

Second in
a series of
Technical
Reports



Reducing the Use of Seclusion and Restraint:

Findings, Strategies, and Recommendations

National Association of State Mental Health Program Directors'

Medical Directors Council

66 Canal Center Plaza, Suite 302, Alexandria, VA 22314

(703) 739-9333 — FAX (703) 548-9517

July, 1999

Table of Contents

Acknowledgments	<i>ii</i>
Process of Report Preparation	1
Background and Purpose	1
Preparation of the Report	1
Editorial Review	2
Problem Statement	3
Definition of the Issues	3
Consensus Reached by Participants	3
Findings: What Works and What Doesn't Work	5
Overview of Research Findings	5
Factors that Contribute to a Safe Environment	6
Summary of Effective Intervention Strategies	8
Prevention Strategies	8
Early Intervention Strategies	9
Intervention Strategies	9
Standards	9
Training	12
What Doesn't Work	12
Recommendations for NASMHPD	13
Recommendations for State Mental Health Agencies	15
Appendices	
Appendix A: Selected References	
Appendix B: Participant List	
Appendix C: NASMHPD Position Statement on Trauma	
Appendix D: JCAHO Standards	
Appendix E: ORYX Definitions	

Acknowledgments

On behalf of the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, I want to acknowledge the many important contributors to this Technical Report. All the participants in the Technical Report Meeting (listed in Appendix B) contributed their time and expertise to the development of an initial document and reviewed numerous drafts. The collaboration that accompanied the development of this Technical Report was inspiring, and this Technical Report could not have been produced without the efforts of each of the participants.

The Medical Directors Council Editorial Board also reviewed several drafts and made significant improvements to this document. Members of the Editorial Board include: Aimee Schwartz, M.D.; Paul J. Barreira, M.D.; Alan Q. Radke, M.D., M.P.H.; Joseph Parks, M.D.; Philip E. Veenhuis, M.D., M.P.H.; and Steven Shon, M.D.

In particular, I want to thank Rupert R. Goetz, M.D., Medical Director at the Mental Health and Developmental Disabilities Division of the Oregon Department of Human Resources, for serving as Chief Editor of this Technical Report. Rupert worked tirelessly in convening the Technical Report Meeting, overseeing the production and editing of several drafts, and securing adoption of this informative and progressive Technical Report by the Medical Directors Council.

Finally, I want to thank Robert W. Glover, Ph.D., Executive Director of NASMHPD, the NASMHPD membership, and the many members of the NASMHPD staff who helped to produce this excellent document. I am confident that this Technical Report will play an important role in ensuring the safety of mental health consumers and in improving the quality of care they receive.

*Thomas W. Hester, M.D.
Medical Director and Director of Facility Operations
Georgia Division of Mental Health, Mental Retardation, and Substance Abuse*

Process of Report Preparation

III Background and Purpose

This report was prepared by the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council as one of an ongoing series of documents intended to provide information and assistance to state mental health commissioners/directors on emerging issues of clinical concern. Topics for technical reports are identified by the Medical Directors Council in conjunction with NASMHPD leadership. In order to ensure that Technical Reports are useful to all the populations served by state mental health systems, each report is, depending on the topic, developed through a process involving NASMHPD divisions and affiliates and outside experts.

The use of seclusion and restraint has been of long-standing concern to state mental health commissioners/directors and to state medical directors. Federal legislation is now being considered to address this issue. NASMHPD is developing an action plan for addressing the use of seclusion and restraint in public mental health settings; this report is the first step in the development of the action plan. The preparation of this report is particularly timely in view of tragedies brought to light by a series of articles in the *Hartford Courant* newspaper.

This report is intended to help guide the development of and to complement a NASMHPD position statement on seclusion and restraint. It includes specific recommendations for action to NASMHPD and to state mental health agencies. It is also intended as a tool for helping states to prevent and reduce the overall need for seclusion and restraint, and to employ "best practices" whenever these interventions are used.

III Preparation of the Report

This report was prepared from the proceedings of a meeting held on February 18 and 19, 1999, in Atlanta, Georgia. Participants in the meeting included two state mental health commissioners/directors, five medical directors, two representatives from state offices of consumer affairs, representatives from other NASMHPD divisions, affiliates, and relevant workgroups, and NASMHPD staff. Representatives were selected by their organizations on the basis of experience, interest, and knowledge about the issue. An external facilitator and a technical writer assisted in the process. A list of participants and their organizational affiliations is included in the Appendix.

Prior to the meeting, relevant materials from the research literature, state policy manuals, and national advocacy groups were distributed to all participants. Although the materials did not reflect an exhaustive search, they provided a comprehensive overview of the field, and formed an empirical basis for the group discussion. This report attempts to integrate the major findings

from the literature as discussed at the meeting with the diverse perspectives and personal experiences brought to the table by meeting participants.

During the meeting, participants engaged in a spirited discussion and debate, putting all sides of the issue on the table, sharing their own viewpoints and personal experiences, and ultimately forging a strong sense of partnership and collaboration in grappling with these very difficult issues. An attempt has been made to capture the complexity of the discussion while striving to integrate different perspectives whenever possible.

III Editorial Review

Drafts of this report were prepared by the technical writer and chief editor and distributed for review and comment to all meeting participants and members of the Medical Directors Council's Editorial Board. The final report was reviewed, amended, and approved by the Medical Directors Council and does not necessarily reflect the viewpoint of the NASMHPD membership.

As part of its review, the Medical Directors Council identified the following issues for further work:

- Differentiation of seclusion from restraint;
- Differentiation of levels of restraint, including protective devices;
- Definition of appropriate environments for use of seclusion and restraint;
- Review of chemical restraints and involuntary medication; and
- Examination of the process of restraining patients (as this is the time of most danger).

Problem Statement

||| Definition of the Issues

The issues raised by the use of seclusion and restraint in the mental health system go far beyond a narrow focus on the techniques involved in the use of these interventions. The overutilization of seclusion and restraint can be seen as a symptom of a larger problem in the culture of the clinical environment. An effective approach to this issue will, therefore, need to include consideration of clinical and cultural issues.

Misapplication of the techniques of seclusion and restraint creates safety problems for both the individual and the staff involved. The rate of work-related injuries is higher in mental health than in the construction industry, and more staff injuries occur during the implementation of seclusion and restraint than occur from unexpected assaults. Thus this report will take a broad, inclusive approach to the issue of the use of seclusion and restraint, attempting to convey some of the complexities involved. The report begins with a discussion of prevention and early intervention, and then identifies standards for safe and effective implementation.

In a fundamental way, this issue is about how mental health systems treat the people they serve. If the goals of the public mental health system are to treat people with dignity, respect and mutuality, to protect people's rights, to provide the best quality care possible, and to assist people in their recovery, any use of seclusion and restraint must be rigorously scrutinized. Many people enter the mental health system for help in coping with the aftermath of traumatic experiences. Others enter the system in hope of learning how to control symptoms that have left them feeling helpless, hopeless, and deeply fearful. Still others enter the system involuntarily. In these cases, the need for treatment has been expressed by the committing authority, not by the recipient. Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individuals involved. In addition, using power to control people's behavior or to resolve arguments can lead to escalation of conflict and can ultimately result in serious injury or even death.

||| Consensus Reached by Participants

Given that seclusion and restraint are virtually always experienced by the individuals involved as traumatic, put both staff and patients at risk, and can seriously jeopardize the treatment milieu, are there ever instances when these interventions are justified? It was a consensus of those present that seclusion and restraint are justified only if they are being used for the clearly defined purpose of maintaining safety and if all other, less intrusive interventions have failed. Clearly, these factors will vary according to setting, with acute care and emergency room settings presenting a different challenge from long-term care settings. For example, substance abuse is more likely to be a complicating factor in emergency room settings than in long-term care facilities. Similarly, the justification for the use of seclusion and restraint may vary over time

even within the same setting, depending on what other alternatives have been tried and on other factors affecting the basic safety of the unit.

Regardless of the context, it is critical that seclusion or restraint be used only as a “last resort measure” to maintain safety. Substantial care must be taken to define the situations in which safety concerns are strong enough to justify the use of seclusion and restraint. Seclusion should be used only in situations of imminent risk to self or others or serious disruption to the treatment milieu, restraint only in situations of imminent risk. Neither technique should ever be included as part of an individual’s treatment plan, or as part of the day-to-day management of a unit. Finally, these interventions should under no circumstances be used as a threat, either implicitly or explicitly, nor should they ever be used as punishment.

Seclusion and restraint should be considered a security measure, not a form of medical treatment. However, given the medical risk of serious injury or even death posed to recipients, the use of seclusion and restraint should be medically supervised.

In addition to seclusion and restraint, it is imperative that other forms of control be closely monitored to ensure that one potentially abusive practice is not substituted for another. In particular, the use of emergency psychotropic medications should be closely monitored. When used properly, psychotropic medications can be helpful in treating agitation due to mental illness, allowing a complete clinical and medical assessment to be done. However, drugs should not be used solely to immobilize or sedate people as a mechanism for control. Over-medication and polypharmacy are of particular concern with children. Similarly, the use of law enforcement and stringent behavioral programs, while appropriate under some circumstances, should always be monitored to prevent misuse.

Findings: What Works and What Doesn't Work

III Overview of Research Findings

Review of the literature and discussion with clinical and administrative leaders in the mental health field reveals that well-documented, effective practices exist to reduce violence and simultaneously reduce or eliminate the use of restrictive measures such as seclusion and restraint. New and emerging treatment approaches in mental health — including a new understanding of the value of peer-delivered services and self-help techniques as well as new medications, a new emphasis on recovery, and an emerging understanding about the relationship between trauma and mental illness — make it increasingly possible to treat people with severe symptoms without resorting to coercive strategies. However, there is a significant gap between what we know about preventing violence and creating a safe clinical environment and what is practiced in many mental health settings. In addition, there is little research on the safest and least harmful methods to implement seclusion and restraint, or on the most effective methods for monitoring and making release decisions.

