Type: CLINICAL MEDICINE – BHC

Policy: Restraint and Seclusion

Replaces: 10/14, 10/15

Purpose: War Memorial Hospital Behavioral Health Center's philosophy is communicated to all members of the organization who have direct care responsibility. This philosophy includes:

- To prevent, reduce, and strive to eliminate the use of restraint and seclusion.
- To prevent emergencies that have the potential to lead to the use of restraint or seclusion.
- To utilize non-physical interventions as preferred interventions.
- To limit use of restraint or seclusion to emergencies in which there is an imminent risk of an individual physically harming himself/herself, other individuals including staff, and/or destroying property.
- To facilitate the discontinuation of restraint or seclusion as soon as possible.
- To raise awareness among staff on to how the use of restraint or seclusion may be experienced by the individual.
- To preserve the individual's safety, rights, and dignity when restraint or seclusion is used.

See Also: Restraints: Staff Training Requirements Policy; Restraint: Quality Monitoring

1.) **Definitions:**

A. Restraint: Any manual, physical, or mechanical device, material or equipment, which immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. This includes holding a patient to administer medications against their will. [MHC 330.1700(i); 42 CFR; CFR 483]

B. Violent vs. Non-Violent Restraint: If restraint is used because of an unanticipated outburst of severely aggressive behavior that poses an imminent danger to the patient or others, the behavioral standard of violent restraint applies. Other uses of restraint for the provision of medical or post-surgical care should be considered under the non-violent standards. (See Restraints: Hospital Use.)

C. Exclusions: A device(s) used to increase a patient's functional ability and mobility is not a restraint. This includes devices such as orthopedically prescribed device, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the

patient to participate in activities without the risk of physical harm (this does not include a physical escort.)

D. **Chemical Restraint:** A drug or medication when it is used as a restriction to manage the patient's behavior in a way that restricts the patient's freedom of movement and is not a standard treatment or dose for the patient's condition.

E. **Continuous observation:** Face-to-face in-person monitoring.

F. **Emergency:** A situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, other patients, the staff, others, or the destruction of property.

G. **Family:** The person(s) who play(s) a significant role in the individual's life, which may include a person(s) not legally related to the individual receiving care. This person(s) is often referred to as a surrogate decision-maker, if authorized to make care decisions for the individual, if he or she loses decision-making capacity.

H. **Least Restrictive Measures:** Progressive measures that impact a patient's freedom of movement. These measures (devices, techniques, actions) progress from no impact to most restrictive impact on a patient's freedom of movement. Restrictive measures are only used to minimize or eliminate those problem behaviors which place the patient at risk for injury to self or others.

I. **Anatomical Support:** Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a recipient's physical functioning.

J. **Team Control Position:** A coordinated staff controlled intervention that uses supportive physical techniques to manage patient behavior that is/will cause harm to the patient or others. Once the Team Control Position has occurred the patient will be moved to a private area and interventions will be employed to assist the patient in regaining self-control. A Team Control Position will result in a physical hold and may progress to seclusion.

K. **Physical force:** Pressure applied to an individual's body.

L. **Physician/P.A. –** Physicians or Physician's Assistant permitted by law and hospital policy as having the authority under his/her license to independently order physical or chemical restraints and /or seclusion for patients at WMH's BHC. The Michigan Mental Health Code does not allow for the ordering of restraints and/or seclusion by a Nurse Practitioner.

M. **Qualified Registered Nurse:** A licensed nurse qualified by experience, training, and competency in the use of seclusion, including the evaluation of the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion.

N. **Seclusion:** The temporary placement of a recipient in a room, alone, where egress is prevented by any means. [[MHC 330.17009(j)]

O. Time out: A voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome. [AR 330.7001(x)]

P. Setting: The requirements for the use of both violent and non-violent restraints are not specific to any treatment setting, but to the situation the restraint is being used to address. Further, the decision to use a restraint is driven not by diagnosis, but by comprehensive individual assessment that concludes that for this patient at this time, the use of less intrusive measures poses a greater risk that the risk of using a restraint of seclusion.

Q. Therapeutic De-Escalation: An intervention, wherein the recipient is therapeutically engaged in behavioral de-escalation techniques and debriefed as to the cause and future prevention of the target behavior. [AR 330.7001(w)]

R. Qualified Staff: Staff that has been trained in CPI and is able to demonstrate competency in the application of seclusion, monitoring, assessment, and providing care for a patient in restraint of seclusion-

- **a.** Before performing any actions as specified in this paragraph.
- **b.** As part of orientation.
- **c.** Subsequently on a periodic basis consistent with hospital policy.

