HEALTH CARE AGENCY
BEHAVIORAL HEALTH SERVICES
ADULT MENTAL HEALTH SERVICES
POLICIES AND PROCEDURES

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☒ NEW ☐ REVISED

SUBJECT: ETS RESTRAINTS & SECLUSION

CHANGE NOTICE: _____

PURPOSE:

To provide Evaluation and Treatment Services (ETS) staff with uniform policy and procedures for the use of seclusion and physical restraint..

SCOPE:

The provisions of this policy are applicable to all Evaluation and Treatment Services (ETS) County and contracted staff members that provide services at ETS.

REFERENCES:

California Health & Safety Code, Sec. 1180.3 – 1180.5

Welfare & Institutions Code, Sec. 5325.1

JCAHO Standards 7.1 – 7.1.16

Professional Assault Response Training Manual

Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraints – David Colton, PhD.

FORMS:

Physician's Order Sheet Form (*FO346-5640)*

Medication Administration Record Form (*F 346-429.2)*

Restraint and Seclusion Monthly Log Form (~~# pending~~) F 346-735

Restraint and Seclusion Flow Sheet (# pending) F 346-732

Denial of Rights Form (*MH 306)* F 346-749

Initial Assessment & Advance Directive Form (# pending) F 346-731

Restraint and Seclusion Debriefing Form (# pending) F 346-735

DEFINITIONS:

RESTRAINT is the forcible and involuntary deprivation of the liberty to move about.

MANUAL RESTRAINT is the restriction of voluntary movement by holding the individual.

MECHANICAL RESTRAINT is the restriction of voluntary movement by means of belts, cuffs, soft ties or similar devices.

SECLUSION is the restriction of voluntary movement by locking an individual in a room. If an individual cannot leave the room at will, the room is considered locked.

EMERGENCY is an instance in which there is an imminent risk of an individual harming him/her self or others, including staff, when nonphysical interventions are not viable and safety issues require an immediate physical response.

CHEMICAL RESTRAINT is a medication used in addition to, or in replacement of, the patient's regular drug regimen to control extreme behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. This does not include regular PRN medications.

METHOD:

The County of Orange, Evaluation and Treatment Services (ETS) is committed to the creation of an environment that minimizes and strives for the elimination of the use of seclusion and physical restraint. This goal shall be achieved through staff orientation and training, frequent review of our policy and procedures, peer review and clinical supervision. Restraints or seclusion shall only be used when all other less restrictive alternatives have been exhausted and were not successful, and only when there is an immediate threat of physical harm to the patient or others, which includes but are not limited to peers, visitors or staff. The County of Orange is aware of the increased risk of serious injury, death and potential infringement on the patient's individual rights of freedom of movement, as well as the loss of dignity during a restraining event. The patient has the right to be free from seclusion, behavioral restraint and chemical restraint. It is never to be used as a means of coercion, discipline, staff convenience or retaliation.

Non-physical interventions shall be our first choice as an intervention unless safety requirements demand an immediate physical response. If physical intervention is clinically justified and absolutely necessary, trained staff will utilize proper *Professional Assault Response Training* techniques in an effort to avoid potential injury or harm to the patient and involved staff members.

ETS recognizes the benefit of collaborating with the patient, the patient's family or other requested designee in both providing a sense of empowerment to them as well as learning prevention techniques specific to that individual prior to the need to use physical restraint and/or during the debriefing period after the event.

I. **TRAINING:**

i) The ETS Program Manager, Service Chief II and Senior Comprehensive Care Nurse will define and articulate the vision and goal of the reduction and elimination of the use of restraints or seclusion.

ii) The ETS staff will be encouraged to participate in the suggestion of methods to achieve the stated goal and a climate of learning and non-punitive approaches will be maintained to encourage improvements in staff performance.

iii) During scheduled staff meetings, trainings and debriefing periods open communication will be encouraged regarding alternative measures to physical intervention and the clinical necessity of its use in specific cases.

iv) The Service Chief II and/or her/his designee will review all cases that involved the use of seclusion or restraints for clinical necessity and the documentation justifying its use. Office support staff will provide the Service Chief II with data regarding the frequency and duration of the use of restraints and seclusion.

v) All staff will be trained on the ETS Restraints and Seclusion P&P yearly and a log of the training will be completed.

vi) All clinical staff working at the ETS will remain certified in *Professional Assault Response Training* (PART). This certification is considered current for the duration of two years after the initial certification. At the end of two years each staff member will take the training and be re-certified.

PART emphasizes the use of verbal crisis intervention, understanding patient needs, rapport building and other approaches designed to de-escalate patients without the use of physical force. The training utilizes lecture, discussion, written group exercises, demonstration, role playing and practice of evasion techniques and, as a last resort, physical restraint in a safe and the least restrictive manner.

vii) Periodic refresher courses will be scheduled based on identified educational needs demonstrated by the ETS staff. Training will continually be reinforced through supervision, mentoring and coaching.

II. STAFFING:

i) Supervision will provide a level of staffing that allows the staff to have enough staff members to handle a crisis situation or emergency. The mix of staff members will be taken into consideration regarding their experience, gender, age, physical ability and individual strengths.

ii) Enough staff will be on duty to provide time for breaks and necessary trainings.

III. ENVIRONMENT:

As the physical environment can be an irritant and contribute to agitation and aggression, the ETS staff will continually assess the milieu for conditions that may cause discomfort, such as, extremes in temperature, noise levels, excessive stimulation and crowding. ETS staff will provide all patients with the most comfortable conditions as possible.