The most effective approach to take when considering the use of seclusion and restraint is a public health model, which addresses primary prevention (in this context, preventing and reducing the need for seclusion and restraint); secondary prevention (early intervention, using the least restrictive methods possible); and tertiary prevention (intervention to reverse or prevent negative consequences), and which uses feedback from each stage to inform and improve subsequent actions. A public health model should always lead to the selection and use of the least possible restriction consistent with the purpose of the intervention.

With this kind of approach, attention would be directed first towards establishing a culture that would minimize the occurrence of events that might lead to the use of seclusion and restraint, and that would emphasize the importance of valuing what service recipients say about what contributes to a safe environment. Efforts would also be made to ensure that conflicts are identified early and resolved before they can escalate, and that all staff are trained and experienced in techniques of early intervention. Finally, policies and procedures as well as staff training would support the safe use of seclusion and restraint on those rare occasions when it was required to maintain safety. Staff and service recipients would fully debrief each instance of the use of seclusion or restraint. Information obtained from the debriefing would be used to help understand what precipitated the event and how similar situations could be avoided in the future.

III Factors That Contribute To A Safe Environment

From the review of the literature and discussion at the meeting, many factors were identified that contribute to a safe environment in which the use of seclusion and restraint are minimized. These factors include:

- Employing a public health model that stresses prevention and early intervention.
- Sensitizing staff to the power differential that exists between themselves and the people they serve in order to prevent the misuse of power. Experiential training and training that involves service recipients can be particularly useful in this regard.
- Implementing individualized treatment plans that are mutually determined by service recipients and staff, and that effectively emphasize the individual recipient's assessment of what works and what doesn't.
- Using clearly defined clinical interventions, including clinical algorithms.
- Making sure that multiple treatment options are available at all times.
- Involving families and others (with permission of the service recipient) who have helpful information about what has worked and what hasn't in the past.
- Teaching skills of self-monitoring and self-control as part of the rehabilitation/recovery process.
- Ensuring that both staff and service recipients have access to mechanisms for resolving disputes without resorting to force.
- Creating a physical environment that minimizes the overstimulating conditions that may lead to conflict or agitation, particularly (but not exclusively) for elderly individuals.
- Developing a clinical paradigm that addresses past trauma as part of the clinical picture.
- Considering the use of seclusion or restraint to reflect a failure to intervene earlier, and aiming for the goal of using these interventions as close to "zero use" as possible.
- Ensuring adequate ongoing staff training specific to the situation and patients being served.

Similarly, many factors were identified that contribute to an environment in which safety concerns are likely to emerge, and in which seclusion and restraint are likely to be misused. These factors include:

- Lack of adequate attention to safety issues and risk factors at intake. Most episodes of seclusion and restraint occur within the first few days after admission, and the majority of incidents occur with a very small number of individuals.
- Lack of an organizational culture of respect.
- Not believing what service recipients say; labeling people as “manipulative.”
- Lack of adequate attention to language accessibility and cultural uniqueness (e.g., race, gender, sexual orientation, trauma history).
- Inadequate staffing, in quantity, training or both. Inexperienced staff are assaulted more frequently; short staffing and the use of temporary staff also increase the likelihood of violence.
- The assumption that “compliance” in and of itself is important for recovery. A culture that permits misuse or display of power, even in “small” ways (e.g., using keys to intimidate).
- The assumption that “structure” and/or rules for behavior are in and of themselves therapeutic, or that they are the only mechanisms for maintaining a therapeutic milieu.
- Responding to violence with violence.
- Inadequate monitoring and debriefing; a culture of secrecy.
- A culture in which direct care staff feel disrespected and “pass on” that disrespect to service recipients.

III Summary of Effective Intervention Strategies

From their review and discussion, the group reached consensus that the following strategies should be adopted by state mental health agencies:

Prevention Strategies

Focus on recovery and rehabilitation.

Emphasizing people's strengths and giving them choices will substantially reduce the boredom and resentment that can lead to conflict and will create a climate of respect. Instilling hope and a sense of control and mastery will assist in the recovery process. Incorporating people in recovery as trainers and staff and including self-help techniques in programs will significantly increase a climate of hope and respect and prevent or reduce the occurrence of violence. Engaging people as full partners in their treatment will increase their "ownership" of and commitment to program activities.

Create a safe and therapeutic program culture.

Service recipients and staff need to feel safe in order to engage fully in program activities. At the same time, therapeutic concerns must remain predominant if the program culture is to avoid becoming custodial in nature.

Introduce a trauma paradigm.

Services should be provided with the assumption that clients may have experienced severe trauma in the past and that current interventions should, where possible, not resurrect these issues. A focus on the negative consequences of interpersonal violence can sensitize staff and service recipients to the power issues that can lead ultimately to the use of restrictive control measures. This approach is helpful for all individuals, and is essential for people with histories of trauma.

Give people a voice in determining the outcomes of conflicts or disagreements.

Giving people (including both service recipients and staff) a mechanism to be heard, and ensuring that power imbalances are reduced or eliminated when conflicts are being addressed will reduce the likelihood that issues will remain buried until they erupt into violence. This issue is particularly important in settings and with populations that encounter barriers to communication, including children and adolescents, people with mental retardation, those who are deaf or hearing impaired, and those for whom English is not their first language.

Early Intervention Strategies

Use risk assessment tools.

Evaluating at intake the short-term risk factors for violence makes early identification and intervention more likely. Established tools exist for this purpose.

Use advance mental health directives.

Having service recipients and staff, in partnership, outline the individual's preferred response to emerging conflict or crisis can help to ensure that early interventions are used to diffuse rather than escalate the conflict.

Train staff to de-escalate power struggles.

Staff should be well-trained in looking for opportunities to de-escalate conflict. The environment will be made substantially safer if staff know how to give service recipients some degree of control over their situation, and are skilled in modifying interventions to reduce the factors that can lead to incidents (e.g., avoiding disciplining a service recipient in front of his/her peers). Experiential training and peer trainers can help to sensitize staff in a unique and powerful way.

Use alternative dispute resolution strategies.

Institute a policy of mediation or other form of alternative dispute resolution (ADR) as an available mechanism for resolving disagreements. ADR processes are structured to reduce inequalities between the parties by using a neutral third party as a mediator. This non-adversarial approach can help parties come to their own solutions prior to or in lieu of filing a formal grievance.

Intervention Strategies

Standards

All state mental health agencies should adopt and implement specific standards concerning the safe use of seclusion and restraint practices. The development of detailed procedural standards lies beyond the scope of this report. However, the following are recommended as foundational, pre-requisite standards that should be adopted by all state mental health agencies. The dignity and privacy of restrained or secluded individuals should be preserved and retraumatization should be avoided to the greatest extent possible during the use of these interventions.

- Restraint and seclusion should never be used (a) as a threat of punishment; (b) in lieu of adequate staffing; (c) as a technique for behavior management or control; (d) as a replacement for active treatment or as part of a treatment plan; or (e) as a convenience.
- Seclusion and restraint orders should always be time-limited, and should be removed as soon as it becomes safe to do so, even if the time-limited order has not expired. Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards should be adopted and viewed as a minimum guideline.
- The individual being restrained or secluded should always be verbally informed about what is happening during the restraint period. Information should include what events or behaviors precipitated the use of restraint or seclusion, and when and under what circumstances they can expect to be released.
- The following should not be used under any circumstances:
 - Face down restraint with back pressure.
 - Any technique that obstructs the airways or impairs breathing.
 - Any technique that obstructs vision.
 - Any technique that restricts the recipient's ability to communicate.
- Vital signs should be checked initially and regularly thereafter (every fifteen minutes at a minimum, if abnormal).
- Only accepted, professionally recognized restraint devices should be used under any circumstances.
- No form of restraint which places the individual in a lying down position should be done in a public place or in the individual's own bedroom. Privacy and respect for the individual should be paramount when implementing seclusion and restraint.
- The following should be prohibited under all circumstances:
 - Client protocols (i.e., orders that trigger seclusion or restraint without an individual assessment of need).

- Policies automatically assigning patients in emergency room settings to seclusion or restraint. The Medical Directors Council notes that this prohibition would be more restrictive than current JCAHO requirements.
 - “Automatic revocation” of release. Any instance of seclusion or restraint ordered subsequent to a prior incident should require a new evaluation and order.
- Individuals who have been secluded or restrained and staff who have participated in these interventions should participate in debriefings, both separately and together, after every incident of seclusion or restraint. Gender concerns should be addressed as part of the debriefing. These debriefings may pose administrative or other challenges but are critical to maintaining a culture of respect and reducing the future need for seclusion or restraint.
 - Only staff who have been adequately trained should ever be involved in the use of seclusion or restraint procedures.
 - Oversight of seclusion and restraint should be an integral part of the organization’s ongoing quality improvement process. This should include (a) baseline measures for comparison; (b) the sharing of data and analyses of seclusion and restraint rates with external stakeholders as well as clinical and administrative leadership; (c) tracking of all serious injuries and deaths that occur during seclusion and restraint; (d) a mechanism to identify and respond to trends that emerge in the data; and (e) the involvement of service recipients as quality improvement monitors, peer supports, and trainers.
 - Every organization using any form of seclusion or restraint should have an established internal review process, and should carefully review every occurrence of seclusion or restraint. States should review their laws on peer review and take steps to protect the confidentiality of this process in order to maximize the honesty of participants and the resulting value of the peer review process.

