SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	4/7/2014
Sub-section	Crisis and Emergency Response	**Version:**	3.0
Policy	Seclusion and Restraint	**Last Revised:**	DRAFT

Director's Approval _____ **Date** _____
Alice Gleghorn, PhD

PHF Medical Director's Approval _____ **Date** _____
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Supersedes: Seclusion and Restraint rev. 5/31/2017

Approvals: PHF Medical Practice Committee: PHF Governing Board:

1. PURPOSE/SCOPE

1.1. To ensure the use of seclusion and restraints at the Santa Barbara County Psychiatric Health Facility (hereafter the "PHF") are in accordance with the requirements set forth in Sections 1180 *et seq*. of the California Health and Safety Code; the California Code of Regulations, Title 22, Division 5, Chapter 9; the Centers for Medicare & Medicaid (CMS) Conditions of Participation for Hospitals codified in the Code of Federal Regulations, Title 42, Part 482; and all other applicable state and federal laws and standards of professional practice.

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. **Violent behavior** – physically aggressive or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member or others.

2.2. **Seclusion** – the involuntary confinement of a patient alone in a locked room or an area from which the patient is physically prevented from leaving for the purposes of modifying a behavior. Seclusion may only be used for the management of violent or self-destructive behavior. Seclusion does not include a timeout or exclusion timeout. [HSC §1180.1(e); 22 CCR §77029; 42 CFR §482.13(e)(1)(ii)]

2.3. **Exclusion timeout** – removing a patient from an activity to another area in the same room or vicinity for a period of time contingent on a specific maladaptive behavior. [22 CCR §77010]

1. Exclusion timeout is voluntary and may be patient-initiated or staff-directed. During exclusion timeout, the patient is not physically prevented from leaving the designated

area; both the patient and staff collaboratively determine when the patient has regained self-control and is able to return to the treatment milieu. When staff do not permit the patient to leave a room because the patient thinks he or she is calm but the staff disagree, then the exclusion timeout becomes a seclusion.

2.4. **Restraint (also known as "behavioral restraint")** – any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint does not include: (1) certain devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, (2) other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm, and (3) a physical escort as defined in Section 2.7 of this policy. [HSC §1180.1(a); 42 CFR §482.13(e)(1)(i)(A) & (C)]

2.5. **Mechanical restraint** – the use of a mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove, and that restricts the freedom of movement of all or part of a patient's body or restricts normal access to the patient's body. Mechanical restraint is used only as an emergency psychiatric intervention when a patient exhibits violent behavior. The PHF utilizes mechanical bed restraints exclusively. [HSC §1180.1(c)]

2.6. **Physical restraint/hold** – any manual or physical method of holding the patient against the patient's will that restricts freedom of movement of all or part of a patient's body, or to restrict normal access to patient's body. For example, holding a patient to give a forced psychotropic medication in a manner that restricts his or her movement, even for a matter of seconds, constitutes a physical restraint. Physical restraint does not include briefly holding a patient without force in order to calm or comfort, or physical contact intended to gently assist a person in performing tasks or to guide or assist a person from one area to another. [HSC §1180.1(d)]

2.7. **Physical Escort** – using a "light" grasp to escort a patient to a desired location. If the patient can easily remove or escape the grasp, it is not a physical restraint. However, if the patient cannot easily remove or escape the grasp this would be a physical restraint. [CMS State Operations Manual: Appendix A Interpretive Guidelines rev. 183, 10/12/18]

~~2.8. **Chemical restraint** – the use of a medication used to restrict the patient's freedom of movement that is not a standard treatment for the patient's new or continuing medical or behavioral condition.~~

2.9. **Licensed Nursing Staff (LNS)** – an individual employed or contracted by the PHF who holds a valid California license as a: registered nurse (RN); licensed vocational nurse (LVN); or licensed psychiatric technician (LPT).

