OREGON STATE HOSPITAL

POLICIES AND PROCEDURES

SECTION 6:	**Patient Care**	**POLICY: 6.003**
SUBJECT:	**Seclusion or Restraint Process**	
POINT PERSON:	**CHIEF MEDICAL OFFICER**	
APPROVED:	**JOHN SWANSON** **INTERIM ADMINISTRATOR**	**DATE: NOVEMBER 22, 2017**

I. POLICY

A. Oregon State Hospital (OSH) provides humane care and treatment to each patient in the least restrictive manner consistent with safety for patients, health care personnel (HCP), and the public. OSH believes that a unit culture and milieu based on respectful, non-coercive interactions between HCP and patients is the safest environment.

B. OSH strives to prevent, reduce, and eliminate the use of seclusion or restraint. Seclusion or restraint use is considered an indicator of treatment failure and a safety measure of last resort as expressed by the Substance Abuse and Mental Health Administration.

C. Non-physical interventions should be used before physical interventions unless safety demands an immediate physical response. HCP must focus on using non-physical interventions early to prevent an emergency situation to decrease the need for using seclusion or restraint.

D. The use of seclusion or restraint poses risks to the physical safety and the psychological well-being of the patient and HCP. Therefore, seclusion or restraint may be used only in an emergency when there is imminent danger of harm.

1. The use of restrictive measures must be the result of careful deliberation by HCP who:

   a. have sufficient clinical knowledge of the patient and the circumstances, and

   b. who are trained in the theory and practice of seclusion or restraint techniques as well as in the prevention of their use.

2. In applying seclusion or restraint in the least restrictive manner, HCP must apply restrictive measures incrementally and only as necessary to deal with the emergency.

3. A patient placed in seclusion or restraint must be protected from self-injury and from injury by others.
4. HCP must reduce restrictions as the emergency abates.

E. Seclusion or restraint may not be used for the convenience of HCP, as a substitute for an activity or treatment, or as punishment.
   1. Corporal punishment is not permitted under any circumstances.
   2. OSH does not use chemical restraint.

F. A patient committed to the Oregon Health Authority (OHA) maintains all rights as outlined in 42 C.F.R. § 482.13, Oregon Revised Statute (ORS) 426.385(1), Oregon Administrative Rules (OAR), and OSH Policy and Procedure 7.005, “Patient Rights,” except as limited by application of this policy.
   1. To the extent that a patient’s rights must be limited during seclusion or restraint as outlined in this policy, such limitations must be lifted as soon as safety allows.
   2. Any limitations must be clinically justified, explained to the patient, and documented in the patient’s medical record.

G. The patient or patient's representative may contest any use of seclusion or restraint or any part of the treatment care plan (TCP) by the use of the grievance procedures as stated in OSH Policy and Procedure 7.006, “Patient Grievances”.

H. HCP roles and responsibilities to verify the provisions of this policy are carried out are identified in Attachment A.

I. Violation of seclusion and restraint policies and procedures or other regulations by a HCP constitutes cause for disciplinary action up to, and including, dismissal.

II. DEFINITIONS

A. "Chief Medical Officer (CMO)" means the physician designated by the Superintendent who is responsible for the administration of medical and psychiatric treatment at OSH.

B. "Chief Medical Officer designee" in this policy means the physician/psychiatric mental health nurse practitioner (PMHNP) or the supervising physician assigned by the CMO.

C. “Chemical restraint” means the use of a medication as a restriction to manage a patient’s behavior or to restrict the patient’s freedom of movement when it is not a standard treatment or dosage for the patient’s condition.

D. “Code Green” means bringing together a group of HCP responders sufficient to respond to an immediate behavioral emergency. “Code Green” is called by Access Control for an immediate response.

E. "Emergency" in this policy means a situation in which:

1. the patient presents an imminent danger of harm to self or others, and
2. nonphysical interventions are not viable, and
3. safety concerns require an immediate physical response.

F. "Health care personnel (HCP)" for the purposes of this policy means the population of health care workers working in healthcare settings. HCP might include, but is not limited to: physicians, nurses, nursing assistants, therapists, technicians, dental personnel, pharmacists, laboratory personnel, students and volunteers, trainees, contractual staff not employed by the facility, and persons not directly involved in patient care (*e.g.,* clerical, dietary, housekeeping, maintenance).

G. "Imminent danger of harm" in this policy means a substantial likelihood of immediate physical harm to the patient or others, an immediate and substantial likelihood of significant property damage, or an immediate and serious disruption of the activities of other patients in the area.
NOTE: A situation in which a patient is shouting or arguing with HCP does not on its own constitute immediate danger of harm.

H. "Manual assistance" means physically holding or guiding a patient's movement in order to provide routine medical care, or to provide care for activities of daily living (ADL), or to manage a behavior when the patient agrees to be held or can easily gain release from the manual assistance (see procedures).

I. "Medical safety device" means a mechanical restraint that is used for medical purposes to maintain a position, limit mobility, or temporarily immobilize a patient during a medical, surgical, or diagnostic procedure, or used for the purposes of healing or protection from injury. Examples of such devices include: helmets, foam bolsters or wedges, soft wrist or waist or crotch restraints, hand mitts, a lap buddy, side rails with or without padding, a recliner, or geri or tray chair.

