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ADMINISTRATIVE BULLETIN TRANSMITTAL MEMORANDUM

DATE ISSUED: April 20, 2000

EFFECTIVE DATE: April 20, 2000

REVISED: September 26, 2008

SUBJECT: **Administrative Bulletin 3:21**
Seclusion and Restraints in the Continuum of Care

The attached Administrative Bulletin has been revised. This Bulletin is being forwarded for your review, action if necessary, distribution to staff as appropriate, and retention in your Administrative Bulletin manual. Please be advised that each recipient of this Bulletin is responsible for being familiar with the content and ensuring that all affected personnel adhere to it. Also attached is a revised Administrative Bulletin Index for your Manual.

PLEASE NOTE THAT ADMINISTRATIVE BULLETIN 4:14– PERSONAL DEFENSIVE AND CONTROL TECHNIQUES IN AGGRESSIVE PATIENT SITUATIONS AND EMERGENCIES – IS HEREBY RESCINDED.

Kevin Martone
Assistant Commissioner

KM:pjt
Attachment

DIVISION OF MENTAL HEALTH SERVICES

ADMINISTRATIVE BULLETIN 3:21

Original Date: April 20, 2000
Revised Date: September 26, 2008

TITLE: SECLUSION AND RESTRAINTS IN THE CONTINUUM OF CARE

I. PURPOSE

To provide a standardized guideline consistent with current best practices for the use of seclusion and restraint, and to increase capacity to provide less restrictive alternatives with the ultimate goal of elimination of seclusion and restraint within the state psychiatric hospital system.

II. SCOPE

This Bulletin applies to all psychiatric hospitals operated by the Division of Mental Health Services.

NOTE: Administrative Bulletin 4:14 - Personal Defensive and Control Techniques in Aggressive Patient Situations and Emergencies - is hereby rescinded.

III. STATEMENT

The hospitals shall promote a preventive and problem-solving approach to patient violence. This approach must be based on a model of recovery which focuses on patient strengths and goals rather than on problems and disabilities, and shall be incorporated into the treatment environment. Policies, procedures and staff training shall emphasize collaboration and empowerment rather than rigid adherence to or enforcement of rules. This approach, which is based upon current best practices, will emphasize use of a variety of tools and assessments that are to be integrated into each patient's plan of treatment, as well as the use of effective de-escalation techniques, comfort rooms and other environmental changes and interventions that will assist patients in emotional and behavioral self-management. Whenever restrictive interventions are necessary, patients shall be treated in a manner that maintains their dignity and exercises efforts to prevent physical or psychological harm or discomfort.

IV. DEFINITIONS

A. **PROTECTIVE DEVICES AND ADAPTIVE SUPPORTS** are any device/support intended to compensate for a specific physical deficit and are used to physically support maximum normative bodily functioning. Examples of these include helmets and orthopedic appliances, such as hand splints or bed rails, in which the patient uses the rail to assist self to turn. Note: Some protective devices (i.e. bed rails) may be used as a restraint; it is the intent of use, not the device itself, that primarily determines whether it is a protective or restraint device.

B. **RESTRAINT** is any method of physically restricting a person's freedom of movement, physical activity, or normal access to his/her body involuntarily in an emergent situation in order to prevent aggressive and/or destructive behavior toward self and/or others.

1. **Behavioral restraint** is the use of devices, materials or equipment attached or adjacent to the patient's body which prevents free bodily movement of choice. These restraints can include two or four-point restraints in a bed or chair, restraint net, limb holder (padded wrist support), protective ambulatory devices, and jumpsuits which the patient cannot freely remove.

   THE USE OF LOCKED RESTRAINT IS PROHIBITED, with the exception of locked restraints utilized at Ann Klein Forensic Center (AKFC). Special precautions at AKFC must be in place to ensure the safety of patients restrained with locked devices. These precautions must be clearly articulated in AKFC's Emergency Procedures document.

2. **Medical restraint** is the use of devices, material or equipment attached to or adjacent to the patient's body which restrict freedom of movement or normal access to his/her body. Examples of medical restraints include body holder, limb holder (padded wrist support), Geri-chair with tray, hand mitts, hand splint to support IV placement. Medical restraints may be utilized to prevent accidental removal/tampering of equipment used to provide needed medical treatment to promote the patient's well being when less restrictive interventions have failed.