2.10. **Licensed Independent Practitioner (LIP)** – any practitioner permitted by law as having the authority under their license to independently order restraints, seclusion or

medications for patients. This includes a doctor of medicine (MD) or osteopathy (DO), or a nurse practitioner (NP).

2.11. **Qualified Registered Nurse (QRN)** – a registered nurse who has received training and demonstrates competency in conducting the one-hour face-to-face evaluation of a patient following seclusion or restraint.

3. POLICY

3.1. The PHF is committed to reducing and preventing the use of seclusion and restraint through early identification and intervention of high-risk behaviors or events when possible. Nonphysical interventions are the preferred method of intervention and the use of seclusion and restraint is considered an exception and not a standard of practice.

3.2. All patients have the right to be free from physical or mental abuse, and corporal punishment as well as the right to be free from restraint or seclusion of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff. This includes, but is not limited to, the right to be free from the use of a drug used in order to control behavior or to restrict the patient's freedom of movement (i.e., chemical restraints), if that drug is not a standard treatment for the person's medical or psychiatric condition.
[22 CCR §77103(c); HSC §1180.4(k); 42 CFR §482.13(e)]

3.3. Restraint or seclusion may only be imposed for behavioral emergencies when a person's behavior presents an imminent danger of serious harm to self or others as a last resort for the management of violent or self-destructive behavior and to ensure the immediate physical safety of the patient, a staff member, or others. Restraint or seclusion shall not be used as an extended procedure and must be discontinued at the earliest possible time.
[22 CCR §77103(a); HSC §1180.4(b & h); 42 CFR §482.13(e)]

3.4. Seclusion and restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
[42 CFR §482.13(e)(2); HSC §1180.4(b)]

3.5. Behavioral restraints shall be utilized only with patients being treated pursuant to Welfare and Institutions Code (WIC) Sections 5150 et seq., or patients that have been judicially committed.
[22 CCR §77103(i)]

3.6. Patients will be afforded the least restrictive mechanical restraint (i.e., least number of restraint points) and the maximum freedom of movement while ensuring the physical safety of the patient and others. [HSC §1180.4(j); 42 CFR §482.13(e)(3)] Application of mechanical restraints at the PHF will include the use of one (1) of the following:

1. 4-point mechanical restraints; or
2. 5-point mechanical restraints when necessary to maintain the patient's safety and the use of the chest restraint is not medically contraindicated.

3.7. With the exception of during the removal or application of mechanical restraints, or to conduct range of motion exercises, at no time will less than a 4-point mechanical restraint be applied.

3.8. Seclusion and restraints are initiated and applied only by trained, qualified staff in accordance with the PHF policy *Staff Orientation and Training for Seclusion and Restraint*. [42 CFR §482.13(f)]

3.9. Orders for seclusion and restraint can never be written as a standing order or on an as-needed (PRN) basis. [42 CFR §482.13(e)(6); 22 CCR §77103(e)]

3.10. The dignity and privacy of patients will be preserved to the greatest extent during the implementation and monitoring of these interventions. [42 CFR §482.13(c)]

3.11. The PHF does not utilize simultaneous seclusion and mechanical restraints, Geri-chair restraints, or walking restraints. Prone restraints (i.e., placing the patient facedown during a restraint) are prohibited.

4. SECLUSION AND RESTRAINT ASSESSMENT AT ADMISSION

4.1. Upon admission, an LNS shall assess the patient for seclusion and restraint risk and identify factors that could minimize the use of seclusion/restraint including, but not limited to:

1. Preventative strategies to mitigate seclusion and restraint;
2. Identification of early warning signs, triggers, and precipitants that cause a person to escalate, and identification of the earliest precipitant of aggression for persons with known or suspected history of aggressiveness, or persons who are currently aggressive;
3. Pre-existing conditions or any physical disabilities or limitations that would place the patient at greater risk during restraint or seclusion;
4. Whether the patient has a behavioral advance directive regarding de-escalation and the use of seclusion and restraints, and ensures that the direct care staff is aware of its content;
5. Any trauma history, including any history of sexual or physical abuse that the affected patient feels is relevant.
[HSC §1180.4(a)(1)-(5)]