J. "Personal protective equipment (PPE)" in this policy means physical equipment that is used by properly trained HCP to provide necessary bodily protection for HCP when managing restrictive interventions.

K. "Physician/psychiatric mental health nurse practitioner" for the purposes of this policy means an individual with an M.D. or D.O. degree, or advanced nursing practice degree, who is licensed to practice medicine in the state of Oregon, and credentialed and privileged by the Medical and Allied Health Professional Staff to provide psychiatric care at OSH.

L. "Pre-escalation skill set" includes skills essential to avoid and to de-escalate a potentially dangerous situation without the use of seclusion or restraint. This skill set is a system using interpersonal skills with the goal to develop and maintain a positive relationship with the person(s) involved.

M. "Restraint" means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely or voluntarily.

OSH distinguishes between "manual assistance", "manual restraint" and "mechanical restraint", and distinguishes between "non-violent/non-self-destructive" and "violent/self-destructive" situations.

1. "Manual restraint" means physically holding a patient in order to immobilize the patient to manage violent or self-destructive behavior or to reduce the patient's ability to move any part of the patient's body when the patient does not volunteer to be held, and cannot easily gain release.
   NOTE: Previously called "manual hold" in earlier versions of this policy.
2. "Mechanical restraint" means any physical or mechanical device or equipment that immobilizes or reduces the ability of a patient to move any part of the patient's body.

   Mechanical restraint *does not* include the following:

   a. Orthopedically prescribed devices or protective helmets to permit the patient to participate in activities without the risk of physical harm.
   b. Medical safety devices as indicated in the definition above.
   c. Devices used for security, detention, or public safety reasons on a patient in forensic custody as ordered by a court, or as otherwise necessary to comply with legal requirements.
3. "Non-violent/non-self-destructive" means a situation normally associated with routine medical, surgical, or activities of daily living (ADL) care or for healing, and requires physical assistance of the patient by HCP to accomplish this care.
   NOTE: Previously called "medical restraint" in earlier versions of this policy.
4. "Violent/self-destructive" means a situation in which a patient exhibits violent, aggressive, or destructive behaviors, and where these behaviors represent an imminent risk to that individual (*i.e.,* self-harm), or harm to others.
   NOTE: Previously called "behavioral restraint" in earlier versions of this policy.

N. "Restrictive interventions" means any use of seclusion or restraint.

O. "Safe Containment" means OSH-specific training supplemental to Professional Assault Crisis Training (ProACT) which provides additional guidance about how to physically contain a patient if emergency restraint is initiated.

P. "Seclusion" means restricting voluntary egress by locking a patient in a room or otherwise restricting a patient's egress from a room. If a patient cannot leave, or if the patient perceives he or she is prevented from leaving a room at will whether or not an actual door exists, the patient is considered to be in seclusion.

Q. "Show of concern" means bringing together a group of HCP sufficient to respond to a potential behavioral emergency.

R. "Voluntary movement restriction" means a patient agrees to restrict his or her movements to a single room or confined area as outlined in OSH Policy and Procedure 6.023, "Voluntary Movement Restriction". Notwithstanding the length of time agreed upon, the patient may leave the room at any time. If the patient is prevented from leaving the room at any time, the voluntary movement restriction becomes seclusion.

III. PROCEDURES

A. Interventions and Seclusion or Restraint

1. Upon admission, a patient must be informed orally and in writing of patient rights and rules governing the use of restrictive interventions at OSH.
2. A clear and simple statement of the OAR governing restrictive interventions and instructions on how to obtain a copy of the rule must be prominently displayed in each unit.
3. HCP must use polite, non-abusive language, and must make every effort to understand the patient's needs, even when the patient is not able to express needs clearly.
4. It is the responsibility and authority of the registered nurse (RN) to continuously assess the milieu to maintain an environment that is therapeutic and free of imminent harm. Where an emergency appears to be developing, the RN is responsible to use or direct preventive measures, including the use of the pre-escalation skill set, whenever possible to avoid an emergency.
5. Where there is indication that an emergency may be developing, HCP must use non-restrictive preventive interventions to prevent the need for seclusion or restraint. These interventions include (in increasing level of restrictiveness): use of pre-escalation skills, offering a voluntary movement restriction, or calling a Show of Concern.
6. When restrictive interventions are required, HCP must review each event and use this information to prevent or reduce the need for such measures in the future. (See the debriefing section below.)

B. Determination of Intervention

1. HCP must apply the most appropriate level of intervention consistent with the patient's behavior. The determination of the most appropriate intervention includes evaluation of:
    a. the stated preference of the patient for a method of intervention and the individual's reaction to various methods as included in the patient's TCP, Personal Engagement Plan (PEP), Behavioral Support Plan (BSP),

Wellness Recovery Action Plan (WRAP), or Psychiatric Advanced Directive;

b. the degree of psychological harm accompanying the various levels of intervention;

c. the risk of physical harm and discomfort accompanying the various levels of intervention;

d. the physical capacity of the patient to engage in violent or destructive behavior;

e. the risk of interference with the patient's ongoing treatment; and

f. the presence of precursors as described below.

2. Precursors reliably shown to be predictors of imminent danger of harm must be documented in the TCP to determine whether imminent danger of harm exists at the time of a potential emergency.