   Note: The intent for the use of medical restraints cannot be for behavior management, regardless of the type of device/equipment utilized. The procedural requirements for the use of medical restraints are therefore different.

3. **Physical holds** are approved manual holds that prevent free bodily movement of choice. Physical holds may be used to immobilize a patient on a 72-Hour Emergency Certification or on Refusing Status for an injection of medication if the patient is uncooperative, or to prevent a patient from harming self or others. Physical holds may also be used to apprehend a committed patient who is attempting to elope. Physical holds do not include escorting/guiding a patient in the performance of ADL, holding a cooperative patient in a manner necessary to administer needed medical, dental or nursing care, or physically directing a non-resistant patient to avoid a confrontation with another patient.

C. **SECLUSION** is the involuntary confinement of a person in a room (locked or unlocked) where the person is prevented from leaving. This does not apply to the routine environmental security measures required for housing patients at AKFC, and when confinement is based on security and not on clinical need. In addition, this does not apply if a room is used as a "Quiet Room" when a patient voluntarily uses a room to self-isolate from external stimuli.

V. GUIDELINES

The hospitals shall provide a continuum of interventions, utilizing the least restrictive necessary. These interventions may include, but are not limited to, manipulation of the environment, use of quiet or "comfort" rooms, de-escalation techniques, alternate dispute resolution, behavioral interventions, and/or medication. Interventions utilized should be in accordance with each patient's own individualized safety plan or Mental Health Advance Directive on psychiatric emergency treatment, when available, in which the patient identifies those interventions which are most effective, as well as those which have been harmful. Intervention decisions should be based on the importance of valuing patients' preferences of alternative approaches that can lead to a safe environment.

Consumer Peer Specialists are essential partners in a recovery-oriented environment to work with patients and staff to provide support and help facilitate patient-centered strength-based treatment services which focus on each individual patient's needs. Consumer Peer Specialists, assigned to each hospital, shall participate in all performance improvement activities, including but not limited to conducting patient satisfaction surveys, assisting patients in development of mental health advance directives or safety plans, participating in or conducting post seclusion/restraint debriefing, partnering with a treatment team member to offer a support group for patients interested in learning new ways to avoid seclusion and restraints, supporting patients in treatment team meetings, participating in staff training and membership on hospital and Division performance improvement committees and/or workgroups.

A. The hospital CEO and leadership staff shall be responsible for maintaining a performance improvement program that has as its goals the reduced use and potential elimination of seclusion and restraint. This performance improvement process shall utilize the six core strategies for the reduction of seclusion and restraint identified by the National Association of State Mental Health Program Directors (NASMHPD). These "best practice" core strategies are:

Leadership Toward Organizational Change – Clear leadership and direction in articulating a vision and philosophy, development of policies and procedures, and implementation of an ongoing performance improvement action plan to minimize the use of seclusion and restraint and encourage an environment of collaboration.

Use of Data to Inform Practice – Gather and analyze data to identify trends/patterns, set improvement goals and monitor use and change over time.

Workforce Development – Through staff development and training, create a treatment environment in which policies, procedures and practices are based on knowledge and principles of wellness and recovery, trauma informed care, and cultural competence.

Use of Seclusion and Restraint Reduction Tools – Individualized treatment which includes use of assessments (risk of violence, history of trauma, physical health risks), development of safety plans and mental health advance directives, comfort rooms and other meaningful treatment activities designed to teach patients emotional and behavioral self-management skills.

Consumer Participation – Inclusion of consumers of services in oversight, monitoring, peer support and significant roles in key hospital committees.

Debriefing Techniques – Rigorous analysis of every seclusion/restraint event and the use of this knowledge to inform policy, procedures and practices to avoid reoccurrence and to mitigate the adverse and potentially traumatizing effects of a seclusion/restraint event on involved patients and staff.