2.) **Policy Elements:**

A. **Goals:** Congruent with the Behavioral Health Center's (BHC) mission and values and with the recommendations of external regulatory ad professional agencies, the BHC staff will advocate for a seclusion and restraint free environment. Restraint and seclusion is used only in an emergency, when there is an imminent risk of an individual physically harming him/her self or others, harming a staff member, or to prevent him/her from causing substantial property damage. Seclusion or restraint will not be used in any manner that causes physical discomfort or harm to the patient. Patient's rights, dignity, and well-being are protected during restraint or seclusion use. Patients safety needs will be individually evaluated and the least restrictive, effective type of restraint will be utilized to protect the patient and others from harm. Non-physical interventions are the first choice, unless safety issues demand an immediate physical response.

B. All patients are treated with dignity and respect, in a physical and psychological environment that supports their rights and well-being. All patients have the right to be free from physical and/or mental abuse and corporal punishment. Seclusion or restraints are applied after assessment of patient's need, with ongoing assessment to encourage the removal of restraint or seclusion at the earliest moment in time. Seclusion is limited to a highly selective population with oversight reflective of its high-risk potential. When restraint or seclusion is used, it is governed by War Memorial Hospital policies, in accordance with State Law, and provides clear guidance to staff to support their use. Information concerning the circumstances of

their use is used in the performance improvement arena to prevent future use and focus on long-term restraint reeducation.

C. Restraint and/or seclusion are high risk, potentially harmful procedures and are intended to be used only when less restrictive measures have been attempted and have not succeeded, or are clearly not likely to succeed in preventing injury to the patient or others. Every effort is made to avoid the most restrictive treatment measures through the use of de-escalation techniques and alternative treatment measures aimed at managing behavior without physical restraint or seclusion. Any application of restraint or seclusion must involve assessment by a Registered Nurse as to the degree and likelihood of the harm that may be produced by the restraint or seclusion. Restraint or seclusion is to be utilized for no longer than is clearly needed and any doubt about the need for restraint or seclusion should be resolved in favor of using an alternative.
D. Following the implementation of restraint or seclusion the individual’s written plan will be reviewed and modified as needed to reduce the likelihood of subsequent restraint or seclusion events. [MHC 330.1740(9)]
E. Leadership supports clinical staffing to the levels appropriate to the needs of the patients in restraint or seclusion and on the unit. Diagnosis, co-occurring conditions, prior treatment, acuity levels, age, and developmental functioning of patients are all considered when making staffing adjustment.
F. Only qualified Registered Nurses, as defined in hospital policy, may initiate restraint or seclusion for a maximum of 30 minutes in an emergency situation before calling the physician. [MHC 330.1742(4)]
G. Only Physicians and/or P.A.’s can order and complete the one hour face to face for restraints and/or seclusion.
H. At a minimum, qualified physicians/P.A.’s must have a working knowledge of hospital policy regarding the use of restraint and seclusion.
I. When restraint or seclusion is the appropriate intervention, it is to be used for the shortest period of time necessary to enable the individual to effectively cope with his/her environment or situation.
J. Each family is notified promptly of the initiation of restraint or seclusion in cases that the individual has consented to have the family kept informed regarding his/her care and the family has requested to be notified.
K. The rights of the individual must be preserved at all times during the use of restraint or seclusion.
L. Individuals placed in restraint or seclusion must have a protected, private, observable environment that safe guards their personal dignity and well-being.
M. Restraint or seclusion may not be used as a means of coercion, discipline, convenience, or retaliation by staff or as a substitute for effective treatment.

N. Restraint or seclusion must be initiated in a way that avoids undue physical discomfort, harm, or pain to the individual. Only the minimum physical force necessary may be used to implement restraint or seclusion, and only accepted nonviolent crisis intervention/prevention techniques may be utilized.

O. Each episode of restraint or seclusion requires full justification for its application and the results of each periodic examination shall be placed promptly in the record of the patient. A separate permanent record of each instance of restraint and seclusion shall be kept and shall comply with applicable standards. [AR 330.7243(1)]

P. Restraint and seclusion must be discontinued at the earliest possible time regardless of the length of time identified in the order.