C. Requirements for Use of Manual Assistance and Manual Restraint

1. The RN must assess each situation and guide the team in the safest, most appropriate, and least restrictive method of assistance or intervention for each patient.

a. The RN must consider information gathered from the initial admission RN assessment regarding pre-existing medical conditions, other physical disabilities, or other limitations.

b. If assessment indicates more restrictive interventions, the RN must lead the team to provide the most appropriate intervention for the patient.

2. When manual assistance or manual restraint is used, the physical position in which a patient is assisted or held must be made based on all available clinical information at the time, in particular patient and HCP safety, patient trauma history, and medical condition(s).

3. During all manual assistance or manual restraint positions, breathing, circulation, and risk must be continuously protected and assessed.

4. The following requirements apply to manual assistance:

a. Manual assistance for routine medical care or ADL care does not require a physician/PMHNP order and may be administered on a patient either by appropriately trained HCP or under the direction of appropriately trained HCP.

b. If manual assistance is required for frequent or ongoing use, the appropriate intervention must be stated in the patient's TCP.

5. The following requirements apply to manual restraints:

a. If non-restrictive interventions are not effective, the RN must assess each situation in person and must be physically present to guide the team in the safest, least restrictive, and shortest duration manual restraint for each patient. (For exceptions, see procedures below.)

b. A manual restraint may be administered on a patient only by appropriately trained HCP.

c. Manual restraint requires a physician/PMHNP order as directed below for mechanical restraint. Standing orders, PRN orders, or standing interventions in the TCP authorizing the use of manual restraint may not be used.

d. A manual restraint to administer an intra-muscular medication against a patient's wishes is considered a restraint whenever the patient does not volunteer to be held or cannot easily break free.

e. A physician/PMHNP order must be obtained when manual assistance has become a manual restraint (because the patient attempted to break free but was not allowed to break free) as part of an intra-muscular medication administration, laboratory draw, physical examination, or escort.

i. If the patient is not combative, and no further restraint or seclusion is needed immediately following the manual restraint, the order may be given as a telephone order, and no face-to-face physician/PMHNP assessment is required.

ii. If a patient becomes combative, or continues to present an imminent danger of harm, a face-to-face physician assessment is required within one hour. The assessment must be documented in a progress note.

f. If a manual assistance has become a manual restraint during an intra-muscular medication administration, laboratory draw, physical examination, or escort, the RN must document the event, including the duration and reason for the event, in a progress note.

D. Requirements for Seclusion or Mechanical Restraint

1. Only rooms specifically approved for seclusion or restraint may be used when secluding or restraining a patient. A contemplation or sensory room is not an approved seclusion or restraint room.

a. If all approved seclusion rooms are in use, the RN must check with adjacent units for seclusion room availability.

b. If, upon approval from the CMO or CMO designee, a room other than an approved room is used, the RN must document the rationale for this alternative room as part of the Seclusion and Restraint Entry Note.

2. Only restraint devices specifically approved by OSH for the purpose of mechanical restraint may be used for mechanical restraint.

a. The following approved devices may be used with a physician/PMHNP order for restraint: restraint backboard, stryker stretcher, or wrist or ankle Velcro restraint.

b. The following approved devices may be used with an order in addition to or in lieu of a standard restraint device: chest strap, net restraint, tray chair, mitts, and medical safety devices.

c. CMO or designated supervising physician approval is required for soft ambulatory restraint in lieu of a four-point restraint.

3. Steel handcuffs or secure transport restraints (STRs) may not be used on clinical units or in patient-care areas for managing behavioral emergencies. STRs may only be used within the parameters indicated in OSH Policy and Procedure 8.039, "Secure Transport Restraints."

a. The only exception includes when jail STRs are still on a patient and due to safety needs the patient will require seclusion or restraint. The STRs may remain on the patient until the patient is safety contained on the unit.

b. The STRs must be removed as soon as possible.

4. The simultaneous use of seclusion and restraint is permitted only in approved restraint rooms, *i.e.*, when the restraint room door to the hallway is locked to prevent intrusions and provide protection for the patient who is in restraint.

5. When restraint, seclusion, or simultaneous restraint and seclusion are employed, HCP must maintain continuous, one-to-one HCP-to-patient ratio and direct visual and verbal contact with the patient.

E. Initiation of Restraint or Seclusion for Violent/Self-Destructive Behaviors

1. Only the RN or the physician/PMHNP may make the decision to initiate restraint or seclusion, except when self-defense is necessary.

2. The patient must be assessed for risk to self and others before initiating seclusion or restraint. The following factors may be considered:

a. underlying causes of threatening behaviors that may be exhibited by the patient,

b. techniques that would assist the patient in controlling such behaviors,

c. methods or tools previously successful in assisting the patient to control similar behaviors,

d. pre-existing medical conditions or physical disabilities or limitations that would place the patient at risk during seclusion or restraint, and

e. history of physical or sexual abuse or other significant trauma that would place the patient at psychological risk during seclusion or restraint.

3. If a HCP person faces potential violence from a patient,

a. the HCP person must first attempt to use pre-escalation skills to defuse the situation.

b. If pre-escalation skills fail, the HCP person should, second, attempt to disengage from the patient.

c. If disengagement fails, the HCP person must then follow Professional Assault Crisis Training (ProACT) principles of evasion.