B. Indications and Contraindications

Seclusion or restraint shall only be used for the safety of patients in emergency situations and never as punishment or for convenience of the staff (N.J.S.A. 30:4-27.11d.3). Every patient shall have a safety or crisis plan that details individual crisis prevention strategies for use during critical times so that seclusion and restraint may be prevented. The patient shall develop a crisis or safety plan as soon as possible after admission, but no later than the time when the Comprehensive Treatment Plan is developed. This shall utilize forms that are approved or mandated by the Medical Director, DMHS, and shall describe what emergency interventions are effective and what ones may be harmful to the patient, as well as describe alternative de-escalation activities or approaches that will be beneficial. These plans must be available in emergency situations for use by staff. Note: If the patient has a Mental Health Advance Directive, then this must be accessed and incorporated into the safety plan prior to the use of seclusion or restraint. The patient's treatment plan must also incorporate the information. In addition, the physician shall conduct a clinical assessment of a patient, which includes medical and psychological indications and contraindications, before authorizing the use of seclusion or restraint.

1. The only indication for seclusion/restraint is to prevent a patient from seriously injuring himself/herself or others, when there is an immediate danger, i.e. a threatened, attempted or actual assault or self-injury, and all efforts of de-escalation and redirection have failed.

2. Contraindications for seclusion may exist if patients are suicidal or self-injurious. Patients who require close physical monitoring because of an unstable medical condition or whose mental condition may deteriorate during isolation or reduced sensory input should not be secluded.

3. Contraindications to restraint use may exist when patients have one of the following:

   a. History of physical and/or sexual abuse whereby application of physical restraint, may trigger fear, re-traumatization and further psychological damage.

   b. Physical conditions such as orthopedic problems (e.g. osteoporosis, recent hip fracture), physical deformities, obesity or circulatory problems whereby application of physical restraint may cause circulatory or respiratory obstruction.

c. Respiratory or cardiac problems (e.g. recent M.I.) wherein patients lying on their back may result in aspiration as a result of vomiting (these patients require constant monitoring).

d. High risk for embolism, e.g. post-operative status, pregnancy or postpartum, birth control pills, congestive heart failure, chronic pulmonary disease, fracture or other injuries of the lower extremities, chronic deep venous insufficiency of the legs and prolonged bed rest, etc. (These patients may require more frequent exercise of limbs/lower limb elevation and orders for special observation for signs of embolism, e.g. shortness of breath.)

4. When use of restraint is necessary, a chair restraint is the least restrictive and therefore the preferred method. Use of bed restraints should be avoided, if possible, as the risk of injury to patients and staff is higher and the risk of traumatization and/or re-traumatization is significantly increased. Risk of re-traumatization of female patients is especially high; therefore, use of bed restraints for female patients is prohibited without justification and prior authorization from the hospital Medical Director or designee, unless areas where patients are restrained preclude the availability of restraint beds (AKFC).

5. Use of prone floor takedown techniques should be avoided due to the high risk of injury to both the patient and staff. If floor techniques are used, a RN not physically involved in the restraining procedure must monitor the patient for signs of duress throughout the period in which the patient is held on the floor.

NOTE: FOLLOWING COMPLETION OF THE REVISED CRISIS PREVENTION AND INTERVENTION TRAINING AT EACH STATE PSYCHIATRIC HOSPITAL, PRONE FLOOR TAKEDOWNS/HOLDS WILL BE PROHIBITED.

6. <u>At no time during the implementation of seclusion or restraint shall patients be subject to any of the following unsafe practices:</u>

a. placing a pillow, blanket, towel, or other items over the face to stop the patient from spitting or biting.

b. full bodyweight applied to the patient's back while he/she is in a face down position.

c. pulling of the patient's arms around upper chest during holds due to the risk of compressional asphyxia.

7. Purchase or consideration of any new restraint devices or equipment <u>must</u> have prior review and approval of the Medical Director, DMHS.

C. Care of Patients in Seclusion/Restraint

1. If seclusion and/or restraint use is necessary, every effort shall be made to insure the privacy, dignity, safety, comfort and well-being of the patient at all times.

2. Procedures for both seclusion and restraint use shall meet JCAHO, CMS, state and national standards of practice in regards to ongoing physical assessment, monitoring of vital signs, loosening/readjusting restraints, bathing, toileting, staffing levels and assignments, etc.

3. Staff shall attempt to calm the patient and communicate the need for the restrictive interventions as well as the behavioral goals for their removal.