In order to ensure that the oversight process has credibility, every organization using any form of seclusion or restraint should be open and accessible to some form of independent, external review process, in addition to JCAHO, state licensing and other quasi-independent review entities. The external review entity should have access to aggregate data and incident reports, and should also have the authority to do an independent review of any death or serious injury occurring during restraint or seclusion. Appropriate external entities would be fully independent from the state mental health agency, have statutory or other legally agreed upon access to all settings where seclusion and restraint are conducted, and have staff who are qualified and trained in conducting reviews.

Training

Training programs that focus on early identification and intervention in conflict situations are essential. Several effective training programs are available.

Several states that have adopted comprehensive approaches to reducing the use of seclusion and restraint have found that staff training is a critical component. Training interventions have been shown to reduce the use of seclusion and restraint, to help staff understand the experience from the perspective of the individuals involved, and to improve communication and problem-solving skills.

Training formats that have proven particularly effective include teams of staff and former patients working together as trainers. This team approach ensures that the perspectives of both parties will be adequately reflected, and also provides a model of clear and direct communication between the parties involved.

The team approach can be used regardless of setting or population. Teams involving children and youth or individuals with developmental disabilities can be particularly powerful as an illustration of how to establish a working partnership with people whose verbal communication skills may be limited.

Experiential training is critical in addressing the impact that restraint and seclusion have on the individuals involved. Training that includes a dialogue between staff and service recipients about the experiences of both parties can be a powerful tool in creating a safe, respectful milieu.

||| What Doesn't Work

Institutions or agencies that focus primarily or exclusively on improving the methods and techniques of seclusion and restraint will not be successful, because only by addressing the larger cultural factors and emphasizing primary and secondary prevention can a context be created that will support fundamental changes in practice.

Imposing interventions unilaterally will also be unsuccessful, since the active participation and buy-in from all stakeholders is crucial to changing attitudes and practice. Service recipients, family members, direct care staff, middle managers, clinical staff and policymakers should all be included in the process of change.

Isolated or one-shot interventions are also likely to fail. Plans for improving practice through a simple training program or through any intervention that ignores the interrelatedness of the different components of a complex system will ultimately be ineffective. Policies, programs, staffing patterns, clinical training, staff supervision, operational procedures and public education must all embody consistent underlying values and a consistent clinical approach in order for real change to occur.

Recommendations for NASMHPD

This technical report should be seen as the first step in a comprehensive action plan designed to address the issues identified in the report. The report is a dynamic document that may be subject to revision in order to reflect promising practices and state-of-the-art treatment strategies. The Medical Directors Council recommends that NASMHPD take the necessary steps to convene interdisciplinary workgroups and/or other mechanisms to address these issues in more detail, including the development of a detailed set of national standards for the safe use of seclusion and restraint within the mental health system and an analysis of the impact of these interventions on people with mental illness in other systems. Specifically, the Medical Directors Council recommends that NASMHPD do the following:

- Take a national leadership role concerning issues of seclusion and restraint by adopting and disseminating a position statement on seclusion and restraint. The statement should be seen as applicable to all adults and children with mental illnesses, while recognizing that differences due to age, developmental differences, and settings may affect the implementation of the position statement.
- Ask its divisions and affiliates to provide specific guidance regarding standards, policies, and procedures for seclusion and restraint that are unique to the population or perspective of the division or affiliate.
- Acknowledge and respond to the unique concerns of gender, culture and language as well as age and developmental differences, in developing a work plan regarding seclusion and restraint.
- Develop common definitions for specific terms, including “involuntary,” “emergency,” “professional judgment,” and “successful” for the benefit of enhancing communication between members of NASMHPD and its divisions. A common vocabulary would be especially useful for interdivisional workgroup activities.
- Review current seclusion and restraint techniques and technologies.
- Develop model language regarding the use of seclusion and restraint for inclusion in state contracts for managed behavioral health care services.
- Through the National Technical Assistance Center for State Mental Health Planning (NTAC), NASMHPD should serve as a clearinghouse for training programs and curriculum and training standards regarding the issues, approaches, and interventions described in this report.

- Work with NIMH and other research entities to facilitate research into all issues discussed in this report, especially those on which little or no data currently exists.

Recommendations for State Mental Health Agencies

The Medical Directors Council recommends that every state mental health agency develop and implement a comprehensive approach to the issues addressed in this report. Specifically, state mental health agencies should:

- Take the necessary steps within their states to ensure that the NASMHPD Position Statement on Seclusion and Restraint is fully implemented in all settings that are operated, funded, or regulated by the state mental health agency.
- Take a leadership role within their states to work with other agencies and organizations that serve people or regulate services for people with mental illness (e.g., juvenile justice, corrections, nursing homes, etc.) to address the issues identified in this report.
- Develop a statewide strategy and work plan for using proven techniques and approaches, including those identified in this report, in order to:
 - Create positive environments and cultures that would reduce the development of situations that may lead to the use of seclusion and restraint.
 - Intervene early in the development of conflict situations in order to reduce and ultimately eliminate the use of seclusion and restraint.
 - Ensure that seclusion and restraint, when used, are carried out in the safest possible manner, for the shortest time possible, and with the fewest possible negative consequences for patients and staff.
- Collect data on the use of seclusion and restraint in all settings where they are used and participate in performance measurement initiatives of the NASMHPD Research Institute, Inc. (NRI) to compare their utilization rates with other states.
- Use seclusion and restraint data as a routine part of their quality improvement system, and should share the resulting analyses with external groups.
- Establish a mechanism to monitor the use of emergency involuntary medications to ensure that they are not being used inappropriately as a substitute for seclusion and restraint.

- Ensure that age and developmental differences are taken into account in all data systems and benchmarking procedures.
- Incorporate the principles and practices outlined in the NASMHPD Position Statement on Trauma in implementing procedures and policies regarding seclusion and restraint (see Appendix).
- Consider cultural diversity issues and should always involve the perspective of service recipients in the planning and implementation of all policies, procedures, training and monitoring activities regarding seclusion and restraint.

Appendix A:
Selected References

Selected References

Bills, L.J., and Bloom, S.L. 1998. "From chaos to sanctuary: Trauma-based treatment in a state hospital system." In B.L. Levin, A.K. Blanch, and A. Jennings, Eds, *Women's Mental Health Services: A Public Health Perspective*, p.#348-367, Sage Publications: Thousand Oaks, CA.

Chandler, D., Nelson, T., and Hughes, C.I. 1998. "Performance improvement through monitoring seclusion and restraint practices," *Administration and Policy in Mental Health* 25(5) 525-539.

Crenshaw, W.B. and Francis, P.S. 1995. "A national survey on seclusion and restraint in state psychiatric hospitals," *Psychiatric Services* 46 1026-1031.

Curtis, L.C. and Diamond, R. 1997. "Power and coercion in mental health practice." In B. Blackwell, Ed., *Treatment Compliance and the Therapeutic Alliance*, p.#97-122, Aarwood Academic Publishers: Canada.

Palmer, L., Abrams, F., Carter, D., and Schluter, W.W. 1999. "Reducing inappropriate restraint use in Colorado's long term care facilities," *Journal of Quality Improvement of the Joint Commission on Accreditation of Healthcare Organizations* 25(2) 78-94.

Ray, N.K., Myers, K.J., and Rappaport, M.E. 1996. "Patient perspectives on restraint and seclusion experiences: A survey of former patients of New York State psychiatric facilities," *Psychiatric Rehabilitation Journal* 20(1) 11-18.

Sagduyu, K., Hornstra, R.K., Munro, S., and Bruce-Wolfe, V. 1995. "A comparison of the restraint and seclusion experiences of patients with schizophrenia or other psychotic disorders," *Missouri Medicine* 92(6) 303-307.

Visalli, H., McNasser, G., Johnstone, L., and Lazzaro, C.A. 1997. "Reducing high-risk interventions for managing aggression in psychiatric settings," *Journal of Nursing Care Quality* 11(3) 54-61.

Further Background Materials:

Weiss, E.M. 1998. "Deadly Restraint," *Hartford Courant* (series of articles on deaths and injuries resulting from seclusion and restraint in psychiatric facilities).

Appendix B:
Participants List

***NASMHPD MEDICAL DIRECTORS' COUNCIL
TECHNICAL REPORT MEETING***

ON

SECLUSION AND RESTRAINT

February 18-19, 1999

Westin Peachtree Plaza Hotel, Tower Room 1405

Atlanta, Georgia

LIST OF PARTICIPANTS

NASMHPD MEMBERS

Meredith Alden, M.D., Ph.D.

Director

Division of Mental Health

Department of Human Services

120N, 200W, Suite 415, 4th Floor

Salt Lake City, UT 84103

Ph: (801) 538-4270

Fax: (801) 538-9892

e: malden@email.state.ut.us

Charles G. Curie

Deputy Secretary for Mental Health

Department of Public Welfare

Office of Mental Health & Substance Abuse

P.O. Box 2675

Harrisburg, PA 17105-2675

Ph: (717) 787-6443

Fax: (717) 787-5394

e: charlescu@dpw.state.pa.us

MEDICAL DIRECTORS COUNCIL

Rupert Goetz, M.D.

Medical Director

Mental Health & DD Services Division

Department of Human Resources

2575 Bittern Street, N.E.

Salem, OR 97310

Ph: (503) 945-2989

Fax: (503) 373-7327

e: goetZR@mail.mhd.hr.state.or.us

Thomas W. Hester, M.D.

Medical Director and Director, Facility Ops.

Division of Mental Health, Mental

Retardation and Substance Abuse Services

Department of Human Resources

2 Peachtree Street, NE, 22nd Floor

Atlanta, GA 30303-3171

Ph: (404) 657-6407

Fax: (404) 657-6424 or 657-2296

e: thester@dhr.state.ga.us

Joseph Parks, M.D.