4. If pre-escalation skills, disengagement, and evasion are not possible or fail, a HCP person may temporarily manually restrain a patient in self-defense or immediate defense of another patient or HCP until the RN is notified and a full Safe Containment team arrives.

   a. Self-defense may only be in response to the use or imminent use of physical force.

   b. The person must use the least restrictive intervention necessary under the circumstances in accordance with principles and techniques indicated in this policy, and the amount of force used must be reasonably necessary to protect the person from violence of assault.

5. To protect the patient and HCP from injury, Safe Containment supplemental techniques or other approved safe mechanical restraint techniques may be used if pre-escalation skills, disengagement, and evasion are not possible or fail.

6. Only tools approved for use during restraint may be used in restraining a patient.

   a. A shield may be used as PPE under the RN's guidance only by HCP specifically trained in its use so that a manual restraint can be safely applied.

   b. During a restraint, the patient's head may only be held with hands. HCP trained in the use of bite gloves may use bite gloves as PPE for restraint of the head or shoulders.

   c. An approved spit hood may be applied under the RN's direction if a patient has a history of spitting, or is actively spitting. While using a spit hood, HCP must constantly observe the patient's face, and verify the patient has the ability for full respiration, and that no part of the spit hood obstructs breathing.

7. If a physician/PMHNP is not immediately available to assess the need for intervention and an emergency exists, the RN may temporarily authorize the use of restraint or seclusion until a physician/PMHNP is contacted. The physician/PMHNP must be notified by the RN as soon as possible, but not to exceed 15 minutes from the initiation of any restraint or seclusion.

8. The RN must provide face-to-face supervision of HCP actions while HCP place a patient in seclusion or restraint, and must direct HCP in order to maintain patient and HCP safety.
    a. The RN who is leading the restrictive event should limit the number of HCP involved in the event to the minimum necessary to manage the event safely. Unneeded HCP should return to assigned work or may be requested to remain nearby but out of sight of the patient.
    b. If the RN determines the patient needs seclusion, the patient may be asked to stand or sit opposite the door until HCP exit the room.
    c. Only in special circumstances to prevent a restraint may a patient be asked to kneel.
        i. In this case, the RN must make the decision, and document the reason.
        ii. The IDT must review the use of kneeling, and determine possible alternative interventions to reduce further trauma.
    d. The RN who is leading the restrictive event should assign individual HCP members to manage each arm, each leg, and the patient's head if manual restraint of the patient is necessary.
    e. If manual restraint of the patient is required, the patient may only be held with hands.
        i. No direct pressure may be placed on the joints, spinal column, neck, or face.
        ii. If the patient is in the prone position, every effort must be made to move the patient to a supine position as soon as possible to prevent positional asphyxiation.
    f. The RN must assess and act to alleviate signs of physical or medical distress in a patient during a seclusion or restraint process. This should include, but not be limited to listening to what the patient is saying, and assessing the need for immediate, appropriate action if the patient expresses difficulty breathing or other medical distress.
    g. Before a patient is placed in seclusion or mechanical restraint, the RN must conduct a face-to-face evaluation of the possessions a patient may have and determine whether a thorough search of the patient for contraband items is necessary, or whether a more limited removal of possessions is most appropriate to support the patient's de-escalation.
        i. The RN may allow the patient to have an object considered to be safe if the object assists the patient to deescalate, or if the removal would needlessly serve to further escalate the patient.

ii. An item may be given to the patient if the item may assist the patient to deescalate.

iii. An item may be removed, inspected, and returned to the patient if the item may assist the patient to deescalate.

iv. If the RN has reasonable cause to believe the patient has contraband, the RN must follow procedures in OSH Policy and Procedure 8.041, "Personal Searches" to authorize a personal search.

v. HCP must follow procedures in OSH Policy and Procedure 8.041, "Personal Searches" if a search is conducted.

vi. Only contraband must be removed from a patient's possession during an event. Safety must drive the RN's decision to remove items that are not contraband.

vii. To avoid further trauma, clothing may not be cut off a patient in the process of restraining the patient unless there is an imminent safety concern determined by the RN, physician, or PMHNP.

h. Before a patient is placed in seclusion or mechanical restraint, HCP must inspect the room and remove any objects that could potentially cause harm to the patient or be used by the patient as a weapon.

F. Assessment and Documentation of Seclusion or Restraint

1. RN Assessment

a. The RN must provide ongoing assessment and monitoring of any patient in seclusion or restraint.

i. The RN may delegate continuous monitoring to assigned qualified HCP.

ii. The RN must provide the level of supervision necessary to verify applicable standards and patient nursing care requirements are met. This must be documented on the Seclusion or Restraint Flowsheet.

b. A face-to-face general assessment must be completed by the RN during the restraining process and directly after a patient is placed in restraint. The assessment must include pulse and respiration, assessment of airway exchange, proper positioning of the head and neck, signs of any injury associated with the event, circulation, physical and mental status, and comfort.

c. The RN must conduct a face-to-face assessment of the patient no less than every 60 minutes while the patient is in seclusion or restraint. The RN assessment must include

i. a brief mental status focusing on psychiatric behaviors that led to the seclusion or restraint, and

ii. determination of whether the patient is no longer an imminent danger of harm to self or others.

d. If an order authorizing the use of seclusion or restraint is within one hour of expiring, the RN must conduct a face-to face assessment of the patient to evaluate the need for continued seclusion or restraint. The only exception is a one-hour order.

e. If the RN determines an additional order may be required, the RN must contact the physician/PMHNP.