4. If seclusion and/or restraint are ordered for a deaf patient, the individual shall retain visual access to the nursing and/or attendant staff. A staff person who has the ability to communicate effectively in the patient's mode of communication, if available, shall participate as early as possible in any deliberations which may lead to the imposition of mechanical restraints and/or seclusion. In no event shall a physician's order for the continuation of seclusion or restraint be entered without such participation, if available. Since restraints effectively prohibit the use of hands and arms for communication, if it becomes necessary to use restraints on an individual who is deaf, the following procedures shall be undertaken, unless contraindication is documented:

   a. Restraints shall be removed from the upper extremities at regular intervals to allow for communication.

   b. A staff person who has the ability to communicate effectively in the patient's mode of communication shall be assigned to the patient so that the patient can communicate his/her needs.

   c. Paper and pencil shall be provided for written communication if recommended as a communication mode by the communication assessment completed upon admission.

5. If seclusion and/or restraint are ordered for a patient who is limited in English and identified as requiring language facilitation, a staff person proficient in the patient's language, a qualified interpreter, if available, or the use of the AT&T language line shall be sought immediately to explain to the patient what is happening and why, as well as communicate to staff the concerns/needs of the patient. Refer to DMHS Administrative Bulletin on "Linguistic Competency Services for Consumers and Their Families in the State Psychiatric Hospitals." This participation shall be sought as early as possible during an escalating situation in an attempt to avert the need for seclusion/restraint and/or to stabilize the situation quickly. In no event, shall a physician's order for continuation of seclusion or restraint be entered without such participation. Each hospital should maintain a

roster of staff deemed qualified and proficient in other languages, to be utilized for translation in a crisis situation.

6. When patients or staff suspect abuse related to seclusion/restraint, it shall be immediately communicated to supervisory staff, the hospital Risk Manager and the DMHS Patient Services Compliance Unit; and the allegation shall be fully investigated. Patients shall be given access to Patient Advocates to discuss treatment concerns related to seclusion and/or restraint.

D. Staff/Patient Debriefing and Patient/Family Education

1. Patients are to be educated regarding the hospital's rationale and procedures for the safe and appropriate use of seclusion and restraint. General information regarding their use will be given to patients at the time of admission to the hospital (via an orientation booklet). This will also be explained to the patient by a team member, if his/her behavior suggests the possible need, i.e. when risk factors are noticed and preventive strategies have been unsuccessfully tried.

2. As indicated, families of newly-admitted patients shall receive information about the hospital's policies on the use of seclusion and restraint, as well as information about the alternative therapeutic approaches to such use, which shall be described in the hospital patient/family handbook and/or other educational materials.

3. When a patient is released from seclusion/restraint, a member of the patient's treatment team or other available mental health professional and a peer consumer advocate, if available, shall meet with the patient as soon as possible, but no later than 24 hours after the event, when the patient has been stabilized, as a debriefing for the purpose of:

   a. Providing emotional support to minimize the negative effects of the experience of seclusion or restraint.

   b. Assisting the patient to develop an understanding of the precipitants which may have evoked the behaviors necessitating the use of seclusion or restraint.

   c. Assisting the patient to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations/emotions/thoughts present themselves again.

   d. Developing and documenting a specific plan of interventions for inclusion in the patient's Treatment Plan with the intent to avert future need for seclusion or restraint.

4. Documentation of the patient debriefing shall be made in the patient's medical record.

5. All staff who participated in the use of seclusion and/or application of restraint shall participate in a debriefing as soon as possible prior to the end of the shift following each episode. The purpose of the debriefing is to assess the factors leading to the use of seclusion or restraint, consider steps to reduce the potential future need for seclusion or restraint of the patient, discuss the clinical/emotional impact of the procedure on the patient, emotional effect on staff, and collect data for performance improvement activities.

   Note: It is recognized that not every restraint/seclusion episode will require debriefing, such as the use of a brief hold or several restraint/seclusion events in a short period of time. The latter situation can be considered a continuous episode for the purpose of debriefing.

6. In cases in which the individual has consented to have the family kept informed regarding his or her care - including the use of seclusion and restraint - and the family has agreed to be notified, then staff shall document contact with the family to inform them of the seclusion/restraint episode.

E. Staff Training

1. All staff who regularly interact with patients (which includes but is not limited to nursing, all clinical, housekeeping and food service staff) shall be trained and have documented competencies in all aspects of dealing with behavioral emergencies, including the use of alternative interventions and de-escalation strategies that may reduce the need for seclusion and restraint, as well as in the safe application of seclusion and restraints. The assessment and documentation of competencies shall occur prior to staff participation in any use of seclusion and/or restraint and shall be assessed periodically as required, but no less than annually.