IV. ADMISSION ASSESSMENT:

i) Upon admission, each patient will receive an initial assessment and whenever possible will include input from the patient and anyone that the patient requests to be present during the initial assessment, which may include a family member, significant other, or authorized representative designated by the patient. The initial assessment will include the following:

1. The patient's Advance Directive regarding de-escalation or the use of seclusion or restraints.
2. Identification of known precipitants, warning signs and triggers.
3. Techniques, methods or tools that would help the patient to maintain control over her or his behavior.
4. Preexisting medical conditions or any physical disabilities that may put the person at greater risk of harm during a restraint or seclusion procedure.
5. Any trauma history, such as sexual or physical abuse, that the patient feels is relevant.

ii) This information will be documented on the *Initial Assessment and Advanced Directive Restraint and Seclusion Form* and noted in the Progress Notes.

V. SAFETY:

i) The patient's safety, physical and emotional health will be of the utmost concern to the ETS staff during a restraint or seclusion procedure. All of the following apply:

1) Since the risk of physical and emotional harm towards the patient and staff significantly increase during a restraint or seclusion procedure, it will only be performed during a behavioral emergency deemed legitimate by the Registered Nurse and the Physician on duty and after all less restrictive methods have failed.

2) No technique or method will be utilized that has the capacity to obstruct the patient's airway or in anyway diminish the patient's ability to breathe. This includes putting pressure on the patient's neck, chest or back, and covering the patient's mouth and/or nose with a sheet, pillow or any other material.

3) No patient will be placed in the prone position that is at risk for positional asphyxiation as a result of one of the following risk factors that are known to ETS staff: a) obesity, b) pregnancy, c) agitated delirium or excited delirium syndromes, d) alcohol, e) exposure to pepper spray, f) preexisting heart disease including but not limited to an enlarged heart or other cardiovascular disorders, g) respiratory conditions including emphysema, bronchitis or asthma, h) cocaine or amphetamine intoxication.

The only exceptions will be on a case-by-case basis, when the physician provides written authorization in the MD order to accommodate the patient's preference or because the physician judges other clinical risks take precedence. The written authorization may not be a standing order.

No patient will be placed in the prone position with their hands behind their back.

VI. RESTRAINTS & SECLUSION PROCEDURE:

i) If during a crisis, the situation escalates to a behavioral emergency the following will apply:

ii) The Registered Nurse and physician on duty will assess the person face-to-face and approve the use of physical force based on the immediate emergency. The physician will write a note in the progress notes justifying the use of seclusion or restraints.

iii) The patient will be assisted to the seclusion room utilizing proper PART technique and the least restrictive method will be used to contain the patient's dangerous behavior. In ascending order it would be unlocked seclusion, locked seclusion, briefly holding the patient, 3-point restraints, and finally 5-point restraints.

iv) During the restraining procedure a team captain will be identified to coordinate the procedure and one other staff member (preferably not physically involved with the procedure) will be responsible to oversee the patient's physical well being during the event.

v) The physician shall provide a written order on the *Physicians Order Sheet* that states the reason for restraints, the number of points of restraints needed, position and the criteria for the patient's release. The order is in effect for a maximum of four hours. If the patient does not meet the criteria for release at the end of four hours, the physician must do another face-to-face assessment to confirm the need for continued restraint and provide another order. No PRN orders for restraints or seclusion will be accepted.

vi) The medication nurse will note the order onto the *Medication Administration Record.*

vii) The clinician will enter the patient into the *Restraint and Seclusion Monthly Log (Code Green Log Book)* and initiate a *Restraint and Seclusion Flow Sheet.* On the flow sheet, the clinician will document all less restrictive interventions that were attempted prior to the event and the patient's response to these interventions.

viii) The patient will be kept under constant face-to-face human observation if the patient is in both seclusion and restraints.

ix) The clinician will make an entry on the *Restraint and Seclusion Flow Sheet* every 15 minutes while the patient is in seclusion or restraints. Additionally, a face-to-face assessment will be documented within 30 minutes and a note will be completed every hour afterwards as to the necessity for continued seclusion or restraints. The patient is to be released as soon as the emergency passes and the patient is no longer dangerous to self or others.

x) Vital signs will be taken and documented within the first 15 minutes and a minimum of every two hours afterwards. Circulation and respirations will be assessed a minimum of every 15 minutes. Fluids will be offered at least every hour, range of motion exercises will be completed every two hours and toileting will be offered at least every 2 hours.

xi) If a patient is in seclusion or restraints at change of shift, a clinician from the off going shift and the oncoming shift will do a face-to-face assessment together.

xii) A *Denial of Rights Form* will be completed reflecting which rights were denied and the patient's time in and out of seclusion or restraints, as well as the total time spent in seclusion or restraints.

VII. QUALITY & CLINICAL REVIEW:

i) As soon as possible, but no later than 24 hours, after the patient is released from seclusion or restraints, a debriefing meeting will take place. It will include, whenever possible, the staff involved, the patient, the patient's family or any representative requested by the patient and the Service Chief II or Senior Comprehensive Nurse.

ii) The focus of the meeting will include the following:

1) Help the patient identify the precipitant of the event and be involved in suggesting alternative methods that would have been safer and more constructive.

2) Both the patient (if willing to attend) and the staff will have an opportunity to discuss the circumstances resulting in the use of seclusion or restraints and to identify ways to avoid the use of seclusion or restraints in the future.

3) Staff will discuss whether the use of seclusion and/or restraints was necessary and implemented within the parameters of the ETS policies and the PART.

iii) After the debriefing, staff will document an additional intervention on the treatment plan that is based upon the information discussed with the patient regarding alternatives to the use of restraints. (i.e. "When agitated, offer 1:1 in quiet place." or "If pacing, offer time-out in unlocked seclusion room.").

iv) The clinician assigned to the patient will complete the *Restraint and Seclusion Debriefing Form.*