2. RN Documentation

a. Upon initiation of seclusion or restraint, the RN must immediately initiate the Emergency Seclusion and Restraint Entry Note and the Emergency Seclusion or Restraint Flowsheet. Each form must be filed and routed as directed on the form.

b. Assessment documentation must be completed on the Seclusion or Restraint Entry Note. Assessment documentation must include respiration, skin color, signs of any injury, patient's orientation within the room, and apparent comfort.

c. An RN progress note must be completed to document manual restraint.

d. The RN must verify completion of appropriate documentation.

3. HCP Documentation

a. In addition to continuous monitoring, HCP must document observations of a patient in seclusion or restraint at least every 15 minutes on the Seclusion or Restraint Flowsheet.

b. The Restrictive Event Data Worksheet and the Restrictive Events Report must be completed by nursing HCP per Nursing Services protocol.

c. Changes from manual assistance to seclusion or manual restraint or mechanical restraint, or vice versa, must be entered into the report as separate events.

4. Physician/PMHNP Assessment and Documentation

a. A physician/PMHNP must conduct a face-to-face evaluation of the patient within one hour of the initiation of seclusion or mechanical restraint. The physician/PMHNP must reassess the patient at intervals specified below.

i. If only an initial order is given, a progress note must be written.

ii. If both an initial and a continuing order is given, a single progress note for both may be written.

b. At the time of each face-to-face evaluation, the physician/PMHNP must:

i. assess the patient to determine possible injuries, and to determine whether seclusion or restraint should be continued;

ii. work with the patient and HCP to identify ways to help the patient regain self-control;

iii. evaluate and review, with HCP, the physical and mental status of the patient, focusing on the patient's current behavior and the connection to psychiatric symptoms;

iv. supply HCP with guidance in identifying ways to help the patient regain self-control so that seclusion or restraint can be discontinued; and

v. write orders as needed.

c. The only exception to the physician/PMHNP one-hour face-to-face assessment is in Junction City when a physician/PMHNP is not physically present on campus and cannot arrive in time to conduct the one hour assessment.

i. If a physician/PMHNP cannot arrive by the one-hour face-to-face evaluation, the physician/PMHNP must assess the patient by the second hour after seclusion or restraint is initiated.

ii. If a physician/PMHNP is unable to arrive by the one-hour face-to-face evaluation, an RN trained and competent to conduct the one-hour face-to-face evaluation must assess the patient within one hour after seclusion or restraint is initiated.

iii. The RN trained to conduct the one-hour face-to-face evaluation must immediately call the physician/PMHNP to provide the required face-to-face evaluation information indicated above, discuss the need for other interventions or treatment, and the need to continue or discontinue seclusion or restraint.

iv. The RN must document the results of each face-to-face evaluation element indicated above.

d. If the patient continues to require seclusion or restraint, a physician/PMHNP must assess the patient face-to-face and document the information indicated above at a frequency no less than:

i. within eight hours after initiation of seclusion or restraint; and

ii. every eight hours thereafter.

e. After each face-to-face assessment, and no later than the end of the physician/PMHNP's work shift, the physician/PMHNP must document the following information in a progress note:

i. the time the physician/PMHNP conducted the face-to-face assessment;

ii. the patient's condition or symptom(s) and specific behavior(s) that justified using the intervention;

iii. the restrictive intervention used, and the patient's response to the intervention;

iv. patient quotes from the interview during the face-to-face interaction or an explanation as to why the patient was unable to participate in a discussion;

v. a summary of the patient's relevant history related to the current behavior and current mental status, including documentation of any patient injury;

vi. the circumstances around any expired orders, if applicable; and

vii. the circumstances around, and the justification for, any unusual methods of releasing a patient from mechanical restraint.

f. The physician/PHMNP must document any consultation obtained during the restrictive event.

g. After each 24-hour period of continuous seclusion or restraint, a consultation to evaluate the need for continued seclusion or restraint must be performed by the ordering physician/PMHNP with the CMO or the CMO designee.

i. If the patient's behavior continues to pose a risk of imminent danger of harm, a new order for seclusion or restraint may be written.

ii. The consultation must be documented in the patient's electronic health record and include current mental status, a description of behavior posing risk of imminent danger, and suggestions for treatment modifications to assist the patient in meeting criteria for release.

5. Enhanced Supervision Documentation

a. Existing Enhanced Supervision orders will resume at the end of the event, unless otherwise ordered.

b. Due to a patient being under constant observation, it is not necessary to complete the Enhanced Supervision Flowsheet, except to note the beginning and the end of the seclusion or restraint event. (See OSH Policy and Procedure 6.010, "Enhanced Supervision".)

