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	Safety and Crisis Response		
Policy	Seclusion and Restraint	**Last Revised:**	5/15/2017

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

PHF Medical Director's Approval _____ **Date** _____
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Supersedes: NG-2.3 – Seclusion, Physical and Mechanical Restraint

Audit Date: 5/15/2020

- **PURPOSE-** To ensure the use of seclusion and restraints at the Psychiatric Health Facility (PHF) are in accordance with all applicable state and federal laws and standards of professional practice.

- **SCOPE –** All staff

- **DEFINITIONS**

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

  - **Seclusion** - is the involuntary confinement of a person alone in a room or an area from which the patient is physically prevented from leaving.
  - **Restraint- MECHANICAL RESTRAINT**:The application or use of any mechanical device, material or equipment attached to the patient's body that restricts freedom of movement or normal access to one's own body as a result of material or equipment attached or adjacent to the patient's body.
  - **Physical- Restraint/Hold**: Any manual or physical method of holding the patient against the patient's will that restricts freedom of movement or normal access to one's body. For example, holding a patient to give a forced psychotropic medication in a manner that restricts his or her movement constitutes a physical restraint.
  - **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. If the patient cannot easily remove or escape the grasp this would be a physical restraint.
  - **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.

- **Violent Behavior** - violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member or others
- **Time Out** - A process (patient initiated or staff directed) in which the patient is provided an opportunity to calm down and/or regain control voluntarily through quiet disengagement from immediate stressors. During Time Out 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/she is calm but the staff disagree, then the time out becomes a seclusion.

- **POLICY**

The Psychiatric Health Facility promotes a violence and coercion-free treatment philosophy that focuses on the prevention of emergencies that have the potential to lead to S/R use. The facility is committed to prevent, reduce and eliminate the use of seclusion/restraint through early identification and intervention of high-risk behaviors or events. Seclusion and restraint (S/R) interventions are implemented only as a last resort to support patient safety when behaviors pose a risk of imminent harm to the patient or others. Nonphysical interventions are the preferred method of intervention and the use of seclusion/restraint is considered to be an exception and not a standard of practice.

All patients have the right to be free from S/R of any form that is imposed as a means of coercion, discipline, convenience or retaliation by staff. The dignity and privacy of patients will be preserved to the greatest extent during the implementation and monitoring of these interventions. In addition, the use of seclusion/restraint is not based on the patient's history of seclusion/restraint or history of dangerous behavior.

S/R procedures are considered to be unusual, high-risk events that warrant timely assessment and continuous monitoring. The leadership team has developed S/R training and competency protocols that are required for all clinical staff prior to patient intervention. These competencies focus on implementation, assessment, monitoring and application while raising staff awareness about how S/R interventions may be experienced by the patient. Cardio-pulmonary Resuscitation (CPR) and the facility's approved method of non-violent crisis intervention (CPI)) are additional competency requirements. Staff is educated to discontinue seclusion/restraint at the earliest time possible when the patient can demonstrate compliance with identified release criteria.

- **PROCEDURE:**

1. The Registered Nurse (RN) upon admission provides information regarding S/R to the patient and/or family, assesses the patient for S/R risk and identifies factors that could minimize the use of seclusion/restraint including:
    - Provides the patient and/guardian with the (PHF) Philosophy and Practice for Seclusion and Restraint Use form and ensures understanding of it.
    - Identifies triggers that place the patient at risk for seclusion/restraint

- Identifies preventive strategies to assist patient to control behavior
- Identifies pre-existing conditions that would place the patient at greater risk including: physical disabilities/limitations (e.g. obesity, pregnancy), medical conditions (e.g. hypoxia, hypoglycemia, infections), and history of sexual/physical abuse.
- Determines whether the patient has a behavioral advance directive and ensures that the direct care staff is aware of its content.