4.2. The PHF shall not use physical or mechanical restraint on a person who has a known medical or physical condition and there is reason to believe that the use would endanger the person's life or seriously exacerbate the person's medical condition. [HSC §1180.4(d)]

4.3. LNS will document contact information for a family member, domestic partner, significant other, or authorized representative designated by the patient who is contacted if the patient requires use of seclusion and/or restraints. This contact person may also be

reached to participate in a debriefing following a seclusion and/or restraint if the patient requests their involvement during the debriefing. [HSC §§1180.4(a) and 1180.5(b)]

5. INITIATION OF PHYSICAL ESCORTS AND PHYSICAL RESTRAINTS

5.1. All physical escorts and physical restraints will follow Crisis Prevention and Intervention (CPI) techniques.

5.2. Trained staff will apply physical escorts and physical restraints in a humane and therapeutic manner while monitoring the patient for safety and freedom from pain.

5.3. If physical restraint is indicated, at least two (2) staff must participate. Physical restraints must be brief and are discontinued as soon as the imminent danger of serious physical harm is mitigated or the patient can be safely transitioned into a more restrictive intervention if required. [HSC §1180.4(h); 42 CFR § 482.13(e)(9)]

5.4. Each episode of physical restraint shall be initiated upon the order of a psychiatrist.

1. In an emergency, PHF staff may initiate a physical restraint as a protective measure provided that a psychiatrist's order is obtained as soon as possible (and when it is safe to do so) after the physical restraint has been applied.
2. Telephone orders for physical restraint shall be received only by LNS, shall be recorded immediately in the patient's health record and signed by the psychiatrist within 24 hours in accordance with Departmental policy.
[42 CFR §482.13(e)(5); 22 CCR §77103(b)]

5.5. At no time shall the PHF use a physical restraint technique that obstructs a patient's respiratory airway or impairs the patient's breathing or respiratory capacity, including techniques in which a staff member places pressure on a patient's back or places his or her body weight against the patient's torso or back. At no time shall a pillow, blanket, or other item cover the patient's face as part of a physical restraint. [HSC §1180.4(c)(1)-(2)]

1. Prone restraints (i.e., placing the patient facedown during a restraint) are prohibited.

6. INITIATION OF SECLUSION OR MECHANICAL RESTRAINT

6.1. Each episode of seclusion or mechanical restraint shall be initiated upon the order of a psychiatrist.

1. In an emergency, the PHF RN Team Leader may initiate a seclusion or mechanical restraint as a protective measure provided that a psychiatrist's order is obtained as soon as possible (and when it is safe to do so) after the seclusion or mechanical restraint has been initiated.
2. Telephone orders for seclusion or mechanical restraint shall be received only by LNS, shall be recorded immediately in the patient's health record and signed by the psychiatrist within 24 hours in accordance with Departmental policy.
[42 CFR §482.13(e)(5); 22 CCR §77103(b)]

6.2. Trained staff will apply seclusion or mechanical restraints in a humane and therapeutic manner while monitoring the patient for safety and freedom from pain.

6.3. At no time shall a pillow, blanket, or other item cover the patient's face as part of a mechanical restraint. [HSC §1180.4(c)(2)]

1. Prone restraints (i.e., placing the patient facedown during a restraint) are prohibited.

7. REQUIREMENTS FOR SECLUSION, PHYSICAL OR MECHANICAL RESTRAINTS

7.1. The *Physical Restraint, Seclusion or Mechanical Restraint and/or Emergency Medicatio*n form (also known as the *Initial Seclusion or Restraint Record*) shall be completed by LNS immediately upon initiation of the intervention.