6. Patient Death Related to Seclusion or Restraint Documentation

a. Any death of a patient within 24 hours of the use of seclusion or restraint or a death otherwise possibly related to the seclusion or restraint (*i.e.,* within one week of a seclusion or restraint event), must be recorded by the physician/PMHNP in the patient's medical record.

i. This note must be written as soon as possible upon learning of the association.

ii. A copy of the note must be forwarded to the CMO.

b. Reporting of the event must occur as indicated in this policy and in OSH Policy and Procedure 6.005, "The Deceased Patient."

G. Orders for Seclusion or Mechanical Restraint

1. A physician/PMHNP may order seclusion or restraint after assessing the patient's condition.
2. An order may not exceed four hours, and must include a brief description of the behavior requiring the use of seclusion or restraint and duration for the order.
3. If a physician/PMHNP is not immediately available to order the use of seclusion or restraint upon initiation of seclusion or restraint, the RN may obtain an initial telephone order for up to one hour from the initiation of seclusion or restraint.
   a. The telephone order must be documented using the approved "Seclusion or Restraint" ink stamp.
   b. If continued seclusion or restraint is indicated, a second order must be made by the physician/PMHNP after a face-to-face assessment. This is a continuing order; the total hours for both stamps combined may not exceed four hours.
4. If an order authorizing the use of seclusion or restraint is within one hour of expiring and it seems unlikely the patient will meet release criteria, the RN must contact the physician/PMHNP.
   a. The physician/PMHNP must review the case with the RN, and may give another telephone order for an additional maximum four-hour period, if necessary.
   b. The physician/PMHNP must complete this order by authenticating (including signing, dating, and timing) the order no later than the end of the physician/PMHNP's shift.
5. If, by seven hours since the last face-to-face assessment, an order authorizing the use of seclusion or restraint is within one hour of expiring, and it seems unlikely the patient will meet release criteria, the RN must contact the physician/PMHNP.
   a. The physician/PMHNP must conduct a face-to-face assessment of the patient no later than eight hours since the last face-to-face assessment to evaluate the need for continued seclusion or restraint (see procedures above).
   b. If the patient cannot be released after the physician/PMHNP face-to-face

assessment, an additional order authorizing the use of seclusion or restraint must be written by the physician/PMHNP.

c. The circumstances must be documented in the electronic health record as indicated in procedures above.

6. A new order is required to move a patient from seclusion to a more restrictive intervention such as restraint. The order must follow instructions above.
7. A separate order is not required when moving the patient to a less restrictive intervention (*e.g*., releasing patient from mechanical restraints on the bed to seclusion in the seclusion room).
8. Orders for the use of seclusion or restraint may not be written as a standing order, on an as-needed basis (*i.e.,* "PRN"), or be included in the TCP.
9. After each 24-hour period of continuous seclusion or restraint, a consultation must be performed with the CMO or designee as instructed above.

H. Patient Care During Seclusion or Mechanical Restraint

1. A patient in seclusion or restraint must be monitored continuously, directly, and visually by HCP.
   a. HCP must be continuously present in the room, at the door with full view of the patient, or in the designated anteroom with full view of the patient via video monitoring.
   b. A HCP member may not monitor more than one patient in seclusion or restraint at one time.
2. A minimum of two HCP must be present for all direct patient care when a patient is in seclusion or restraint. The patient's gender, trauma history, and preferences must be considered when deciding on the gender of the HCP who will provide direct patient care.
3. A patient's environment while in seclusion or restraint must be made as comfortable as reasonably possible. This could include elevating the patient's head, providing a blanket or pillow, etc.
4. The patient must have as much freedom as safely possible as determined by the RN.
5. Nutrition and hydration needs must be assessed no less than every two hours. The patient must be offered nourishment according to regular meal and snack schedules.
6. Hygiene and elimination needs must be addressed as requested, but no less than every two hours.
7. A patient in mechanical restraint must be given the opportunity to exercise for a period not less than ten minutes during every two hours of mechanical restraint.

a. Each limb must be assessed for injury (*e.g.,* bruising or skin tears) when released for exercise.

b. Decreased levels of mechanical restraint must be employed as necessary to permit exercise, including range of motion movement.

8. Patient care during seclusion or restraint must be documented on the Seclusion or Restraint Flowsheet.

I. Patient Release from Seclusion or Mechanical Restraint

1. The RN or physician/PMHNP must re-inform the patient in seclusion or restraint hourly of the behavioral criteria for release from the restrictive intervention. Criteria must be communicated in terms easily understandable by the patient, and must be documented on the Seclusion or Restraint Flowsheet.

2. The RN or physician/PMHNP must determine the patient's readiness for release. Criteria for moving a patient to a less restrictive intervention may include, but are not limited to: "calm affect," "verbal contract for safe behavior," "assessed effectiveness of PRN medication," "cooperation with debriefing of event," or "patient is sleeping."

a. If the patient appears to be calm or asleep, or is rated 0-1 on the agitation scale, and 0 on the Seclusion or Restraint Flowsheet aggression scale for two consecutive 15-minute observation checks, the RN must evaluate the patient for release from seclusion or restraint.

b. If not released, the RN must consult with the physician/PMHNP, and must document rationale for continuing the restrictive intervention on the Seclusion and Restraint Flowsheet.

3. A patient may be released from restraint and changed to seclusion, be titrated out of restraint by the release of opposite limbs (arm and leg), or be released from restraint in one step. The RN must, while physically present, supervise the titration or release of the patient from restraint.