2. The RN assesses patient behavior on a regular basis to determine any imminent risk of the patient physically harming self, staff or others.
3. The RN and unit staff implement the least restrictive, non-physical interventions, utilizing patient identified preferred de-escalation preferences and information from the initial assessment prior to seclusion/restraint, including:

   - Redirecting the patient's focus
   - Employing verbal de-escalation
   - Separating patient from group or community
   - Engaging the patient in 1:1 activity to promote safe expression of feelings
   - Offering the use of the quiet room to decrease stimuli and regain control
   - Offering food or drinks
   - Administering medication as ordered by the physician to help the patient more effectively function in his/her environment.
   - Documents the alternative attempted or the rationale for not using alternatives
4. The Physician/RN assesses the need for restrictive intervention and a written or telephonic order is obtained from the physician for the S/R on the Seclusion/Restraint Order form as follows:
   - Adults 18 and older up to 4 hours
   - The physicians' orders specify the reason for restraint and seclusion usage, the type of restraint and their duration. The S/R can be ordered for less than the above stated maximum. The length of the S/R is limited by the continued need for the intervention rather than the length of the order.
   - In an emergency, the Nursing Supervisor/Charge Nurse may initiate a seclusion/restraint as a protective measure provided that a physician order is obtained as soon as possible, but no longer than 1 hour after the initiation of the seclusion/restraint
   - Reviews, with staff, the physical and psychological status of the patient
   - Ensures that seclusion/restraint orders are not written as standing or PRN orders
   - Exceptions to use of PRN or Standing Orders include:
     Geri Chair: if a patient requires the use of a Geri chair with the tray locked in place in order for the patient to safely be out of bed.
     Raised side rails: If a patient's status requires that all bedrails be raised (restraint) while the patient is in bed. It is not necessary to obtain a new order each time the patient is returned to bed after a brief period out of the bed, e.g. for toileting.
     Repetitive self-mutilating behavior: if a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyham Syndrome, and the

patient engages in repetitive self-mutilating behavior, a standing or PRN order for restraint can be applied along with specific parameters established in the treatment plan.

5. RN notifies the Attending Physician or designee as soon as possible but no longer than 1 hour if he/she did not provide the initial order.
6. Staff removes all potentially dangerous personal items from themselves, such as jewelry, neckties and glasses, if indicated, prior to intervening with the patient.
7. The RN in collaboration with unit staff evaluates the patient's behavior and implements appropriate CPI techniques to maintain patient and staff safety for escort to quiet room, placement on transport gurney and/or restraint bed.
8. If physical restraint is indicated, 2 staff must participate in the physical hold application.
9. If mechanical restraint is indicated, staff secures patient extremities with approved mechanical restraints ensuring that:

    - The tip of 2 fingers, up to the first joint, may be fitted between the restraint cuff and patient skin for optimal circulation
    - Leg restraint cuffs are tethered together to maintain dignity and respect
    - Potentially dangerous personal items, contraband (i.e. shoes and shoelaces, glasses, jewelry), are removed from the patient and/or patient's clothing
10. Trained staff applies mechanical restraints in a humane and therapeutic manner, while monitoring the patient for safety and freedom from pain. The restraints are applied to identified locations on the bed ensuring that the staff member:
    - Places the patient on his or her back (**no prone restraints are allowed**)
    - Protects the head from injury
    - Ensures that weight is not placed directly on joints or bony prominences such as knees, ankles, elbows, etc.
    - Ensures that joints are not hyper-extended and that circulation is not impaired
    - Ensures that weight is not placed directly on the chest cavity to inhibit adequate breathing
    - Ensures that all restraint cuffs are checked for adequate circulation and makes adjustments if indicated
    - Places restraints with 1 arm in the up position and 1 arm in the down position
11. RN/designee notifies the patient’s legal guardian/identified emergency contact individual, as applicable, as soon as possible and documents the notification in the patient’s chart.
12. The RN ensures that the rationale for seclusion/restraint is communicated to the patient in understandable terms and identifies behavioral criteria for its discontinuation.
13. RN assigns a staff member, competent in CPR and CPI, and who has been trained and deemed competent in the usage and monitoring of seclusion and restraints, to conduct continuous in-person observation/monitoring for the duration of the seclusion/restraint episode.
    - During seclusion episodes, staff is to continuously monitor the patient through the window of the locked quiet room door. If the patient moves out of direct staff

view, the staff is to open the door to maintain continual visual contact with the patient.
- During mechanical restraint episodes, staff is to continuously monitor the patient via face to face, 1:1 observation.