7.2. As allowed by law and scope of practice, a psychiatrist or other Licensed Independent Practitioner (LIP), Qualified Registered Nurse (QRN), or physician assistant (PA) – collectively referred to as "practitioner" – conducts a face-to-face evaluation of the patient in seclusion, physical or mechanical restraints within one (1) hour of initiation and documents their findings on the *One-Hour Face-to-Face Evaluation* form.

7.3. The *One-Hour Face-to-Face Evaluation* form will document the following:

1. The intervention(s) used;
2. Justification for seclusion, physical or mechanical restraint;
3. Alternatives or other less restrictive interventions attempted (as applicable);
4. The patient's response to the intervention;
5. Evaluation of the patient's immediate situation and medical and behavioral condition; and
6. The rationale to continue or terminate the seclusion, physical or mechanical restraint. [42 CFR §482.13 (e)(12) & (16)]

7.4. A psychiatrist or other LIP that is onsite during a seclusion, physical or mechanical restraint will be responsible for completing and signing the One-Hour Face-to-Face Evaluation form. If a psychiatrist or other LIP is not immediately available onsite during the seclusion, physical or mechanical restraint, a QRN or PA will complete the evaluation and form.

1. If a QRN or PA conducts the face-to-face evaluation, they must consult with a psychiatrist or other LIP who is responsible for the care of the patient as soon as possible after the completion of the one (1) hour face-to-face evaluation. [42 CFR §482.13(e)(14)]
2. **Physical restraints only.** Typically, a physical restraint is brief and discontinued before a practitioner arrives to perform the one-hour face-to-face evaluation. This practitioner is still required to conduct the evaluation within one (1) hour after the initiation of the physical restraint.

7.5. The patient should be informed of the violent or self-destructive behavior requiring seclusion, physical or mechanical restraint, and specific behavioral criteria required for release.

7.6. Orders for seclusion, physical or mechanical restraints shall remain in effect until the patient's behavior or situation no longer requires seclusion, physical or mechanical restraints.

1. **Seclusion or mechanical restraint only.** A renewal order will be obtained every four (4) hours if the patient does not meet criteria for release. Renewal documentation must be completed for each order and includes the (a) *Physical Restraint, Seclusion or Mechanical Restraint and/or Emergency Medication* form (also known as the *Initial Seclusion or Restraint Record*), and (b) *One-Hour Face-to-Face Evaluation* form. Orders for seclusion or mechanical restraint may only be renewed for up to a total of 24 hours. [42 CFR §482.13]
2. After 24 hours, before writing a new order for the use of seclusion or mechanical restraint, a psychiatrist or other LIP must see and assess the patient. [42 CFR 482.13(e)(2)(ii)]

7.7. If a patient was recently released from seclusion, physical or mechanical restraint, and again exhibits behavior that can be handled only through the reapplication of seclusion, physical or mechanical restraint, a new order is required.

7.8. Within 24 hours, a psychiatrist will complete the *Post-Seclusion or Restraint Evaluation* form to indicate any treatment recommendations to reduce the future incidence of seclusion or restraints.

7.9. For each incident of seclusion, physical or mechanical restraint, licensed staff will complete the applicable sections in the *Denial of Rights* form.

1. Licensed staff will also notify the Patients' Rights Advocate immediately following a seclusion, physical or mechanical restraint.

8. EMERGENCY MEDICATIONS

8.1. The PHF may utilize physical or mechanical restraints to administer emergency medications. An emergency exists when there is a sudden marked change in the patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is not practical to first obtain consent. If antipsychotic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient. [9 CCR §853]

8.2. Following the administration of emergency medications, staff are to monitor the patient and complete vital signs every 15 minutes for one (1) hour, as the patient allows and it is deemed safe to do so by staff.

8.3. Please refer to the PHF's policy *Emergency Medication* for further instructions.

9. SECLUSION: CARE AND MONITORING

9.1. A designated staff who is trained and has demonstrated competency in cardiopulmonary resuscitation (CPR), CPI and the use and monitoring of seclusion will provide ~~continuous~~ 1:1 direct observation of the patient every 15 minutes to monitor the physical and psychological effects of the seclusion. Direct observation will be conducted immediately outside the locked seclusion room door. If this type of observation distresses the patient, observation will occur via video monitor.