4. Under the guidance of the physician/PMHNP and the RN, HCP must take action as directed to re-engage the patient back into the milieu.

J. Follow-Up and Debriefing

1. If the patient consents to notification, the RN must notify the patient's family of an episode of seclusion or restraint, unless such contact is deemed by the IDT to be clinically contraindicated. If the patient's family is not contacted, the rationale for not contacting the patient's family must be documented in the medical record (see OSH Policy and Procedure 6.021).

2. Immediately after initiation of a seclusion or mechanical restraint, a HCP debriefing must be held with HCP involved in the event as indicated on the "Emergency Seclusion or Restraint Review" form.

3. HCP must attempt to debrief with the patient throughout the seclusion or mechanical restraint. The debrief and debrief attempts must be documented on the "Emergency Seclusion or Restraint Review" form.
4. Each use of seclusion or restraint must be reviewed and debriefed by the designated IDT, including the patient whenever possible, within five working days of the event.
    a. After each episode of seclusion or mechanical restraint, TCP interventions must be reviewed or modified to reduce the need for seclusion or restraint, or the psychiatrist or PMHNP must write a progress note documenting why the current TCP interventions are still the most appropriate interventions.
    b. The IDT review must be documented in the patient's medical record in the "IDT Review of Seclusion or Restraint Event" section of the "Emergency Seclusion or Restraint Review" form (OSH STK #75061).
        i. Any indicated changes must be documented on the patient's TCP.
        ii. If there are no changes, the justification for no changes must be clearly documented on the form.

K. Use of Medical Safety Devices for Non-Violent/Non-Self-Destructive Behaviors

1. Use of medical safety devices to support healing or posture and to allow active involvement in ADL is permitted with a physician/PMHNP order, or as an entry into the TCP.
2. The order may not exceed 48 hours, and must include:
    a. the type of equipment;
    b. the frequency of use if applicable, and alliance
    c. the duration of use.
3. Where such a device is ordered, documentation must be completed by the physician/PMHNP, and must include the lesser restrictive interventions that were considered. The documentation must also indicate the risks and benefits which were considered in the decision that the device was necessary.
4. Each time a medical safety device is used, the RN must document a progress note including the following information: the device, the reason for the device, other interventions attempted, and the patient's understanding of the use of the device.
5. Use of medical safety devices for behavioral control, such as to prevent a patient from intruding on others, or to prevent possible falls, is considered a mechanical restraint, and may only be used for behavioral control in an emergency situation. Medical safety devices used for behavioral control as a mechanical restraint must be documented as a mechanical restraint according to procedures above.

6. If a medical safety device is included as an intervention on the patient's TCP, the intervention must be reviewed monthly.

L. Seclusion or Restraint Incident Reviews

1. If indicated, an incident report must be completed as required in OSH Policy and Procedure 1.003, "Incident Reporting".
2. Seclusion and restraint data must be reviewed by the Seclusion and Restraint Committee to identify opportunities for organizational improvement from the aggregate information.
3. Any death associated with an episode of seclusion or restraint must be immediately reported to the CMO and the Standards & Compliance Department Director. In this context, this reporting requirement includes a death where:
   a. the death occurred during the restrictive event;
   b. the death occurred within 24 hours of the restrictive event; or
   c. the death occurred within one week after a restrictive event and it is reasonable to assume that use of restraint or placement in seclusion may have contributed directly or indirectly to a patient's death.
4. Reporting of a seclusion or restraint-related death must occur according to procedures in OSH Policy and Procedure 6.005, "The Deceased Patient".

M. Training Requirements

1. Each physician/PMHNP, direct-care HCP, and any other HCP involved in the use of seclusion or restraint must receive ongoing training, and must demonstrate competency and understanding of the following:
   a. OSH goals, philosophy, and policies regarding the use of seclusion or restraint;
   b. underlying causes of threatening behaviors exhibited by a patient, and how to appropriately respond;
   c. possible medical conditions, history of trauma, age or developmental variables, and cultural issues that may contribute to aggressive behaviors;
   d. how HCP behaviors affect patient behaviors;
   e. techniques including, but not limited to de-escalation and collaborative problem solving;
   f. how information gathered about the patient may be used to inform use of pre-escalation skills or restrictive interventions;
   g. Professional Assault Crisis Training (ProACT).
   h. techniques including self-protection, safe containment, and voluntary movement restrictions;

i. signs of physical distress in a patient who is being secluded or restrained;

j. principles related to manual and mechanical restraint, and the application, use, monitoring, and discontinuation of the use of restraints; and

k. viewpoints of patients who have experienced seclusion or restraint.

2. In addition to the training described above, nursing HCP members must receive ongoing training and demonstrate competence in the following:

   a. techniques to identify HCP behaviors, patient behaviors, events, or environmental factors that may trigger the use of seclusion or restraint;

   b. use of non-physical interventions;

   c. choosing the least restrictive intervention;

   d. recognizing signs of incorrectly applied restraints when restraints are used;

   e. monitoring and taking appropriate action to protect the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to: respiratory and circulatory status, range of motion in the extremities, skin integrity, and vital signs;

   f. checking for nutritional or hydration needs, and meeting those needs;

   g. addressing hygiene and elimination needs;

   h. recognizing readiness for discontinuing seclusion or restraint, including observing and reporting specific behavioral changes that indicate seclusion or restraint is no longer necessary, and how these relate to individual release criteria;

   i. helping a patient meet behavior criteria for the discontinuation of seclusion or restraint;

   j. recognizing when to contact the physician/PMHNP or emergency medical services in order to evaluate or treat the patient's physical or mental status;

   k. completing Cardiopulmonary Resuscitation (CPR); and

   l. using first aid techniques.