14. Assigned staff conducts 15-minute patient observations on the Seclusion/Restraint Hourly Flow Sheet that includes the following:
    - Reviews for signs of injury related to restraint application
    - Evaluates patient behavior, staff interventions and patient responses
    - Evaluates for breathing
    - Monitors for circulation and skin integrity
    - Performs range of motion exercises*

-- A minimum of 2 staff must be present when releasing restraint cuffs for range of motion

-- Restraints are released using an alternate limb approach (ex: left arm, right leg)

- Offers food during meal times using paper products*
- Offers fluids or upon request
- Assists with toileting *
- Assists with personal hygiene
- Obtains vital signs*
- Notifies RN of any changes in physical or psychological status/comfort needs
- Assesses patient, every 15 minutes, to determine if release criteria is met.
- If criteria is met, immediately notify RN for final assessment and directive for release.

** Remove restraints for patient meals, use of toilet, ROM and vital signs except when freedom of action may result in physical harm to self or others.*

15. A Physician, Qualified RN (QRN), or other Licensed Independent Practitioner as allowed by law and scope of practice conducts an in-person, face to face assessment of the patient in S/R within 1 hour of initiation and documents findings on the One Hour Face to Face Evaluation. The purpose of this evaluation by the Licensed Independent Practitioner (LIP) or QRN is to determine if the use of these measures is justified to prevent the patient from causing harm to self or others. It is also completed to ensure that the use of S/R poses no undue risk to the patient's medical or psychological well-being. The face to face evaluation is performed even in those situations where the person is released early (prior to one hour), The evaluation incorporates the following:

- Reviews, with the staff, the physical and psychological status of the patient.
- Evaluates the patient's immediate situation, the patient's reaction to the intervention, the patient's behavioral condition, and the need to continue or terminate the S/R.
- Identifies specific behavioral/cognitive changes indicating if S/R may be discontinued (includes assessment of behaviors, attitude, orientation, mood and affect).

- Evaluates the patient's medical condition, including a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, medications, most recent lab results, etc. This comprehensive review of the patient's condition is to determine if other factors, such as drug or medication interactions, electrolyte imbalances, or hypoxia are contributing to the patient's violent or self-destructive behavior.
- Ensures that the use of S/R poses no undue risk to the patient's medical or psychological well being.
- Determines if the use of these measures is justified to prevent the patient from causing harm to self or others and if less restrictive alternatives can be employed to contain the potentially dangerous behavior.
- Assesses the safety of patients in S/R, including the appropriate implementation/application of S/R interventions and their physical and emotional status.

The LIP/QRN:

- Guides staff in identifying ways to assist patient in regaining control to promote discontinuation of S/R.
- Provides or obtains an order if not already completed.
- Contacts the Attending Physician or designee to discuss the evaluation of the patient, the need for other interventions or treatments and the need to continue or discontinue the S/R. This needs to be done as soon as possible after completing the One Hour Face to Face Medical & Behavioral Evaluation but no longer than 30 minutes after the evaluation is completed.
- Documents findings on the S/R One Hour Face to Face Medical & Behavioral Evaluation form.

Special training, in addition to the S/R training completed by all clinical staff, is required for Registered Nurses prior to conducting the one hour face to face evaluation (see the QRN Training for Seclusions/Restraints Policy).

- Certification of competency is required to successfully complete training.
- Competency reassessment is to be renewed annually.
- The Medical Director/DON or designee conducts the training sessions.

16. The RN/RA demonstrates through their documentation in the patient's chart that the seclusion/restraint is the least restrictive intervention that protects the patient's safety and that its utilization is based on an individualized patient assessment.

- Documents seclusion/restraint information on the Seclusion/Restraint Clinical Note. Documentation of condition or symptoms that warranted the use of seclusion/restraint describes patient's specific behaviors that were observed. The documentation includes a detailed description of the patient's physical and mental status and an assessment of any environmental factors (e.g. physical milieu, activities) that may have contributed to the situation at the time of the intervention.
- Initiates/updates the Treatment Plan of Care within 24 hours to reflect current seclusion/restraint intervention and updates changes in treatment approach when

indicated. The RN/therapist discusses with the patient the recommended changes in his/her treatment plan.