2. Training of staff shall focus upon their identifying the earliest precipitant of violence in patients with a known, suspected, or current history of aggressiveness, and on developing treatment strategies to prevent exacerbation or escalation of these behaviors. The role of the patient and family involvement in the identification of precipitants to violence shall be reinforced. Concepts of recovery and patient choice and collaboration in the treatment process, including development and incorporation of mental health advance directives and/or safety plans must be included in staff training.

3. Training shall also include:

   - Content relating to the risks for positional asphyxia, aspiration and traumatization.
   - Content relating to the use of team, i.e. team roles as well as techniques for facilitating team communication and cohesion.
   - Concepts relating to prevention, such as treatment processes, transference, counter-transference, use of de-escalation techniques, mediation, problem-solving and other non-physical interventions.

- Understanding and recognition of the underlying physical and emotional conditions, medications and their potential effects as well as how age, developmental level, cultural background, history of trauma, physical or sexual abuse, and prior experience with seclusion and restraint may influence behavioral emergencies and affect the response to seclusion and restraint.
- Increase in competence and self-awareness of how staff culture, biases, values and perceptions influence their response to behavioral emergencies and how their behavior might escalate a potentially volatile situation.
- Concepts of wellness and recovery, consumer empowerment and choice, and collaboration in the treatment process.
- Information on DMHS and hospital policies and procedures relating to the use and monitoring of seclusion and restraint.

4. Training shall be provided to clinical, direct care and other appropriate staff during employment orientation and at least annually thereafter. Staff shall be expected to demonstrate current competence in alternative interventions as well as seclusion/restraint procedures.

F. Continuous Performance Improvement Monitoring

1. The leadership staff of each state psychiatric hospital shall develop and maintain a performance improvement program designed to continuously review, monitor and analyze the use of seclusion and restraint as well as issues related to these processes. Ongoing efforts will be made to reduce utilization of seclusion and restraint. Information and analysis should inform and impact key areas in the organization, including strategic planning, workforce development, policies, procedures, etc.

2. The Chief Executive Officer of each state psychiatric hospital shall be responsible for assuring that ongoing documentation and monitoring of patients placed in seclusion and/or restraint is maintained. Monitoring shall, at minimum, consist of reviewing the necessity for use of or continuation of these interventions, the failed use of less restrictive alternatives, patient and staff "debriefing", treatment plan revisions, and incidents where the physician involved does not see the patient within the required timeframe for the initiation of seclusion and/or restraint or to sign orders.

3. Data collection processes will utilize standardized forms and assessments approved by the Medical Director, DMHS. Data will include unit/ward, shift, time of day, staff, injury information, demographic data of patient (gender, age, race/ethnicity, diagnosis, etc.), duration of event, staff involved and alternate interventions attempted. Monitoring of seclusion/restraint reduction tools, i.e. risk assessments, use of safety plans or mental health advanced directives, use of comfort rooms and other alternative activities and/or equipment, and effectiveness of workforce development and debriefing processes will also be conducted

utilizing data collection and analyses approved by the Medical Director, DMHS.

4. All levels of personnel who are active in the assessment, application, monitoring and documentation processes involved with seclusion and restraint are to have their duties, tasks and requirements specified in hospital-based policies.

5. The hospital Medical Director shall provide a process for clinical consultation and/or case review for any patient who has been in seclusion or restraint for three or more discreet episodes within a one-month period of time.

6. All serious injuries and/or deaths that occur while a patient is being placed in seclusion/restraint or result from being placed in seclusion/restraint shall be reported to the hospital Chief Executive Officer and Central Office as required by DHS Administrative Order 2:05, "Reporting of Unusual Incidents." The incident shall also be reported to the DHS Clinical Review Board as required in DHS Administrative Order 1:80, "Procedures for Clinical Review Board," and other applicable entities such as JCAHO, etc.