3. Junction City Nursing Services management must be trained and demonstrate competency annually to complete the one-hour face-to-face assessment.

IV. ATTACHMENTS

Attachment A Emergency Seclusion or Restraint HCP Roles and Responsibilities Flowsheet

V. REFERENCES

42 CFR § 482.13

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Joint Commission Resources, Inc. (2017). *The joint commission comprehensive accreditation manual for behavioral healthcare*, CTS.05.06.Oakbrook Terrace, IL: Author.

Huang, L. (2011, May 17). *Alternatives to seclusion and restraint in behavioral healthcare: Urgency to address s&r in behavioral treatment settings* [Presentation]. Substance Abuse and Mental Health Services Administration.

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Oregon Administrative Rules §§ 309-033-0730 — 309-033-0735

Oregon Administrative Rules § 309-035-0167

Oregon Administrative Rules §§ 309-112-0000 — 309-112-0035

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Oregon Revised Statute §§ 426.070 — 426.072

Oregon Revised Statute § 426.228

Oregon Revised Statute §§ 426.232 — 426.233

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Oregon Revised Statute § 426.415

Oregon State Hospital Policy and Procedure Manual. *Acute milieu emergency*, 6.039. Author.

Oregon State Hospital Policy and Procedure Manual. *Clinical documentation*, 6.045. Author.

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Oregon State Hospital Policy and Procedure Manual. *Enhanced supervision*, 6.010. Author.

Oregon State Hospital Policy and Procedure Manual. *Incident reporting*, 1.003. Author.

Oregon State Hospital Policy and Procedure Manual. *Interdisciplinary treatment team*, 6.011. Author.

Oregon State Hospital Policy and Procedure Manual. *Medical emergency (code blue)*, 8.038. Author.

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Oregon State Hospital Policy and Procedure Manual. *Patient food*, 6.047. Author.

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Oregon State Hospital Policy and Procedure Manual. *Restrictive event reporting*, 6.027. Author.

Oregon State Hospital Policy and Procedure Manual. *Secure transport restraints*, 8.039. Author.

Oregon State Hospital Policy and Procedure Manual. *Sentinel events*, 2.012. Author.

Oregon State Hospital Policy and Procedure Manual. *Staff response to alleged criminal acts, contraband, and critical incidents*, 8.019. Author.

Oregon State Hospital Policy and Procedure Manual. *Trauma screening*, 6.052. Author.

Oregon State Hospital Policy and Procedure Manual. *Voluntary movement restriction*, 6.023. Author.

Time↓					
Discipline →	**RN**	**MD/PMHNP**	**Staff**	**IDT**	**CMO**
Before	• Trained, competent • Knows: patient, TCP, interventions	• Trained, competent • Knows: patient, TCP; interventions • OD can rely on RN	• Trained, competent • Knows: patient, TCP, interventions	• Trained, competent • TCP has interventions in place based upon assessments and patient knowledge • Trauma, pre-existing conditions, health issues, preferences, and culture are taken into consideration regarding seclusion or restraint interventions • Least restrictive interventions are considered	
Immediately	• Authorizes the temporary intervention • Supervises and guides actions of staff • Completes health assessment once patient has been placed in restraints • Initiates seclusion and restraint flow sheet	• If present, assess need for intervention and orders the intervention • Time stamp the beginning of the seclusion or restraint • Document assessment in Avatar progress notes	• Continuous observation • No less than every 2 hours: hygiene and elimination		
Within first 15 min.	• If the MD is not present, call to get an order • Time stamp the beginning of the seclusion or restraint		• Offer: Nourishment • Mech Restraints: Must exercise and each limb assessed		
Within 1 hr.*	(For Junction City only, see policy 6.003)	• Face-to-face assessment • Write order as needed • Restamp if a phone order. Time is **continued** from the first stamp	As requested and no less than q2hr: Hygiene and elimination		
No less than 1x/hr.	• Face-to -ace assessment to determine release readiness • Assessment of any health and comfort needs • Let patient know the criteria for release				

Discipline →	RN	MD/PMHNP	Staff	IDT	CMO
Before the 4 hr. expiration	Face-to face-assessment If seclusion or restraint is to continue, call MD for an order	Give telephone order to continue intervention			
Before the next 4 hr. expiration (8 hrs.)		Face-to-face reassessment, if continuing order is necessary, order and document			
At 24 hrs.	CMO or designee must be contacted				Assess and write note
***Following the physical intervention**	• Calls staff who were involved together to debrief incident. • Debriefs with patient	Join in debrief if at all possible and pertinent	Join in debrief if at all possible and pertinent		
Within 24 hrs.	Seclusion or restraint debriefing section is completed and placed for the IDT to review				
5 days				• Complete Seclusion and Restraint IDT debriefing. • Update TCP	