1. For information on orientation and training, please see the PHF's policy *Staff Orientation and Training for Seclusion and Restraint*.

9.2. Trained staff will provide evaluation at the initiation of the seclusion and every 15 minutes thereafter while in seclusion. A written record shall be kept of these evaluations and maintained in the individual patient's health record. Evaluation will include:

1. Signs of any injury associated with seclusion; and
2. Patient's readiness for discontinuation of seclusion.
   [22 CCR §77103(g)]

9.3. Trained staff will notify the PHF Team Leader of any changes in the patient's physical or psychological status/comfort needs.

9.4. On an hourly basis, a RN who is trained and has demonstrated competency in CPR, CPI and the use and monitoring of seclusion will conduct an assessment of the patient to determine their physiological and psychological status. If needed, the RN may modify the frequency of this assessment. This assessment includes, but is not limited to:

1. Nutrition and hydration monitoring;
2. Hygiene and elimination monitoring;
3. Vital signs (if allowed by patient); and
4. Justification for continued use of the seclusion.
   [42 CFR §482.13(e)(10)]

9.5. A trained RN will evaluate the need to continue or terminate the seclusion. Discontinuation will occur if:

1. The behaviors or situations that prompted the use of seclusion are no longer evident; or
2. It is determined that less restrictive means will be effective in protecting the patient and others.

10. MECHANICAL RESTRAINTS: CARE AND MONITORING

10.1. A designated staff who is trained and has demonstrated competency in CPR, CPI and the application and monitoring of mechanical restraint will provide continuous, 1:1 face-to-face observation of the patient to monitor the physical and psychological effects of the mechanical restraint. Direct observation will occur at the patient's (open) doorway.
[HSC §1180.4(i); 42 CFR §482.13(e)(15); 22 CCR §77103(f)]

1. For information on orientation and training, please see the PHF's policy *Staff Orientation and Training for Seclusion and Restraint*.

10.2. Trained staff will provide bedside evaluation at the initiation of the mechanical restraint and every 15 minutes thereafter while in mechanical restraints. A written record shall be kept of these evaluations and maintained in the individual patient's health record. The evaluation will include:

1. Signs of any injury associated with applying mechanical restraint;
2. Review of mechanical restraints to ensure they remain properly applied; and
3. Justification for continued use of the mechanical restraint.

[22 CCR §77103(g)]

10.3. On an hourly basis, a RN who is trained and has demonstrated competency in CPR, CPI and the application and monitoring of mechanical restraint will conduct an assessment of the patient to determine their physiological and psychological status. If needed, the RN may modify the frequency of this assessment. This assessment includes, but is not limited to:

1. Signs of any injury associated with applying mechanical restraint;
2. Evidence of any cardiopulmonary compromise;
3. Circulation in the extremities (radial, pedal pulses) and skin integrity;
4. Nutrition and hydration monitor;
5. Hygiene and elimination monitor;
6. Range of motion exercise for at least 10 minutes shall be provided to the patient (unless contraindicated and documented by a physician); and
7. Patient's readiness for discontinuation of the mechanical restraint.

[22 CCR §77103(h); 42 CFR §482.13(e)(10)]

10.4. A trained RN will evaluate the need to continue or terminate the mechanical restraint. Discontinuation will occur if:

1. The behaviors or situations that prompted the use of mechanical restraint are no longer evident; or
2. It is determined that less restrictive means will be effective in protecting the patient and others.