- Ensures that seclusion/restraint information is logged on the Seclusion/Restraint Log.
- Assesses the patient's medical and psychological status and readiness for discontinuation every hour and documents on the Seclusion/Restraint Flow Sheet.
- Ensures that a Restriction of Rights Notice is completed for every seclusion/restraint episode and concurrent administration of involuntary medication and is filed under the legal section of the medical record.
- Documents patient's response to intervention used, including rationale for continued use of intervention.
- Ensures that the Seclusion/Restraint Patient Debriefing form is completed within 24 hours of patient release from seclusion/restraint and filed in the patient's chart.
- Ensures that the Staff Debriefing form is completed as soon as possible but no longer than eight hours and filed in the patient's chart.

17. If a patient is released from seclusion or restraints prior to the expiration of the order, the RN must obtain a new order to re-employ the seclusion or restraint.
18. **Debriefing of Staff:**
    - The Charge Nurse or designee conducts a debriefing of the staff who were immediately involved in the S/R as soon as possible after the incident but not to exceed eight hours.
    - The debriefing should, at minimum:
    - Identify if any staff obtained injury during the intervention
    - Identify precipitating triggers to behaviors which led to the S/R
    - Evaluate if appropriate techniques were used to de-escalate the patient and/or contain the incident
    - Identify alternative actions to prevent or minimize future need for S/R.
19. **Debriefing of Patients:**
    - The Unit Manager/RN Supervisor or designee appoints a staff member to debrief the events which resulted in the S/R with the patient after she/he has regained enough composure to be able to communicate with the staff within their normal capacity, e.g. no longer acutely agitated; able to talk and listen to staff.
    - Debriefing should occur within 24 hours of release from S/R, when possible.
    - Debriefing should occur in a location that is private and dignified.
    - The designated staff does not have to be a member of the team who implemented the S/R
    - The designated staff should be a person who is objective and is capable of good rapport with the patient.
    - Staff assists the patient to identify the series of events which ultimately resulted in the S/R.
    - Allow the patient to describe events in his/her own words without interruption.
    - Encourage identification of triggers, including those related to staff, peers, external stressors and the environment.

- After the patient has described his/her perceptions of the incident, the staff member offers objective observations of what he/she witnessed as possible triggering events.
- Staff negotiates alternative actions for the patient and staff to take in order to prevent or minimize the need for future use of S/R should similar triggering events occur.

20. Performance Improvement Department staff in collaboration with the Unit Manager/Designee collects, analyzes and aggregates seclusion/restraint data and reports to the Performance Improvement Committee. The data on all S/R episodes are collected from and classified for all settings/units/locations by the following:

- Shift
- Staff who initiated the proces
- The length of each episode
- Date and time each episode was initiated
- Day of the week each episode was initiated
- The type of restraint used
- Whether injuries were sustained by the patient or staff
- Age of the patient
- Gender of the patient
- Multiple instances of S/R experienced by a patient within a 12 hour time frame
- The number of episodes per patient
- Instances of S/R that extend beyond 12 consecutive hours
- Use of psychoactive medications as an alternative for or to enable discontinuation of S/R
- Triggers for behaviors leading to S/R

21. The PI process and treatment plan includes information from the patient and staff debriefings in order to reduce the use of seclusion and restraint.

REPORTING SECLUSION AND RESTRAINT RELATED DEATHS

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

  a. while in seclusion or restraints;

  b. within 24 hours after being released from a seclusion or restraint; or

  c. within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion 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.

- Each death must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.

- Staff must document in the patient's medical record the date and time the death was reported to CMS.

REFERENCE

California Health and Safety Code
Sections 1180.1-1180.6
California Code of Regulations
Title 22, Section 77103

Code of Federal Regulations
Section 482.13(e)

RELATED POLICIES

Staff Orientation and Training for Seclusion and Restraint

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).