Q. Orders for the use of restraint and seclusion must never be written as a standing order or as needed basis (PRN.)

R. If restraint or seclusion are implemented it will be in accordance with safe and appropriate techniques.

S. The hospital requires appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

  a. Staff must be trained and able to demonstrate competency in the application of restraint, seclusion, monitoring, assessment, and providing care for a patient in restraints or seclusion. This will occur before as part of orientation and subsequently on an annual basis consistent with hospital policy.
  b. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion.
  c. The use of nonphysical intervention skills.
  d. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, behavioral status, or condition.
  e. The safe application and use of all types of restraint and seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia.)
  f. Clinical identification of specific behavior changes that indicate that restraint or seclusion is no longer necessary.
  g. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the one (1) hour face-to-face evaluation.
  h. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

i. The training must be documented in the staff personnel records and must document that the training and demonstration of competency were successfully completed.

j. The training must be provided by a qualified individual as evidenced by education, training, and experience in techniques used to address patients' behaviors.

3.) Initial admission nursing assessment:

A. At the time of admission or intake every patient is assessed for risk of harming him/herself or others. Information is obtained about the individual that could help minimize the use of restraints or seclusion. As part of the admission process a Comforts and Triggers Tool is completed to assist in the pre-identification of potential triggers and the patient's interventions for managing their triggers. In the event the patient is not able to complete the form due to behavioral problems and/or psychosis this will be documented on a daily basis until the form can be completed with the patient.

B. The initial nursing assessment identifies:

i.) Techniques, methods, or tools that would help the individual control his/her behavior. When appropriate, the individual and/or family assist in the identification of such techniques.

ii.) Pre-existing medical or psychological conditions or any physical disabilities and limitations that would place the individual at greater risk during restraint or seclusion must be considered and evaluated when ordering restraint or seclusion.

iii.) Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint or seclusion must also be considered.

iv.) Whether the patient has an Advance Directive with respect to Behavioral Health Care and ensures that direct care staff is aware of the Directive.

v.) The patient's preference regarding the use of more restrictive measures in the event it is necessary to manage unsafe patient behavior.

vi.) The role of the family, including their notification of a restraint or seclusion episode, is discussed with the individual when appropriate. This is done in conjunction with the individuals' right to confidentiality.

4.) Patient and Family Education. The patient and family, where appropriate, are educated on the use of restraints and seclusion. Patient and family education includes:

A. An explanation of the patient's behavior that may cause restraint use or seclusion.

B. A discussion of the alternatives available to the use of restraints or seclusion.

C. Possible patient and family participation in the care that could limit or halt restraint use or seclusion.

D. The patient's preferences should be incorporated whenever possible.

E. An explanation of how restraints or seclusion may be used to maintain needed therapy.
F. Patients will be educated prior to restraint or seclusion use the reason(s) they will be put in restraints or seclusion. Staff will check for patient understanding and if the patient is agreeable to the restraint or seclusion.

5.) Restraint and Seclusion Use Requirements:

A. Prior to the use of seclusion or restraint alternative strategies, including preventive and verbal interventions, shall be trialed to minimize the use of seclusion or restraint and its effectiveness, and will be documented in the medical record. Alternatives may include:
   i. Review Comfort and Triggers assessment form completed upon admission.
   ii. Modify the environment (alter lighting, lower bed, clear clutter, etc.)
   iii. Review medications with physicians.
   iv. Relieve discomfort or pain.
   v. Improve communication with/for the patient.
   vi. Reduce sensory stimulation/provide quiet environment.
   vii. Encourage/provide family presence and support.
   viii. Allow patient to verbalize angry feelings, de-escalating the patient.
   ix. 1:1 time with the patient.
   x. Increase level of observation.
   xi. Use time out or quiet room.
   xii. Redirecting the patient's focus.
B. The use of restraint or seclusion is limited to an emergency in which there is an imminent risk of an individual physically harming him/her self, staff or others, or causing substantial property damage when non-physical interventions would not be effective or viable. Non-physical techniques are the preferred intervention in the management of behavior. Such interventions may include redirecting the individual's focus or employing verbal de-escalation. Restraint or seclusion use is limited to:
   i. The type of physical intervention selected takes into consideration information learned from the individual's initial assessment.
   ii. The use of restraint or seclusion is not based on the individual's history or diagnosis but solely on current dangerous behavior.
C. If a patient is restrained or secluded repeatedly, the patient's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of restraints or seclusion. [MHC 330.1742(7)]
D. Simultaneous restraint and seclusion use are only permitted if the patient is continually monitored face to face by a trained staff member. This monitoring

must be in close proximity to the patient. (For the purposes of this provision, "continually" means ongoing without interruption.)