Deputy Director for Psychiatry

Department of Mental Health

1706 East Elm Street, P.O. Box 687

Jefferson City, MO 65102

Ph: (573) 751-2794

Fax: (573) 751-7815

e: parksj@mail.dmh.state.mo.us

Alan Q. Radke, M.D., M.P.H.

Medical Director

Department of Human Services

444 Lafayette Road, North

St. Paul, MN 55155-3826

Ph: (651) 296-6193

Fax: (651) 297-1539

e: alan.radke@state.mn.usa

ADULT SERVICES DIVISION

Debra Kupfer, M.H.S.
Mental Health Planner
Department of Human Services
Division of Mental Health Services
3824 West Princeton Circle
Denver, CO 80236
Ph: (303) 866-7418
Fax: (303) 866-7428
e: debbie.kupfer@state.co.us

**CHILDREN, YOUTH & FAMILIES
DIVISION**

Gary Blau, Ph.D.
Bureau Chief of Quality Management
Department of Children & Families
505 Hudson Street
Hartford, CT 06106
Ph: (860) 550-6421
Fax: (860) 566-8022
e: gary.blau@po.state.ct.us

FORENSIC DIVISION

John E. Main
Chief Executive Officer
Forensic Psychiatric Hospital
Division of Mental Health Services
Department of Human Services
P.O. Box 7717, Stuyvesant Avenue
West Trenton, N.J. 08628
Ph: (609) 633-0892
Fax: (609) 633-0971
e: jmain@dhs.state.nj.us

LEGAL DIVISION

Marybeth McCaffrey, J.D.
Special Assistant Attorney General
Department of Developmental and Mental
Health Services
103 South Main Street
Waterbury, VT 05671-1601
Ph: (802) 241-3024
Fax: (802) 241-1129
e: mmccaffrey@ddmhs.state.vt.us

OLDER PERSONS DIVISION

Kathy R. Grissom
Director
Mary Starke Harper Geriatric Psych. Ctr.
Department of Mental Health
P.O. Box 21231, 200 University Boulevard
Tuscaloosa, AL 35402
Ph: (205) 759-0906
Fax: (205) 759-0931
e:

NAC/SMHA

Cathy Bustin Baker
Director of Consumer Affairs
Department of Mental Health
and Mental Retardation & Substance Abuse
Service
State House, Station 40
Augusta, ME 04333
Ph: (207) 287-4229
Fax: (207) 287-4291
e:

Karen Kangas
Director of Community Education
Department of Mental Health
410 Capitol Avenue
P.O. Box 341431, MS 14CED
Hartford, CT 06134
Ph: (860) 418-6948
Fax: (860) 418-6786
e:

ORYX WORKGROUP

Barbara Carey
Chief, Quality & Risk Management
Mental Hygiene Administration
Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, MD 21201
Ph: (410) 767-6540
Fax: (410) 333-5402
e:

FACILITATOR

John Gates, Ph.D.
Director
Mental Health Program
Carter Center, Emory University
One Copenhill, 453 Freedom Parkway
Atlanta, GA 30307
Ph: (404) 420-5165
Fax: (404) 420-5158
e:

WRITER/RECORDER

Andrea Blanch, Ph.D.
Consultant
38 Mead Point Road
Gardiner, ME 04345
Ph: (207) 724-2676
Fax:
e: akblanch@aol.com

NASMHPD STAFF

66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
Ph: (703) 739-9333
Fax: (703) 548-9517

Bruce Emery, MSW x28
Director of Technical Assistance
bruce.emery@nasmhpd.org

Robert W. Glover, Ph.D. x29
Executive Director
bob.glover@nasmhpd.org

John Kotler x31
Senior Writer/Editor
john.kotler@nasmhpd.org

Roy E. Praschil x20
Director of Operations
roy.praschil@nasmhpd.org

Jenifer Urff, J.D. x34
Director of Government Relations
jenifer.urff@nasmhpd.org

Appendix C:
NASMHPD Position
Statement on Trauma

NASMHPD Position Statement on Services and Supports to Trauma Survivors¹

The National Association of State Mental Health Program Directors (NASMHPD) recognizes that the psychological effects of violence and trauma in our society are pervasive, highly disabling, yet largely ignored. NASMHPD believes that responding to the behavioral health care needs of women, men and children who have experienced trauma from violence is crucial to their treatment and recovery and should be a priority of state mental health programs. The goal of recovery from trauma is a fundamental value held by NASMHPD and its individual members, state mental health authorities. Toward this goal, it is important to develop an understanding of the resiliency factors, and the kinds of treatment, services, and supports that contribute to recovery.

The experience of violence and trauma can result in serious negative consequences for an individual's mental health, self-esteem, use of substances and involvement with the criminal justice system. Indeed, trauma survivors can be among the people least well served by the mental health system as they are sometimes referred to as "difficult to treat" -- they often have co-occurring mental health and substance use disorders, can be suicidal or self-injuring and are frequent users of emergency and inpatient services.

Trauma is an issue that crosses service systems and requires specialized knowledge, staff training and collaboration among policymakers, providers and survivors. Study findings indicate that adults in psychiatric hospitals have experienced high rates of physical and/or sexual abuse, ranging from 43% to 81%. Other research recently has found that 92% of homeless women and 81% of non-homeless women in poverty had been physically and/or sexually abused. Trauma is also frequently experienced as highly stigmatizing and often can create a reluctance to seek help. There is reason to believe that men may significantly under-report childhood abuse.

Services for trauma survivors must be based on concepts, policies, and procedures that provide safety, voice and choice as defined by consumers/survivors. Trauma services must focus first and foremost on an individual's physical and psychological safety. Services to trauma survivors must also be flexible, individualized, culturally competent, and promote respect and dignity.

Innovations in trauma services are becoming a focus of increased discussion and change within the public mental health system. A number of state mental health authorities have begun to address the needs of trauma survivors in the mental health system by revising seclusion and restraint guidelines to prevent the repetition of the experience of trauma, adopting clinical guidelines for people with serious mental illnesses who have histories of trauma, developing statewide strategic action plans, producing training materials, and empowering statewide committees to develop and improve trauma services.

¹ For purposes of this position statement, the term trauma refers to physical and/or sexual abuse.

NASMHPD Position Statement
on Services and Supports to
Trauma Survivors
page 2 of 2

NASMHPD is dedicated to furthering the understanding of the effects of physical and/or sexual abuse and increasing its treatment within the public mental health system. State mental health authorities are committed to recognizing and responding to the needs of trauma survivors with mental illnesses and their families. It should be a matter of best practice to ask persons who enter mental health systems, at an appropriate time, if they are experiencing or have experienced trauma in their lives. NASMHPD recognizes that some policies and practices in public and private mental health systems and hospitals, including seclusion and restraint, may unintentionally result in the revictimization of trauma survivors, and therefore need to be changed.

NASMHPD is committed to working with states, consumers/survivors and experienced professionals in the trauma field to explore ways to improve services and supports for trauma survivors. These efforts may include, but are not limited to: developing improved methods for reducing stigma related to trauma; developing and disseminating information and technical assistance on best practices; providing forums for a national dialogue on the needs of trauma survivors; and cooperating with other state and national organizations to develop prevention and education initiatives to address the issue of trauma.

Passed Unanimously by the NASMHPD Membership on December 7, 1998.

Appendix D:
JCAHO Standards



Standards, Intents, and Examples for Special Procedures

These standards address interventions that call for special sensitivity to patient rights and risk management, such as aversive therapies, electroconvulsive therapy, and restraint and seclusion. Clinicians take special precautions to ensure these interventions are warranted and do not endanger patients.

Standard

TX.7 The hospital ensures that special procedures are safely and appropriately used.

Intent of TX.7

Policies and procedures for the use of special interventions are developed through an interdisciplinary process and approved by medical staff and administration. Staff roles and responsibilities in the use of special procedures are identified for all appropriate disciplines. Requirements for documenting the justification and use of these procedures are defined.

Examples of Evidence of Performance for TX.7

- Interviews with clinical staff
- Hospitalwide policies and procedures addressing special procedures
- Medical records
- Patient unit visits

Standards for the Use of Restraint and Seclusion for Behavioral Health Patients*

Introduction to the Restraint and Seclusion Standards TX.7.1 through TX.7.1.3.2 for Psychiatric Hospitals, Patients in Psychiatric Units in Acute Care Organizations, and Patient Receiving Behavioral Health Services in Designated Beds in Acute Care Hospitals†

Creating a physical, social, and cultural environment limiting restraint and seclusion use to clinically appropriate and adequately justified situations or that actually reduces their use through preventive or alternative strategies helps organization staff focus on the patient's well-being. The leaders' role is to help create such an environment. This requires planning and, frequently, new or reallocated resources, thoughtful education, and performance improvement. The result is an organization approach to restraint and seclusion that protects the patient's health and safety and preserves his or her dignity, rights, and well-being.

Restraint or seclusion may be used in response to emergent, dangerous behavior; addictive disorders; as an adjunct to planned care; as a component of an approved protocol; or, in some cases, as part of standard practice. Because restraint or seclusion may be necessary for certain patients, health care organizations and providers need to be aware of the associated risks of both use and nonuse. They also need to be able to use restraint or seclusion when essential to protect patients from harming themselves, other patients, or staff.

In its broadest context, *restraint* is any method of physically restricting a person's freedom of movement, physical activity, or normal access to his or her body. In the context of these standards, restraint is considered involuntary use as either part of an approved protocol, or as indicated by individual orders. *Seclusion* refers to the involuntary confinement of a person alone in a room where the person is physically prevented from leaving.

Restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of an individual's rights, and even death. Because of the associated

* Effective January 1, 1999.

† See also "Introduction to the Restraint Standards in Acute Medical and Surgical (Nonpsychiatric) Care" on pages TX-57 through TX-62.

risks and consequences of use, organizations are increasingly exploring ways to decrease restraint and seclusion use through effective preventive strategies or the use of alternatives. For some organizations, a restraint- and seclusion-free environment is appropriate to their patient populations and clinical services and is achievable now or in the future. But, for many organizations, restraint or seclusion use may continue to be necessary in clinically justified situations and in the foreseeable future, given the organization's patient populations and clinical services, the current state of knowledge, and available effective alternatives.

These standards for restraint and seclusion address processes and activities that

- identify areas of organization leadership and action that will limit restraint and seclusion use to clinically justified situations and may, when appropriate, seek to reduce restraint use through performance improvement;
- guide an organization's efforts to prevent the need to restrain or seclude patients; and
- provide a patient-focused framework to guide any actual restraint or seclusion use through clinical protocols or individual orders.

Standard(s)

- TX.7.1.1 through TX.7.1.1.7 address limiting restraint and seclusion use;
- TX.7.1.2 addresses reducing restraint and seclusion use as part of performance improvement;
- TX.7.1.3 addresses the policies and procedures associated with restraint and seclusion use;
- TX.7.1.3.1 through TX.7.1.3.1.8 address restraint and seclusion use initiated through individual orders; and
- TX.7.1.3.2 addresses medical record documentation.

Many of these standards for restraint and seclusion parallel or duplicate existing standards found in other chapters of this manual. Those standards are scored in those appropriate chapters. They appear here, however, to provide a complete perspective on all the requirements.

Applicability of These Restraint and Seclusion Standards

Standards TX.7.1 through TX.7.1.3.2 are applicable to any organization where restraint or seclusion use is initiated by individual orders for patients receiving behavioral health services in psychiatric hospitals or in psychiatric units or designated beds in acute care hospitals.

The standards do not apply to

- standard practices that include temporary immobilization or limitation of mobility related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes (for example, surgical positioning, IV armboards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients).
- adaptive support in response to assessed patient need (for example, postural support, orthopedic appliances, tabletop chairs).
- therapeutic holding or comforting of children or to a time-out when the person to whom it is applied is physically prevented from leaving a room for 15 minutes or less and when its use is consistent with the behavior management standards.
- forensic and correction restrictions used for security purposes. However, restraint or seclusion use related to the clinical care of an individual under forensic or correction restrictions is surveyed under these standards.

Standard

TX.7.1 Restraint or seclusion use within the organization is limited to those situations with adequate, appropriate clinical justification.

Intent of TX.7.1

Limiting the use of restraint or seclusion to clinically justified situations requires clear policies and procedures, well-trained staff, and the support of the organization's leaders and culture.

Clinical justification can be guided by clear criteria present in practice guidelines, practice parameters, pathways of care, or other standardized care processes from relevant professional organizations. When not available, the qualified staff of an organization establishes criteria or otherwise guides justification for the patient population served and clinical services provided by the organization.

Example of Implementation for TX.7.1

A hospital appointed a performance-improvement (PI) team to review bed rail use on all patient care units. The review was conducted to determine whether use was based on the assessed safety and protective needs of patients and whether the new Joint Commission standards would apply. The review revealed considerable variation in bed rail use among units and within units. In one unit, staff raised the bed rails at 9 PM for all patients. In another unit, bed rails were raised in the evening for all older adults. Because both of these practices were not based on the assessed needs of patients, the PI team determined that this type of bed rail use was considered restraint, and Joint Commission standards would apply. In the remaining units, staff conducted standardized patient assessments to determine the need for bed rails and noted the outcomes in routine medical record notes. In these instances, it was determined that the Joint Commission standards would not apply because bed rail use was clearly based on individual assessed patient need for this type of medical protective device.

The hospital then conducted a two-week, in-service program to implement standardized patient assessments to guide bed rail use. Based on the success of the bed rail use review and staff education process, the hospital then decided to conduct a similar review of the use of lap belts and Posey vests.

Standards

TX.7.1.1 *Organization leaders support limited, justified use of restraint or seclusion through appropriate:*

TX.7.1.1.1 *Plans, policies, and priorities;*

TX.7.1.1.2 *Human resource planning;*

TX.7.1.1.3 *Staff orientation and education creating a culture emphasizing prevention and appropriate use and encouraging alternatives;*

TX.7.1.1.4 *Patient and, when appropriate, family education;*

TX.7.1.1.5 *Assessment processes that identify and, when appropriate, prevent potential behavioral risk factors;*

TX.7.1.1.6 *Design and delivery of patient care; and*

TX.7.1.1.7 *The development and promotion of preventive strategies and use of safe and effective alternatives.*

Intent of TX.7.1.1 Through TX.7.1.1.7

Limiting the use of restraint or seclusion to those situations with appropriate and adequate clinical justification requires:

- effective leadership to shape the culture of the organization;
- supportive plans, policies, and priorities;
- an understanding of the human resource implications of limited use and choices related to reduced use;

* Behavioral health services is the contemporary term for a broad array of mental health, chemical dependency, and mental retardation/developmental disabilities services provided in settings such as acute, long term, and ambulatory care.

- ongoing staff orientation and education;
- patient and, when appropriate, family education; and
- the integration of restraint and seclusion into the organization's performance-improvement activities.

In particular, attention is directed toward

- refining behavioral health* diagnostic patient assessment processes to identify earlier the potential risk of dangerous patient behavior and the prevention, when appropriate, of those behaviors;
- reviewing and, when necessary, redesigning patient care processes associated with restraint and seclusion use; and
- identifying, developing, and promoting preventive strategies and the use of safe and effective alternatives.

Example of Implementation for TX.7.1.1.2

An acute care hospital with a psychiatric inpatient unit introduced the use of restraint and seclusion throughout the organization into the annual human resource planning process. The hospital reviewed its use of restraint and seclusion

- in emergent situations, especially in the emergency department and the psychiatric unit;
- as part of approved protocols in units, such as intensive care and postoperative care; and
- as a component of standard practice, such as in the operating room.

The leaders brainstormed several possibilities related to limiting its use and then identified the staffing implications of each possibility in terms of staffing patterns, staff mix, and staff education.

Example of Implementation for TX.7.1.1.3

Patient care staff needed to be aware of its psychiatric hospital's plans, policies, and strategies for limiting the use of restraint and seclusion. A staff education program was created to provide the knowledge, skills, and behaviors needed to support this effort. The information in the program included

- the impact of restraint and seclusion on the patient and his or her rights and dignity;
- patient assessment strategies identifying potential patient behavioral risk factors;
- care planning incorporating strategies to prevent or manage risk factors;
- the alternatives to restraint and seclusion effective for different patient behaviors;
- the correct application and removal (as guided by manufacturer's directions) when restraint is used; and
- clinical strategies to identify and meet emergent patient needs during use of restraint or seclusion.

The leaders decided that the education program should include patients who had experienced restraint or seclusion and activities that would give staff the opportunity to experience restraint and seclusion more personally. Orientation for new staff also included this information. In addition, periodic reviews were offered.

Example of Implementation for TX.7.1.1.4

A 50-bed acute care hospital was exploring ways to limit the use of restraint for confused geriatric surgical patients who remove surgical dressings or disconnect IV lines. The hospital decided that the patient and, when appropriate, family could play a significant role in implementing alternatives that would limit use. Education, however, was needed to support patient and family participation. The patient and family education included

- explanation of the behaviors that might cause restraint to be incorporated into the plan of care based on assessed patient needs or on an emergent basis;
- explanation of how the organization uses restraint as a component of surgical care;
- explanation of available alternatives to the use of restraint;

- identification of possible patient and family participation in the care process that could limit or halt the use of restraint;
- discussion of patient and family preferences and insights related to prevention and alternatives; and
- incorporation of patient preferences, whenever possible.

Example of Implementation for TX.7.1.1.5

Early identification of the potential risk of patient behavior resulting in the disruption of cardiac monitoring and IV medication was built into an acute care hospital's assessment process for a new heart transplant critical care pathway. Staff also identified environmental risk factors that may alleviate, precipitate, or escalate such behaviors or that had the potential to support positive behaviors. While such an assessment may be unplanned and almost instantaneous in an acute care situation with a person whose behavior poses an immediate danger to self or others, they were incorporated into the routine assessment for cardiac surgical care.

In either case, early identification of potential risk and potential alternatives as a routine component of patient assessment permitted care providers and the patient to plan for, rather than react to, such behaviors. This assessment also assisted in the development of care protocols that contained clear criteria for the application and discontinuation of restraint for these behaviors.

Example of Implementation for TX.7.1.1.6

As part of an organization's periodic risk management assessment, patient care processes that frequently include restraint and seclusion are reviewed. The review provides suggestions for process redesign to accommodate the use of alternatives and appropriately respond to potentially dangerous behaviors that are identified during assessment or that emerge during care.

Now, all medical, dental, surgical, and diagnostic patient care processes that include restraint are guided by protocols that include criteria related to patient behavioral risk factors. If the criteria are met, alternatives are ruled out, and restraint is considered clinically necessary, then use is initiated. Similarly, if the criteria are no longer met, the use of restraint is discontinued.

Standard

TX.7.1.2 Performance-improvement processes identify opportunities, when appropriate, to reduce restraint or seclusion use.

