable; and safety issues require an immediate physical response.</td>
<td><strong>Action Plan</strong></td>
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<td>- When the patient poses an immediate danger to self and/or others;</td>
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<td>- When the patient threatens serious disruption to the therapeutic environment;</td>
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<td>- When less restrictive measures/approaches are/have been unsuccessful.</td>
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**Initial Assessment:**

Comprehensive assessment is critical in coming to an effective intervention decision of what would be the greater benefit to a patient. Evaluation of whether devices could be used as restraints must include:
- how they benefit the patient;
- whether a less restrictive device/intervention could offer the same benefit at less risk.

If the effect of using an object fits the definition of restraint for that patient at that time, then for that patient at that time, the device is a restraint.

**Orders for the use of Restraint/Seclusion:**

- All restraint/seclusion is used and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his/her LIP designee
- Written or verbal orders for initial and continuing use of restraint/seclusion are time limited to:
  - 4 hours for individuals 18 and older
  - 2 hours for children and adolescents 9 to 17
  - 1 hour for children under age 9
- Orders for restraint/seclusion are not written as a standing order or on an as needed basis (i.e., PRN)
- The organization may authorize qualified registered nurses or other qualified, trained staff members who are not LIPs to initiate the use of restraint/seclusion
- The qualified RN or other qualified staff notifies the LIP and an order is obtained no longer than one hour after the

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<th>Initiation of Restraint/Seclusion</th>
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<td>• When restraints/seclusion are discontinued early and the same behavior is still evident, the original order can be reapplied if alternatives remain ineffective. The time limit for the original order is cumulative. Release of the patient from restraints/seclusion for a period longer than 60 minutes requires obtaining a new MD order to include additional clinical justification.</td>
<td>• The LIP reviews with the staff the physical and psychological status of the patient, determines whether restraint/seclusion should be continued, gives staff guidance in identifying ways to help the individual regain control in order to discontinue restraint/seclusion, and gives an order</td>
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<td>• Must be ended at the earliest possible time</td>
<td>• If restraint/seclusion needs to continue beyond the expiration of the time-limited order, a new order (written or verbal) for restraint/seclusion is obtained from the LIP, or his/her LIP designee limited to the time frames outlined above</td>
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<td>• If restraints/seclusion are discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating seclusion or reapplying the restraints and the requirements restart.</td>
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### Notification Requirements:
- All uses of restraint/seclusion are to be recorded on the Critical Incident Log for each new restraint/seclusion event.
- All uses of restraint/seclusion are reported daily to the Medical Director or a designee (Nurse Coordinator) for review.
- If restraint/seclusion continues beyond 48 hours or if the patient requires restraint/seclusion more than 4 times in one week, the RN will request a case conference with the MD and other team members to discuss alternatives.

### Monitoring/Care Requirements:
- Each restrained/secured patient will be placed on the appropriate PICR (10/15 minute flow sheet).
- Nursing staff will check the patient every 15 minutes (or less) depending upon patient need. (Children 14 years of age or younger must be checked every 10 minutes or less).
- Each reassessment for monitoring purposes is used to determine the patient's well being and must be documented.
- If the patient's condition warrants, restraints are removed every 2 hours and the patient exercised (while awake). If the patient is assessed to be at risk for violence, the restraints will not be removed unless repositioning, circulation and mobility is impaired. (Under these circumstances, the restraint is removed from one extremity at a time with range of motion provided to the free extremity.)
- The personal needs of the patient (e.g., nourishment, fluids, hygiene, and use of the toilet) must be attended to every 2 hours while awake during each 8-hour shift. Other comfort measures are provided as appropriate and desired by the patient.
- If a patient is restrained in a security room, the door to the room may not be locked. Any patient in 4-point restraints will be monitored 1:1 by staff.

### Notification Requirements:
- The RN who initiates restraint/seclusion must consult with the patient's treating MD, as soon as possible, if the restraint/seclusion is not ordered by the patient's treating MD.
- The individual's family is notified promptly of the initiation of restraint or seclusion, in cases where the individual has consented to have the family kept informed regarding his/her care and the family has agreed to be notified.
- Clinical leadership is informed of instances in which individuals experience extended, or multiple episodes of restraint/seclusion (e.g., remains in restraint/seclusion for more than 12 hours; experiences 2 or more separate episodes of restraint/seclusion of any duration within 12 hours). The leadership is notified every 24 hours if either of the above conditions continue.

### Monitoring/Care Requirements:
- A trained and competent staff member assesses the individual at the initiation of restraint/seclusion and every 15 minutes thereafter, to include:
  - signs of injury;
  - nutrition/hydration;
  - circulation and range of motion in extremities;
  - vital signs;
  - hygiene and elimination;
  - physical and psychological status and comfort; and
  - readiness for discontinuation of restraint/seclusion.
- Monitoring is accomplished through continuous in-person observation by an assigned staff member.
- After the first hour, an individual in seclusion only, may be continuously monitored using simultaneous video and audio equipment, if this is consistent with the individual's condition or wishes.
- If the individual is in a physical hold, a second staff person is assigned to observe the individual.
- The individual is made aware of the rationale for restraint/seclusion and the behavior criteria for its discontinuation (e.g., ability to contract for safety; orientation to the environment; and/or cessation of verbal threats).
toileting/elimination, range of motion, exercise of limbs and systematic release of restrained limbs;  
- assessment of mental status;  
- assessment and justification for continued use of restraint/seclusion;  
- who has the authority to discontinue restraints or seclusion, and, under what circumstances.  