6.) Performance Improvement

A. Using individual identifiers, restraint and seclusion data is collected by the program to monitor and improve its performance of process that involve risks or may result in sentinel events.

B. Restraint and seclusion data is collected for the following purposes:

   i. In order to ascertain that restraint and seclusion is used only as emergency interventions.
   ii. To identify opportunities for incrementally improving the rate and safety of restraint and seclusion use.
   iii. To identify any need to redesign care processes.

C. Data on all restraint and seclusion episodes is collected from and classified by, but not limited to the following:

   i. Shift.
   ii. Staff who initiate the process.
   iii. The one (1) hour face to face medical and behavioral evaluation.
   iv. If restraint is used to manage violent or self-destructive behavior.
   v. A description of the patient's behavior and the intervention used.
   vi. Alternatives or other less restrictive interventions attempted.
   vii. The patient's condition or symptom(s) that warranted the use of the restraint.
   viii. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.
   ix. All staff names and credentials involved in the process.
   x. The length of each episode.
   xi. Date, time, and day of the week each episode was initiated.
   xii. Type of restraint used.
   xiii. Injuries, if any, that were sustained by the individual or staff.
   xiv. Age of the individual.
   xv. Gender of the individual.
   xvi. Whether the physician/P.A. performed face to face assessment within (one) 1 hour of initiation of restraint or seclusion.
   xvii. A provider shall ensure that documentation of staff monitoring and observation is entered into the medical record of the patient. [AR 330.7243(3)]

D. Analysis of data by program staff will always include:

   i. Multiple instances of seclusion or restraint experienced by an individual within a12- hour timeframe.
   ii. The number of episodes per individual.

iii. Instances of restraint or seclusion that extends beyond eight (8) consecutive hours.
iv. Use of psychoactive medications as an alternative for, or to enable discontinuation of, restraint or seclusion.

E. A restraint/seclusion log becomes part of the database.
F. Results from the monitoring activities are reported to the Quality Management Department at least quarterly, sooner when problems are noted.

7.) Occurrence Reporting:

A. Any deaths associated with the use of restraint or seclusion need to be immediately reported to the Program Director, Director of Nursing, Hospital CEO, and the Recipient Rights Officer.
B. The hospital must report to the CMS regional office, by the next business day, any death that occurs while a patient was in restrained or in seclusion for behavioral health reasons, or where it is reasonable to assume that the patient's death is a result of being in restraint or seclusion for behavioral health reasons. The hospital must also report each death that occurs within 24 hours after the patient is removed from restraint or seclusion. The hospital must also report each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or seclusion contributed directly or indirectly to the patient's death. "Reasonable to Assume" in this context includes, but is not limited to, death related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation. The date and time of CMS notification will be entered into the patient's medical record.
C. Deaths are reported to Michigan Department of Health and Human Service as indicated by state law.
D. A restraint or seclusion associated death is considered a sentinel event and is investigated under the hospital sentinel event policy and reported accordingly

Initiating Restraint/Seclusion when Physician/P.A. is NOT present:

Who	Step	Action
Qualified RN	1	Initiate restraint or seclusion in an emergency situation based on assessment of the present risk to the patient, others including staff, or property.
Qualified RN	2	Contact the physician/ P.A. by telephone with required information no later than 30 minutes following initiation of the procedure. It is preferable to notify the on-call provider immediately to allow adequate time to arrive on the unit for the face-to-face evaluation within one (1) hour. Also call Clinical Director of Nursing and notify. If after being contacted, the provider does not order or authorize restraint, the restraint shall be removed. [MHC 330.1740(3)] If, after being contacted, the physician does not authorize the seclusion, the patient shall be removed from seclusion. [MHC 330.1742(3)] The provider is not then required to perform a face-to-face assessment.
Qualified RN	3	If applicable, notify family of restraint/seclusion. Document unsuccessful de-escalation techniques attempted prior to restraint/seclusion. Update the patient's plan of care.
Physician/ P.A.	4	See and evaluate the patient and document the need for restraint or seclusion within one (1) hour after the initiation of the intervention. This face-to-face assessment must include: • The patient's immediate situation. • The patient's behavior and reaction to the intervention. • The patient's medical and behavioral condition. • The decision to continue or terminate the intervention. This assessment is used to identify with patient and staff ways to help the individual regain control, and make necessary revisions to the individual's treatment plan. Even if the patient is released prior to one (1) hour, the face-to-face evaluation is still required to assess for underlying causation.
Physician/ P.A.	5	Provide order for restraint or seclusion, including all necessary elements: • Duration of order. • Type of restraint. • Body parts to be restrained • Conditions of release.
Qualified RN	6	After restraint or seclusion has been implemented, the RN must discuss and document with the patient the specific behaviors that necessitated restraint or seclusion and the behaviors that must be demonstrated to be released from restraint or seclusion.
Qualified RN	7	Notify physician/P.A. if patient is released before expiration of the order.
Physician/ P.A. or Qualified Nurse Practitioner	8	Conduct and document an in-person evaluation of the individual within 24 hours of release.
Physician/ P.A.	9	Prior to expiration of original order: • Perform a reassessment and document findings.