Intent of TX.7.1.2

Restraint and seclusion are high risk and problem prone and thus are a logical component of an organization's performance-improvement program. The measurement and assessment process related to restraint and seclusion seeks to understand the root cause of their use and incorporates this understanding into the organization's plans and priorities to evaluate and, if appropriate, reduce their use. This understanding is advanced by the assessment of aggregate data on restraint and seclusion episodes from all units, for all shifts, and for all purposes for which restraint and seclusion are used. Particular attention is paid to instances of multiple episodes of use for individual patients and the frequency of restraint use by type(s) of staff.

Example of Implementation for TX.7.1.2

1. Staff viewed restraint use in the emergency department of a large urban acute care hospital as high risk and problem prone. The organization also measured the volume of restraint use for behavioral health patients. Assessment revealed a high volume of instances of multiple episodes of restraint for individual patients and the variation of restraint use by staff category. In response, the inpatient psychiatric department staff instituted a "debriefing" policy in which staff, who initiated the restraint, and the affected patient would identify the triggers that led to its use and seek ways to minimize the likelihood of a reoccurrence of restraint use.

2. Staff in an inpatient psychiatric unit in an urban hospital noted frequent aggressive behavior among teenage male patients. When the behavior escalated, restraint or seclusion was needed in about 25% of the incidents. During the routine debriefing of staff and patients after each incident, a pattern of phrases and words used by female staff when addressing adolescent male patients was noted. Patients perceived the language used as infantile and demeaning, although it was clearly not intended to convey that message.

A plan was developed to review the unit rules and consequences of unacceptable behaviors with the patients and to train staff to use neutral or passive language when attempting to diffuse an incident or modify behavior. Subsequent monitoring revealed a 50% decrease in restraint or seclusion use.

3. A suburban acute care hospital planned to build a new wing for inpatient, partial, and day hospitalization behavioral health programs. The hospital worked with the design firm to help create soft, warm, and quiet interiors by positioning the building on its site for maximum light and views of adjacent woods. Interior space was designed to contain a variety of small spaces that were pleasant and quiet. These interior spaces were part of a new program designed to reduce patient stress and agitation and to de-escalate emerging potentially dangerous behaviors.

The hospital visited other new facilities, held discussions with staff and patients, and reviewed literature to help it establish the space specifications for the new program.

4. A hospital monitored emergency restraint and seclusion use and the total number of hours they were used. This monitoring was initiated after staff met to discuss the variation of how restraint and seclusion were used throughout the organization. The data from the assessment revealed that emergency restraint and seclusion use was discontinued quicker for some patients. These patients were usually those for whom restraint or seclusion was deemed clinically necessary near the end of the shift of the individual who initiated the use. Therefore, the individual who reassessed the patient and made the decision to continue or discontinue restraint or seclusion was *not* the individual who originally initiated its use. Subsequent interviews with staff and patients led to the conclusion that staff who did not initiate the original use of restraint conducted more objective, impartial reassessments of the need for continued use.

Consequently, the hospital developed a policy that did not allow staff who initiated the original restraint use to perform reassessments. While continued monitoring showed no decrease in the number of emergency restraint episodes, the total number of hours of use dropped 30% due to increased early release at reassessment.

Standard

TX.7.1.3 When restraint or seclusion is used, organization policy and procedures guide appropriate and safe use.

Intent of TX.7.1.3

Several essential elements govern how an organization uses restraint and seclusion in a way that is appropriate to the population and individuals served. These elements focus on the patient and are described in organization policy(ies) and procedure(s) and include appropriate details as to how the organization

- protects and preserves the patient's rights, dignity, and well-being during use;
- bases use on the patient's assessed needs;
- makes decisions about least-restrictive methods;
- assures safe application and removal by competent staff;
- monitors and reassesses the patient during use;
- meets patient needs during use;
- limits individual orders to licensed independent practitioners;
- time-limits orders; and
- documents in the medical record when restraint or seclusion is used, or individual orders written.

These essential elements assure that any use of restraint or seclusion protects and preserves the patient and his or her rights, dignity, and well-being. Appropriate staff approve policy(ies) and procedure(s) related to restraint and seclusion.

Standard

TX.7.1.3.1 *Individual orders for restraint or seclusion are consistent with organization policy.*

Intent of TX.7.1.3.1

Individual orders are the most common source for initiating restraint or seclusion, especially in behavioral health settings. Who is authorized to order restraint or seclusion, how orders are conveyed, the details provided in an order (for example, those related to time limits), and who is authorized to carry out the order are all essential aspects of processes to protect the individual patient, other patients, and staff.

Standard

TX.7.1.3.1.1 *Patient rights, dignity, and well-being are protected during restraint or seclusion use.*

Intent of TX.7.1.3.1.1

Each patient has a right to respectful care that maintains his or her dignity. Restraint and seclusion have the potential to significantly restrict these rights and can have serious adverse impact on the patient's well-being. Thus, each episode of use considers how the intervention will affect the patient including whether

- the application or initiation respects the patient as an individual;
- the environment is safe and clean;
- the patient is able to continue his or her care and participate in care processes; and
- modesty, visibility to others, and comfortable body temperature are maintained.

Standard _____

TX.7.1.3.1.2 Restraint or seclusion use is based on the assessed needs of the patient.

Intent of TX.7.1.3.1.2

Single episodes of use or continued use of restraint or seclusion is based on patient needs as identified in the initial assessment process or by qualified staff in emergent situations that pose the risk of injury to self or others. Thus, there is clinical justification for each episode of use, including emergency use when a licensed independent practitioner is not available.

Use is not based solely on prior history of use or history of dangerous behavior. Rather, use is based on the patient's needs in the immediate care environment and the interaction of the patient and staff with other patients in that environment. The organization does not permit any other use, such as for punishment or staff convenience.

Use appropriate to the needs of patients is assured by

- the training and skill of those who decide to apply restraint or initiate seclusion for emergency reasons in the absence of a licensed independent practitioner;
- clinical oversight by a licensed independent practitioner;
- review and evaluation of multiple episodes of use or continuous use; and
- organization policy.

Standard _____

TX.7.1.3.1.3 The least-restrictive safe and effective restraint or seclusion method is employed.

Intent of TX.7.1.3.1.3

The choice of restraint or seclusion method is guided by policy. The choice of a safe, effective, and least-restrictive method is determined by the patient's assessed needs and the effective or ineffective methods previously used on the patient. In the absence of previous experience, policy describes whether and how least-restrictive methods are to be tried first. Once employed, monitoring and reassessment of the patient assures that less-restrictive methods are used when possible and their use is discontinued as soon as possible. Patient and staff safety are considered in making these decisions.

Standard _____

TX.7.1.3.1.4 Restraint or seclusion is used correctly by competent, trained staff.

Intent of TX.7.1.3.1.4

Competent staff is essential to the safe and effective use of restraint or seclusion and to the protection of patients during use. Appropriate use of restraint or seclusion is essential if the patient's rights are to be respected and harm to the patient avoided. The organization identifies, educates, and determines the competency of those staff members who apply or remove restraint or who initiate or terminate seclusion. Frequently repeated in-service education, including an understanding of manufacturer's instructions for use of restraint devices, helps assure safe use.

If possible, and as appropriate to the patient population and methods used, the insights of former patients who have experienced being placed in restraints are included to help staff better understand all aspects of their use.

Standard

TX.7.1.3.1.5 Patients in restraint or seclusion are monitored and reassessed appropriately.

Intent of TX.7.1.3.1.5

Patients can experience harm, unintentional limitation of their rights and dignity, deterioration in well-being, and feelings of isolation when restraint or seclusion methods are used. Monitoring is essential to prevent or reduce such occurrences. Patient reassessment during monitoring permits the reduction in or early termination of restraint or seclusion.

Organization policy defines the monitoring frequency as continuous or not less frequent than every 15 minutes and defines the nature and extent of appropriate monitoring by observation and direct, face-to-face interaction with the patient.

Reassessment associated with monitoring is used primarily to determine the patient's well-being. Reassessment associated with time-limited orders is used primarily to determine the continuing need for the restraint or seclusion.

Standard

TX.7.1.3.1.6 Patient needs are met during restraint or seclusion use.

Intent of TX.7.1.3.1.6

A patient's physical and emotional needs are considered while the patient is in restraint or seclusion. The basic rights of human dignity and respect are maintained and physical well-being is preserved through adequate exercise, nourishment, and personal care.

Standard

TX.7.1.3.1.7 Restraint or seclusion use is ordered by a licensed independent practitioner.*

Intent of TX.7.1.3.1.7

Licensed independent practitioners have the responsibility for overseeing how their patients' assessed needs are met. This requires knowledge about and involvement in any use of restraint and seclusion.

Each licensed independent practitioner can best carry out his or her responsibility when he or she

- provides verbal or written orders for initial use or to reauthorize continuing emergency use;
- participates in daily reviews of restraint and seclusion use related to his or her patients; and
- participates in measuring and assessing use for all patients within the organization.

Organization policy identifies who (in accordance with state law) is authorized by the organization to give verbal or written orders for restraint or seclusion and who may receive, record, and initiate verbal orders. Organization policy also identifies the process for reviewing and reauthorizing emergency restraint or seclusion use.

The organization may authorize an individual who is not a licensed independent practitioner to order emergency restraint or seclusion use in response to a patient who poses an immediate danger to himself or herself or to others. However, a licensed independent practitioner is called within one hour. Continued use depends on authorization by a licensed independent practitioner.

* licensed independent practitioner Any individual permitted by law and by the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

Standard

TX.7.1.3.1.8 Orders for restraint or seclusion use define specific time limits.

Intent of TX.7.1.3.1.8

Time-limited orders. Written orders for restraint or seclusion are limited to

- 4 hours for adults;
- 2 hours for children and adolescents ages 9 to 17; or
- 1 hour for patients under age 9.