VI. PROCEDURES

A. Seclusion

1. Seclusion shall be used only with a physician's order. In emergency situations, a RN may initiate the use of seclusion for the protection of the patient and/or others. The physician on duty/on-call shall be contacted immediately, and a verbal order may be obtained; he/she shall see the patient within 30 minutes of the initiation of seclusion and then shall write/countersign the order for the seclusion and document his/her assessment of the patient in the medical record. In emergency situations only, such as after hours MOD coverage when the MOD is responding to another crisis situation and is therefore not available, a trained RN can conduct the 30-minute assessment and consult the physician as soon as he/she is available.

2. The physician's order shall not exceed one (1) hour. Physician orders shall not allow a RN to extend seclusion orders beyond the one (1) hour maximum. Orders shall specify "up to" one (1) hour rather than a predetermined amount of time.

3. The RN shall complete an assessment of the patient's mental status, physical status and behavior at least every half hour and document findings. The assignment of a staff person to provide continuous visual observation of the patient while in seclusion is required. If at any time the patient meets the criteria for release from seclusion, the RN shall authorize release of the patient and immediately notify the physician.

4. When the seclusion order nears expiration, the RN shall complete an assessment of the patient and document findings in the progress notes.

5. Specific behavioral criteria shall be written by the physician to specify when the seclusion may be discontinued prior to the expiration of the order, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before seclusion can be reordered. PRN ORDERS FOR SECLUSION ARE PROHIBITED.

6. Patients in seclusion shall be monitored continuously with observations documented by the assigned staff person at routine intervals not to exceed 15 minutes.

7. A RN shall be required to assess the patient at least every half hour and document this assessment on the 15-minute observation form.

8. Each patient shall be searched prior to being placed in seclusion. Potentially dangerous clothing or objects shall be removed from the patient and the seclusion area. Appropriate non-dangerous attire or safe objects that are therapeutically indicated (i.e. soft or non-injurious objects, magazines, etc.) may be allowed.

9. During the seclusion process, each patient's privacy, dignity and need for physical care shall be carefully monitored and addressed. Opportunity for personal care, including fluids, bathroom use, exercise, meals and hygiene, shall be provided and documented throughout each seclusion incident. STRIP SECLUSION IS PROHIBITED.

10. The use of seclusion for more than six (6) consecutive hours shall be reviewed and approved by the hospital Medical Director or designee.

11. Seclusion areas shall have physical and structural features that insure patient safety and comfort (e.g. outwardly swinging doors, free from dangerous furnishings, temperature controls, adequate space etc.) and allow for complete visual observations while maintaining patient privacy.

B. Behavioral Restraints

1. As part of the intake process, staff shall assess whether or not a patient has a history of being sexually or physically abused or has experienced other trauma. Staff shall discuss with patients strategies to avoid the use of restraint (or seclusion), and if needed, what would be most helpful and least traumatic for them. Staff shall also focus on having patients identify intervention strategies, short of seclusion and restraint, that would be beneficial in helping them to maintain control. Refer to DMHS Administrative Bulletin, "Trauma Informed Care in the Provision of Mental Health Services."

2. Restraint devices may be used only in accordance with manufacturer instructions and for the purpose intended. PRN ORDERS FOR

RESTRAINT ARE PROHIBITED. THE USE OF LOCKED RESTRAINTS ARE PROHIBITED, with the exception of PADs at AKFC. Special precautions at AKFC must be in place to ensure the safety of patients restrained with PADs.

3. Restraints shall be used only with a timed/dated physician's order specifying the type of device, its duration, the reason for its use and the behavior required for its discontinuation. In emergency situations, a RN may initiate the use of restraint for the protection of the patient and/or others. The physician shall see the patient within 30 minutes of the initiation of the restraint and then shall write/countersign the order for the restraint and document his/her assessment of the patient in the medical record. In emergency situations only, such as after hours MOD coverage when the MOD is responding to another crisis situation and is therefore not available, a trained RN can conduct the 30-minute assessment and consult the physician as soon as he/she is available.

4. Each patient shall be checked while being placed in restraint for potentially dangerous objects, which are to be removed from the patient to ensure his/her safety.

5. The physician's order for restraint shall not exceed one (1) hour. Physician orders shall not allow a RN to extend restraint orders beyond the one (1) hour maximum. Orders shall specify "up to" one (1) hour rather than a predetermined amount of time.

6. The RN shall complete an assessment of the patient's mental status, physical status and behavior at least every half hour and document findings. The assignment of a staff person to provide continuous visual observation of the patient while in restraints is required. If at any time the patient meets the criteria for release from restraints, the RN shall authorize release of the patient and immediately notify the physician.