		• A personal examination by a physician/P.A. shall be conducted not more than 30 minutes before the expiration of the expiring order for the restraint or seclusion. [AR 330.7243(6b)]
Physician/ P.A. authorizing continuation	10	Physician/P.A. needs to document the rationale and justification for the restraint/seclusion order in the patient's medical record.
Qualified RN	11	Complete patient record.

Initiating Restraint/Seclusion when Physician/P.A. is Present:

Who	Step	Action
Physician/ P.A.	1	Conduct a face-to-face assessment of the individual and provide the order for restraint/seclusion. Document the face-to-face assessment and determine if continuation of the procedure is indicated.
Physician/ P.A.	2	Write the order for restraint/ seclusion to include: • Date, time and length of restraint or seclusion order - not to exceed four (4) hours. • Type of restraint, including body part to be restrained. • Criteria for release, continuation requirements. Document results of face-to-face evaluation: • Specific behavior exhibited requiring use of restraint/seclusion. • The patient's reaction to the intervention. • The patient's medical and behavioral condition. • Less restrictive strategies tried and unsuccessful. • Discuss with patient the specific behaviors that must be demonstrated to be released from seclusion/restraint.

Notification of Family

Who	Step	Action
Qualified RN	1	The individual's family is notified promptly of the initiation of restraint/seclusion in cases that the patient has consented to have the family kept informed regarding his/her care and the family has requested to be notified. In the event the patient has a guardian, the guardian will be notified as soon as staff is able.

Restraint/Seclusion Log

Who	Step	Action

Qualified RN	1	Each instance of restraint/seclusion is documented in the restraint/seclusion log. Said log will include date, patient name, case number, type of restraint/seclusion, time in, time out, name of RN/Physician/P.A. who initiated the restraint/seclusion, and time of physician face-to-face evaluation. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention. The RN shall ensure that documentation of staff monitoring and observation is entered into the medical record of the resident.

Monitoring and Care

Who	Step	Action
Qualified RN	**1**	At shift change, both shifts shall review: • Time procedure initiated. • Patient's current status: o Physical, emotional and behavior status. o Medication administered. o Type of care needed and time needed to provide care.
Qualified staff	**2**	Provide continuous face to face observation of an individual in mechanical restraint/seclusion. The staff monitoring a patient in seclusion must remain outside the seclusion room door monitoring the patient and documenting their behavior every 15 minutes in the flow sheet. When monitoring a patient in restraints the staff member monitoring the patient will remain in the room where the patient is restrained. • After one (1) hour patients in seclusion without restraints may be monitored by using continuous audio and video equipment providing patient can be seen at all times on the video surveillance. This monitoring must be in close proximity to the patient. • Simultaneous restraint and seclusion use is only permitted if the patient is continuously monitored. • Preferably staff members will be of the same gender as the patient.
Qualified Staff	**3**	After one (1) hour an individual placed in seclusion will be monitored every 15 minutes, more often if clinically indicated.
Qualified RN	**4**	Provide continuous observation when a patient in seclusion has also been administered psychoactive medication on an emergency basis.
Qualified Staff	**5**	Monitor secluded patients continuously during mealtimes.
Qualified RN	**6**	Monitoring the physical and psychological well-being of the patient who is restrained or secluded. Also recorded on the restraint/seclusion flow sheet including, but not limited to: [MHC 33.1740(6), AR 330.7243] • Adequate respiration, circulation status, vital signs and skin integrity must be ensured at all times. • The patient will be clothed or otherwise covered to ensure dignity. • Each patient will be given the opportunity to sit or lie down. • Bathroom privileges at least every (1) hour (more frequently if