Early release. Staff can use criteria to guide early restraint or seclusion termination. When restraint or seclusion is terminated early and the same behavior is still evident, the original order can be reapplied if alternatives remain ineffective.

Continuation of orders. After the original order expires, the patient receives a face-to-face reassessment by a licensed independent practitioner. The licensed independent practitioner writes a new order if restraint or seclusion is going to be continued. Organization policy and the original order may permit a licensed, qualified, and authorized individual (such as a registered nurse) to perform the reassessment and make a decision to continue the original order for an additional

- 4 hours for adults up to a maximum of 24 hours;
- 2 hours for children and adolescents ages 9 to 17 up to a maximum of 24 hours; or
- 1 hour for children under age 9 for periods up to a maximum of 24 hours.

Standard

TX.7.1.3.2 Documentation in medical records reflects organization policy.

Intent of TX.7.1.3.2

The use of restraint or seclusion is recorded in the patient's medical record. The purpose and focus of an entry(ies) is on the patient.

Each episode of use is recorded and includes

- clinical justification for use;
- orders for restraint or seclusion that meet the requirements described in organization policy; and
- measures taken to protect the rights, dignity, and well-being of the patient including monitoring, reassessment, and attention to patient needs.

Standard

TX.7.2 Electroconvulsive and other forms of convulsive therapy are used with adequate justification, documentation, and regard for patient safety.

Intent of TX.7.2

Written policies regulate the use of electroconvulsive and other forms of convulsive therapy. Whenever convulsive therapy is used, the procedure is adequately justified and documented in the patient's medical record.

Before initiating electroconvulsive therapy for a child or adolescent, two qualified, experienced child psychiatrists who are not directly involved in treating the patient

- examine the patient;
- consult with the psychiatrist responsible for the patient; and
- document their concurrence with the treatment in the patient's medical record.

Standard

TX.7.3 Psychosurgery or other surgical treatments for emotional, mental, or behavioral disorders are performed with adequate justification, documentation, and regard for patient safety.

Intent of TX.7.3

Written policies and procedures regulate the use of psychosurgery or other surgical treatments for mental, emotional, or behavioral disorder. Whenever these procedures are used, they are adequately justified and documented in the patient's medical record.

Standards

TX.7.4 Use of behavior-management procedures conforms to the patient's treatment plan and hospital policy.

TX.7.4.1 Qualified staff review, evaluate, and approve all behavior-management procedures.

Intent of TX.7.4 and TX.7.4.1

The hospital defines staff roles and responsibilities for all appropriate disciplines involved in using special procedures. When behavior-management procedures are used, they are included in the patient's plan of treatment. Policies describe

- under what conditions specific behavior management* procedures can be used and when they should not be used, and
- requirements for approval of behavior management procedures in a patient's plan of treatment.

The hospital uses educational and positive reinforcement techniques (for example, alternative adaptive behaviors) wherever possible. When more restrictive techniques are clinically necessary, the least restrictive alternative is used to avoid harm to the patient. Time-out and procedures using restraining devices or aversive techniques are used only consistent with the patient's plan of treatment, policies and procedures, and state and federal laws. The hospital protects the patient's nutritional status and physical safety (for example, from corporal punishment).

Other patients may assist in implementing a patient's behavior management program only if

- it is conducted as part of a structured treatment plan;
- it is conducted under the supervision of qualified staff;
- it is limited to empowering patients to provide positive reinforcement; and
- it does not become abusive.

* behavior management
The use of basic learning techniques, such as biofeedback, reinforcement, or aversion therapy, to manage and improve an individual's behavior.

Introduction to the Restraint Standards in Acute Medical and Surgical (Nonpsychiatric) Care*

In its broadest context, *restraint* is any physical method of restricting a person's freedom of movement, physical activity, or normal access to his or her body. Restraint may be used in response to emergent, dangerous behavior; as an adjunct to planned care; as a component of an approved protocol; or, in some cases, as part of standard practice. Because restraint may be necessary for certain patients, health care organizations and providers need to be able to use restraint when essential to protect patients from harming themselves, other patients, or staff. They also need to be aware of the associated risks of both its use and nonuse.

* Effective January 1, 1999.

Restraint has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, violation of an individual's rights, and even death. Because of the associated risks and consequences of use, organizations are increasingly exploring ways to decrease restraint use through effective preventive strategies or the use of alternatives. For some organizations, a restraint free environment is appropriate to their patient populations and clinical services and is achievable now or in the future. But for many organizations, restraint use may continue to be necessary in clinically justified situations and in the foreseeable future, given the organization's populations and clinical services, the current state of knowledge, and available effective alternatives.

A physical, social, and organizational environment that limits restraint use to clinically appropriate and adequately justified situations and that seeks to identify opportunities to reduce the risks associated with restraint use through the introduction of preventive strategies, innovative alternatives, and process improvements is an environment that helps organization staff focus on the patient's well-being. The leader's role is to help create such an environment. This requires planning and, frequently, new or reallocated resources, thoughtful education, and performance improvement. The result is an organization approach to restraint that protects the patient's health and safety and preserves his or her dignity, rights, and well-being.

Applicability of these Restraint Standards in Acute Medical and Surgical (Nonpsychiatric) Care

Standards TX 7.5 through TX 7.5.5 apply to the use of restraint in the care of medical and surgical patients, which includes patients receiving pediatric, obstetrical, or rehabilitation care. This includes patients of any age who are

- hospitalized in an acute care hospital in other than a psychiatric unit in order to receive medical or surgical services;
- in the emergency department for the purpose of assessment, stabilization, or treatment, even if awaiting transfer to a psychiatric hospital or psychiatric unit;
- awaiting transfer from a nonpsychiatric unit to a psychiatric hospital or psychiatric unit after receiving medical or surgical care;
- in medical observation beds;
- receiving subacute services, unless, at the request of the hospital, such subacute services are surveyed under the Joint Commission protocol for subacute programs;
- undergoing same-day surgical or other ambulatory health care procedures, or
- undergoing rehabilitation as an outpatient or inpatient.

The specific nature of the device used to restrain a patient does not in itself determine whether these standards are to be applied. Rather, it is the device's intended use (ie, physical restriction), its involuntary application, and/or the identified patient need that determines whether the device use triggers the application of these standards. Therefore, these standards do not apply to

- standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes (for example, surgical positioning, IV armboards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients);
- adaptive support in response to assessed patient need (for example, postural support, orthopedic appliances, tabletop chairs);
- helmets;
- therapeutic holding or comforting of children or adolescents, or pediatric behavior management methods (to which the behavior management standards in this manual apply—TX.7.4 and TX.7.4.1);
- restraint for patients hospitalized on psychiatric units or for psychiatric purposes (to which the restraint standards in this manual for psychiatric patients apply); or
- forensic and correction restrictions used for security purposes.

Organizational Oversight of Restraint Use

Standard

TX-7.5 The organization's leaders determine the organization's approach to the use of restraint in the care of nonpsychiatric patients, which limits its use to those situations where there is appropriate clinical justification.

Intent of TX.7.5

Limiting the use of restraint to clinically justified situations requires clear policies and procedures, well-trained staff, and the support of the organization's leaders.

Clinical justification can be guided by clear criteria present in practice guidelines, practice parameters, pathways of care, or other standardized care processes developed by relevant professional organizations. When not available, the qualified staff of an organization establishes criteria or otherwise guides justification for the patient population served and clinical services provided by the organization.

Limiting the use of restraint to those situations with appropriate clinical justification requires

- the organization's leaders to determine the organization's approach to the use of restraint in the care of nonpsychiatric patients;
- supportive plans, policies, and priorities;
- understanding of the staffing needs associated with alternatives to restraint;
- ongoing staff orientation and education; and
- patient and, when appropriate, family education.

In particular, attention is directed toward

- refining medical, dental, surgical, and diagnostic patient assessment processes to identify earlier the potential risk of dangerous patient behavior and the prevention, when appropriate, of those behaviors;
- reviewing and, when necessary, redesigning patient care processes associated with restraint use;
- developing policy(ies), procedure(s), and protocols for the proper use of restraints; and
- identifying, developing, and promoting preventive strategies and the use of safe and effective alternatives.

Standard

TX-7.5.1 Performance-improvement processes seek to identify opportunities to reduce the risks associated with restraint use through the introduction of preventive strategies, innovative alternatives, and process improvements.

Intent of TX.7.5.1

The measurement and assessment process related to restraint seeks to understand why it is used and incorporates this understanding into the organization's plans and priorities to evaluate and, if appropriate, reduce its use. This understanding can be advanced by an initial baseline assessment of aggregate data on restraint episodes, followed by targeted monitoring.

Standard

TX.7.5.2 Organization policy(ies) and procedure(s) guide appropriate and safe use of restraint.

Intent of TX.7.5.2

Several essential elements govern how an organization uses restraint in a way that is appropriate to the population and individuals served. These elements focus on the patient and are described in organization policy(ies) and procedure(s) and include appropriate details as to how the organization

Group A Elements

- protects the patient and preserves the patient's rights, dignity, and well-being during use;
- bases use on the patient's assessed needs;
- makes decisions about least-restrictive methods;
- assures safe application and removal by qualified staff;
- monitors and reassesses the patient during use, using qualified staff;
- meets patient needs during use;

Group B Elements

- addresses risk associated with vulnerable patient populations, such as emergency, pediatric, and cognitively or physically limited patients;
- makes efforts to discuss the issue of restraint, when practical, with the patient and family around the time of its use;
- when orders are needed, limits individual orders to licensed independent practitioners (see standards TX.7.5.3.1 and TX.7.5.3.2);
- requires renewal of orders in accordance with applicable state law; and
- documents restraint episodes in the medical record (see standard TX.7.5.5).