11. CLINICAL/QUALITY REVIEW AND DEBRIEFING

11.1. The PHF shall conduct a clinical and quality review for each episode of the use of seclusion, physical or mechanical restraints. [HSC §1180.5(a)]

11.2. Staff must conduct a debriefing as quickly as possible, but no later than prior to the end of the shift after the use of seclusion, physical or mechanical restraints. This debriefing shall include the patient if they wish to participate. If the patient requests it, the patient's

family member, domestic partner, significant other, or authorized representative will be asked to participate in the debriefing, if the desired third party can be present at the time of the debriefing at no cost to the PHF. [HSC §1180.5(b)]

11.3. Debriefings shall include the staff members involved in the incident, if reasonably available, and a supervisor/Team Leader to discuss how to avoid a similar incident in the future. The purposes of the debriefing shall be to do all of the following:

1. Assist the patient to identify the precipitant of the incident and suggest methods that are safer and more constructive for responding to the incident.
2. Assist the staff to understand the precipitants to the incident, and to develop alternative methods of helping the patient avoid or cope with those incidents.
3. Help treatment team staff devise treatment interventions to address the root cause of the incident and its consequences, and to modify the treatment plan.
4. Help assess whether the intervention was necessary and whether it was implemented in a manner consistent with staff training and PHF policies.
[HSC §1180.5(b)]

11.4. During the debriefing, the PHF shall provide both the patient and staff the opportunity to discuss the circumstances resulting in the use of seclusion, physical or mechanical restraints, and strategies to be used by the staff, the patient, or others that could prevent the future use of seclusion, physical or mechanical restraints. [HSC §1180.5(c)]

11.5. A follow-up debriefing will be held the following day during the patient's treatment team meeting. This follow-up debriefing shall include the patient if the patient wishes to participate.

11.6. The PHF staff shall document in the patient's record all debriefing sessions that took place and any changes to the patient's treatment plan that resulted from the debriefings. [HSC §1180.5(d)]

12. REPORTING SECLUSION- AND RESTRAINT-RELATED DEATHS

12.1. The Centers for Medicare & Medicaid Services (CMS) require that all certified hospitals report to CMS any death associated with the use of seclusion, physical or mechanical restraint. The PHF will inform CMS whenever a patient dies:

1. While in seclusion, physical or mechanical restraints;
2. Within 24 hours after being released from a seclusion, physical or mechanical; or
3. Within one (1) week after a seclusion, physical or mechanical restraint, where it is reasonable to assume that the placement in seclusion or use of physical or mechanical restraints contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation. [42 CFR §482.13(g)(1)]

12.2. Each death must be reported to the CMS Regional Office by submitting the CMS-10455 form ~~by telephone~~ no later than the close of business the next business day following knowledge of the patient's death.
[CMS Survey and Certification Group Memo, 5/8/2014; 42 CFR §482.13(g)(1)]

12.3. Staff must document in the patient's medical record the date and time the death was reported to CMS. [42 CFR §482.13(g)(3)]

REFERENCE

California Health and Safety Code
Sections 1180, 1180.1-1180.6

California Code of Regulations
Title 22, Section 77029, 77103

Code of Federal Regulations
Title, Section 482.13(e)

Centers for Medicare & Medicaid Services (CMS)
State Operations Manual. Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. Revision 183, 10/12/2018. Accessed at:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

Survey and Certification Group Memo, 5/8/2014. Hospital Restraint/Seclusion Deaths to be Reported Using the Centers for Medicare and Medicaid Services (CMS) Form CMS-10455, Report of a Hospital Death Associated with Restraint or Seclusion. Accessed at:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-27.pdf

RELATED POLICIES

Staff Orientation and Training for Seclusion and Restraint

Emergency Medications

Beneficiary Rights

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
8/18/16	2.0	• Removed sections on Seclusion and Restraint Assessment, Debriefing and Training Requirements. Sections will be retained in other policies or guideline documents. • RN assessment of patient conducted hourly (previous policy stated every 2 hours) • Streamlined and separated care and monitoring guidelines for seclusion and restraint into two sections • Emphasized modifying the patient's care plan following seclusion or restraint

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).