### Documentation:
The medical record for a restrained/secured patient must include:  
- precipitating factors and patient's behavior prior to intervention;  
- less restrictive alternatives used and the patient's response;  
- explanation given to patient addressing the reason for restraint seclusion and conditions for discontinuation;  
- RN assessment at the time of initiation and notification of attending MD;  
- initiation of PICR with visual checks every 15 minutes;  
- reassessment by the RN at regular intervals (at least once per shift);  
- attention to patient needs by nursing staff;  
- time of discontinuation of restraint seclusion and patient's response;  
- MD signature with date/time for each order received.

### Documentation:
Documentation in the patient’s record should include:  
- the patient’s behavior and the intervention used;  
- the rationale for the use of the physical restraint or seclusion;  
- the patient’s response to the use of physical restraint/seclusion.  

Documentation in the patient’s record should indicate a clear progression in how techniques are implemented with less intrusive restrictive interventions attempted (or considered) prior to the introduction of more restrictive measures.

### Documentation:
Medical records document that the use of restraint/seclusion is consistent with organization policy. The clinical record verifies:  
- that the individual/family was informed of the organization's policy on the use of restraint/seclusion;  
- any pre-existing medical conditions or any physical disabilities that would place the individual at greater risk during restraint/seclusion; and  
- any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint/seclusion.  

Each episode of use is recorded to include:  
- the circumstances that led to their use;  
- consideration or failure of non-physical interventions;  
- the rationale for the type of physical intervention selected;  
- notification of the individual's family, when appropriate;  
- written orders for use;  
- behavior criteria for discontinuation of restraint/seclusion;  
- informing the individual of behavior criteria for discontinuation of restraint/seclusion;  
- each verbal order received from a LIP;  
- each in-person evaluation and reevaluation of the patient;  
- 15 minute assessments of the patient's status;  
- assistance provided to the patient to help him/her meet the behavior criteria for discontinuation of restraint/seclusion;  
- evidence of continuous monitoring;  
- debriefing of the individual with staff; and  
- any injuries that are sustained and treatment received for these injuries...or any deaths resulting from injury.  

Documentation is accomplished in a manner that allows for the collection and analysis of data for performance improvement activities.
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<td>Staff with direct patient care responsibilities are trained in:</td>
<td>All staff who have direct patient contact must have ongoing education and training in:</td>
<td>All direct care staff are trained/competent to minimize the use of restraint and seclusion, and demonstrate an understanding:</td>
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<td>• identification of potential risk behaviors;</td>
<td>• the proper and safe use of restraint/seclusion application and techniques;</td>
<td>• of the underlying causes of threatening behaviors;</td>
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<td>• the appropriate use of alternative strategies;</td>
<td>• alternative methods for handling behavior symptoms, and situations that traditionally have been treated through the use of restraints/seclusion</td>
<td>• that some aggressive behavior may be related to a medical condition;</td>
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<td>• correct application and removal of restraints;</td>
<td>• of how their own behaviors can affect the behaviors of patients;</td>
<td>• in recognizing signs of physical distress in individuals who are restrained/secluded.</td>
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<td>• clinical strategies to meet emergent patient needs.</td>
<td>• of the use of de-escalation, medication, self-protection and other techniques, such as time-out; and</td>
<td>All staff authorized to physically apply restraint or seclusion receive ongoing training and demonstrate competence in the safe use of restraints, including:</td>
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<td>• in recognizing signs of physical distress in individuals who are restrained/secluded.</td>
<td>• physical holding techniques;</td>
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<td>All staff who have direct patient contact must have ongoing education and training in:</td>
<td>• take-down procedures; and</td>
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<td>• the proper and safe use of restraint/seclusion application and techniques;</td>
<td>• the application and removal of mechanical restraints.</td>
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<td>• alternative methods for handling behavior symptoms, and situations that traditionally have been treated through the use of restraints/seclusion</td>
<td>Staff who are authorized to perform 15 minute assessments of individuals in restraint/seclusion receive ongoing training and demonstrate competence in:</td>
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<td>• taking vital signs and interpreting their relevance;</td>
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<td>• recognizing nutritional/hydration needs;</td>
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<td>• checking circulation and range of motion in extremities;</td>
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<td>• addressing hygiene and elimination needs;</td>
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<td>• addressing physical and psychological status and comfort;</td>
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<td>• assisting individuals in meeting behavior criteria for the discontinuation of restraint/seclusion;</td>
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<td>• recognizing when to contact a medically trained LIP or EMS to evaluate/treat the patient's physical condition.</td>
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<td>Staff who are authorized to initiate restraint/seclusion, in the absence of a LIP, and/or perform evaluations/reevaluations of individuals who are in restraint/seclusion are educated and demonstrate competence in:</td>
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<td>• recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual reacts to physical contact; and</td>
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<td>• the use of behavior criteria for the discontinuation of restraint/seclusion and how to assist individuals in meeting this criteria.</td>
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