7. Within 15 minutes of the restraint order expiration time, if the RN's assessment indicates that the patient continues to meet the criteria for restraint, the physician is to be notified to conduct an assessment for a new order. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before restraints can be reordered.

8. Patients in restraints shall be placed on constant 1:1 observation, and observations shall be documented every 15 minutes by attending staff. The record shall provide an accurate description of the patient's behavior/status by the staff person assigned the 1:1 observation. A RN is responsible for the assignment of nursing staff to the 1:1 observation and shall monitor that observation forms are properly completed by the assigned staff.

9. The physical needs of the patient shall be continuously assessed and shall be met promptly. Opportunity for personal care, including fluids,

bathroom use, exercise, meals and hygiene, shall be provided and documented throughout each restraint incident.

10. The use of restraints for more than six (6) consecutive hours shall be reviewed and approved by the hospital Medical Director or designee.

C. Medical Restraints

1. Medical restraints are to be utilized following an assessment of a patient's need for medical treatment and the documented inability to provide such care without use of a restraint device.

2. The order for restraint for medical care is to be written by the medical physician in consultation with the treating psychiatrist. The order may be written for up to 24 hours, and under no circumstances can it exceed 24 hours. The order is to include the specific device to be used, for what purpose, the time and duration of use, and the criteria for discontinuation of use.

3. Patients who are in medical restraints must be monitored, assessed, and re-evaluated as clinically appropriate by a RN. The RN can discontinue the medical restraint when the criteria for discontinuation is met, based on documented clinical evaluation of the patient, and must notify the physician within one (1) hour. The patient's status while in medical restraint must be documented at the time of initiation, every two hours, and at the time of discontinuation.

4. The physical needs of the patient shall be assessed and shall be met promptly. Opportunity for personal care, including fluids, bathroom use, exercise, meals and hygiene, shall be provided and documented throughout each restraint use.

D. Physical Holds

1, Physical holds are used only in situations where the patient's behavior presents a clear threat of harm to self or others and it is necessary to use approved physical hold techniques to prevent injury to self or others. Physical holds are used only as long as necessary to protect the patient from hurting self or others. However, physical holds should not generally exceed five (5) minutes in duration. If the patient has not regained control at this time, the patient shall be transitioned to mechanical restraint.

2. Physical holds involving prone restraint are to be avoided.

NOTE: FOLLOWING COMPLETION OF THE REVISED CRISIS PREVENTION AND INTERVENTION TRAINING, PRONE FLOOR TAKEDOWNS/HOLDS WILL BE PROHIBITED.

Standing holds are to be utilized once staff have been trained in these techniques. Physical holds may also be used to immobilize a patient on 72-Hour Emergency Certification or a Refusing Status patient for an

injection of medication if a patient has refused oral medication and is uncooperative with receiving an injection. Physical holds may also be utilized to apprehend a committed patient who is attempting to elope.

3. Physical holds are directed toward reducing and/or eliminating a patient's potential for serious physical harm to self and/or others and require a physician's order. The order for the physical hold may specify up to five (5) minutes rather than a predetermined amount of time.

4. In an emergency situation, the RN may initiate the use of a physical hold and will notify the physician on duty immediately for a verbal order. The physician shall assess the patient in person as soon as possible, but no longer than one hour after the physical hold, and document the patient's mental and physical status. If the physician is not available, such as an after hours MOD who is responding to another emergency, the RN can conduct the patient assessment and notify the physician as soon as is practical.

   If the RN is not present, <u>any trained staff</u> can and should intervene as required to prevent harm to the patient and/or others. The RN must be notified immediately or as soon as possible. A verbal order can be obtained from the physician as soon as is possible.

VII. <u>HOSPITAL OPERATIONAL PROCEDURE</u>

Each hospital shall develop and implement appropriate local operational procedures within sixty (60) days of the effective date of this policy to assure compliance with the provisions of this bulletin. A copy of the hospital policy shall be forwarded to the Director of the Office of State Hospital Management, or the Assistant Division Director to whom the hospital Chief Executive Officer reports, and to the Medical Director, DMHS.

Kevin Martone
Assistant Commissioner

KM:YP:dj