		indicated.) • An opportunity to drink water or liquids every15 minutes (more frequently if indicated.) • Restraints shall be removed every two (2) hours not less than 15 minutes, unless medically contraindicated; this may be done in an alternating fashion with opposing limbs. [MHC 330.1740(7)] • A bath/shower at least once daily (or more frequently if indicated.) • Regularly prescribed medications, unless otherwise ordered by the physician. • Regularly scheduled meals and snacks served in a manner that is appropriate for safety. • An environment free of safety hazards adequately ventilated and appropriately lighted. • Each episode of restraint/seclusion in addition to documentation on the flow sheet must be summarized in the progress notes. • If a resident is restrained or secluded repeatedly, the patient's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of restraints or seclusion. • All areas of the flow sheet shall be completed without exception. • Topics requiring a large area for definition shall be written in detail in the medical record. • The patient's behavior. • The patient's mental status. • Each instance of restraint or seclusion requires full justification for its application and the results of each periodic examination shall be placed promptly in the record of the patient. • No patient shall be restrained in a prone (face-down) position.
Qualified RN	**7**	• Checks for circulation, skin color, and respiration at least every 15 minutes and documented (or more if deemed necessary by the prescribing physician/P.A.) [AR 330.7249(9)] • Assess for range of motion every 15 minutes and provide at least every two (2) hours.
	8	• Protect patients from assault by others while in restraint/seclusion.
Qualified Staff	**9**	The patient's right to retain personal possessions and personal articles of clothing may be suspended during restraint or seclusion when necessary to ensure the safety of the individual or others.
	10	In the event of an emergency code like fire or disaster the BHC staff member monitoring the use of seclusion will release patient from seclusion or restraints in order to assist patient to a safer location.

Release from Restraints or Seclusion

Who	Step	Action
Qualified	1	Patents must be released when demonstrating specific behavior previously

RN		agreed upon. Restraint and seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
Qualified Staff	2	A patient who falls asleep while in seclusion or restraint must be released- staff should take care not to wake patient when removing restraints.
Qualified Staff	3	Staff must take appropriate actions to facilitate the individual's reentry into the milieu following release from restraint or seclusion, including but not limited to: • Providing an opportunity to discuss the experience privately within 24 hours following release. • Providing the individual with an appropriate transition and opportunity to return to ongoing activities.
	4	If an emergency health situation (e.g. seizure) occurs, the patient must be immediately released from restraint or seclusion as soon as possible as dictated by the emergency and appropriate medical care initiated.
	5	Removal from restrain for more than 30 minutes shall result in termination of the restraint order.
Physician/ P.A.	6	If the individual is not exhibiting the required release behaviors at the end of the time period designated in the written order, and after a face to face assessment by the physician/P.A., they believe seclusion is still necessary, the physician/P.A. must write a new order, including a description of behaviors that meet the definition of emergency and necessitate the new order.
Physician/ P.A.	7	A progress note must be written by the attending physician/P.A. who addresses the effectiveness of the intervention.

Debriefing

Who	Step	Action
All Staff	**1**	Staff shall be debriefed as soon as possible after each episode of restraint of seclusion. A copy of staff debriefing will not be kept in the patient's chart.
	2	The patient, and if appropriate, the patient's family, participate with staff who were involved in the episode and who are available in a debriefing about each episode of restraint or seclusion.
Qualified Staff	**3**	The debriefing occurs as soon as possible and appropriate, but no longer than 24 hours after the episode.
	4	The debriefing is used to: • Identify what led to the incident and what could have been handled differently; ascertain that the patient's physical well-being, psychological comfort, and right to privacy were addressed. • Counsel the patient involved for any trauma that may have resulted from the incident. • When indicated, recommend modification to the patient's treatment plan. • Information obtained from the debriefing is used for performance improvement activities.

		• The patient debriefing shall always be documented in the patient's medical record.

Administrative Monitoring

Who	Step	Action
Qualified RN	**1**	All uses of all restraint or seclusion in an emergency situation shall be reported daily to the Clinical Director of Nursing and appropriate action is taken to correct unusual or unwarranted utilization patterns.
Qualified RN	**2**	The Program Director and Clinical Director of Nursing are immediately notified of any instance in which an individual remains in restraint or seclusion for more than eight (8) hours or experiences two (2) or more separate episodes of restraint and/or seclusion of any duration within 12 hours. The nurse for each shift must report the total time in restraint or seclusion in the past 24 hours.
Clinical Director of Nursing	**3**	Restraint/seclusion logs will be maintained in the department. At the end of each quarter the Clinical Director of Nursing will review all episodes of seclusion/restraint, observing for trends and opportunities for improvement. Copies of the log, results of the evaluation and plan for improvement will be submitted to the Quality Manager.

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