These essential elements assure that any use of restraint, whether initiated by an individual order or through the use of a protocol, protects the patient and preserves his or her rights, dignity, and well-being.

The organization policy(ies) and procedure(s) are developed by appropriate staff and approved by the medical staff, nursing leadership, and, when appropriate, others.

Restraint Use by Individual Order or Protocol

Standard

TX.7.5.3 Any use of restraint (to which these standards apply) is initiated pursuant to either an individual order (standard TX.7.5.3.1) or an approved protocol (standard TX.7.5.3.2).

TX.7.5.3.1 Individual orders for initiation and renewal of restraint are consistent with organization policy(ies) and procedure(s), and are consistent with the patient's needs and clinical condition.

Intent of TX.7.5.3 and TX.7.5.3.1

Restraint of an acute medical or surgical patient (to which these standards apply) is only used pursuant to either an individual order or an approved protocol.

Individual orders provide the framework for ensuring clinical justification of restraint use and for protecting the rights, dignity, and well-being of the patient.

Individual Orders for Restraint (except for restraint initiated under a protocol as described in standard TX.7.5.3.2);

- Restraint (to which these standards apply) is used upon the order of a licensed independent practitioner. If a licensed independent practitioner is not available to issue such an order, restraint use is initiated by a registered nurse based on an appropriate assessment of the patient. In that case, a licensed independent practitioner is notified within 12 hours of the initiation of restraint and a verbal or written order is obtained from that practitioner and entered into the patient's medical record. If the initiation of restraint is based on a significant change in the patient's condition, the registered nurse immediately notifies a licensed independent practitioner. A written order, based on an examination of the patient by a licensed independent practitioner, is entered into the patient's medical record within 24 hours of the initiation of restraint.
- Continued use of restraint beyond the first 24 hours is authorized by a licensed independent practitioner renewing the original order or issuing a new order if restraint use continues to be clinically justified. Such renewal or new order is issued no less often than once each calendar day and is based upon an examination of the patient by the licensed independent practitioner.

Content of Individual Orders

- The individual order is consistent with organization policy(ies) and procedure(s).
- The individual order identifies any variation from organization policy(ies) and procedure(s) for monitoring of the patient and for release from restraint before the order expires.

Standard

TX.7.5.3.2 Protocols for restraint use contain criteria to ensure only clinically justified use.

Intent of TX.7.5.3.2

During the treatment of certain specific conditions (eg, post-traumatic brain injury) or the use of certain specific clinical procedures (eg, intubation) restraint may often be necessary in order to prevent significant harm to the patient. For specified conditions or procedures, protocols for the use of restraint may be established, based upon the frequent presentation in those conditions or procedures of behavior by patients that seriously endangers the patient or seriously compromises the effectiveness of the procedure. Such restraint protocols include guidelines for assessing the patient, criteria for applying restraint, criteria for monitoring the patient and reassessing the need for restraint, and criteria for terminating restraint. Authorized staff can initiate, maintain, and terminate restraint in accordance with these criteria, based on the individual patient's need and appropriate clinical justification, without obtaining an order from a licensed independent practitioner. The initiation of restraint in the absence of such a protocol requires the order of a licensed independent practitioner (see standard TX.7.5.3.1). The criteria for use of restraint that are incorporated into such a protocol reflect the organization policy(ies) and procedure(s) on the appropriate and safe use of restraint, and are approved by the medical staff, nursing leadership, and, when appropriate, others.

Patient Monitoring

Standard

TX.7.5.4 Patients in restraint are monitored.

Intent of TX.7.5.4

Organization policy(ies) and procedure(s), applicable state law, protocols, individual orders, the setting (eg, emergency department, outpatient surgery, endoscopy suite), and individual patient needs are used to establish the frequency, nature, and extent of monitoring of a patient in restraints. At a minimum, a patient in restraints is monitored every two hours. Monitoring is accomplished by observation, interaction with the patient, or related direct examination of the patient by qualified staff. Monitoring determines

- the physical and emotional well-being of the patient;
- that the patient's rights, dignity, and safety are maintained;
- whether less restrictive methods are possible;
- changes in the patient's behavior or clinical condition needed to initiate the removal of restraints;
- whether the restraint has been appropriately applied, removed, or reapplied.

Note: Documentation of monitoring is in accordance with organization policy(ies) and procedure(s) (see standard TX.7.5.5). Documentation is scored at standard TX.7.5.5.

Documentation

Standard

TX.7.5.5 Each episode of restraint use is documented in the patient's medical record, consistent with organization policy(ies) and procedure(s).

Intent of TX.7.5.5

Organization policy(ies) and procedure(s) establish the frequency, format (if appropriate), and content of entries in the patient's record relative to each episode of restraint use. The purpose of the entry is to provide clinical justification for use and document clinical oversight. Such documentation includes relevant orders for use, results of patient monitoring, reassessment, and significant changes in the patient's condition. When restraint is used as part of a protocol, the patient's record contains the protocol or references the protocol.

Appendix E:
ORYX Definitions

INDICATOR: Q12: USE OF SECLUSION IN PSYCHIATRIC INPATIENT UNITS**OTHER PERFORMANCE MEASUREMENT SYSTEMS: JCAHO ORYX**

RATIONALE FOR USE: Mental health service providers that are consumer-focused value an individual's autonomy and independence. Therefore, these providers seek to maximize the use of service modalities that are minimally, if at all, restrictive. While restrictive treatments are sometimes necessary, utilization of such treatments must be minimized and closely monitored. Overutilization of highly restrictive treatments may represent the unavailability of more appropriate, less restrictive therapies or the presence of treatment providers who lack respect for client autonomy and dignity.

APPROACH TO MEASURE: While the amount of hours in seclusion is one indicator, data suggest that a small number of consumers experiencing seclusion account for a disproportionate share of the total time. The second measure obtains the actual number of persons experiencing seclusion.

MEASURE 1: Hours of seclusion as a percent of client hours

Numerator: The total number of hours that all clients spent in seclusion.

Denominator: Sum of the daily census (excluding clients on leave status) for each day (client days) multiplied by 24 hours

Measure 2 Definition: Percent of clients secluded at least once during a reporting period

Numerator: The total number of clients (unduplicated) who were secluded at least once during a reporting period

Denominator: The total number of unduplicated clients who were inpatients at the facility during a reporting period

Related Definitions:

Seclusion - the involuntary confinement of a client alone in a room where the client is physically prevented from leaving (from JCAHO standards). Physically preventing egress may be accomplished via a variety of means including but not limited to manually or electronically locked doors, doors constructed so that when closed and unlocked they may not be opened from the inside (e.g. "one-way doors"), and the presence of staff proximal to the room preventing exit. A seclusion event should not be reported if an individual is prevented from leaving a room secondary to being restrained.

Begin and End Times - an "episode" of restraint or seclusion is an event that begins when an individual goes into seclusion or restraint ("Event Begin Time") and ends when the individual is released ("Event End Time"). It is possible for one event to be associated with multiple orders. For example, if an order for restraint is renewed and the client never exits the restraints between the original order and the renewal, only one event has occurred. Also, cases may exist in which a client has multiple seclusion or restraint events associated with a single order. For example, this would occur if an individual is removed from seclusion within the time limits of the initial seclusion order and staff are allowed to reapply seclusion without obtaining a new order. If a client is removed from seclusion or restraint only briefly for the purpose of toileting or to evaluate the need for continuation of the intervention and is then quickly

returned to seclusion or restraint, the initial event should be considered to have continued. In such a case, only one event has occurred.

SOURCE/S OF INFORMATION: MIS, Hospital Incident Monitoring System

CURRENT IMPLEMENTATION STATUS: A recent NRI study analyzed the implementation status and reported utility and burden of this performance indicator in 44 SMHAs. These states report:

	Total Implementing	Implementing Statewide	Implementing in Some Programs	Piloting	Burden 1=low 5=high	Utility 1=low 4=high
Community	4	1	2	1	3.0	2.3
Hospital	28	23	2	3	2.5	3.5

POPULATIONS:

- Children with a Serious Emotional Disturbance All Children
 Adults w/ a Serious Mental Illness All Adults Geriatric

SETTINGS:

- Psychiatric Inpatient Settings Community-based Settings

ISSUES: This indicator is being implemented by the NRI ORYX System.

[Return to Indicator List](#)

INDICATOR: Q13: USE OF RESTRAINTS IN PSYCHIATRIC INPATIENT UNITS**OTHER PERFORMANCE MEASUREMENT SYSTEMS: JCAHO ORYX**

RATIONALE FOR USE: Mental health service providers that are consumer-focused value an individual's autonomy and independence. Therefore, these providers seek to maximize the use of service modalities that are minimally, if at all, restrictive. While restrictive treatments are sometimes necessary, utilization of such treatments must be minimized and closely monitored. Over-utilization of highly restrictive treatments may represent the unavailability of more appropriate, less restrictive therapies or the presence of treatment providers who lack respect for client autonomy and dignity.

APPROACH TO MEASURE: While the amount of hours in restraint is one indicator, data suggest that a small number of consumers experiencing restraint account for a disproportionate share of the total time. The second measure obtains the actual number of persons experiencing restraint.

MEASURE 1 DEFINITION: Hours of restraint as a percent of client hours

Numerator: The total number of hours that all clients spent in restraint during a reporting period

Denominator: Sum of the daily census (excluding clients on leave status) for each day in a reporting period (client days) multiplied by 24 hours

MEASURE 2 DEFINITION: Percent of clients restrained at least once during the reporting period

Numerator: The total number of clients (unduplicated) who were restrained at least once during a reporting period

Denominator: The total number of unduplicated clients who were inpatients at the facility during the reporting period

Related Definitions:

Restraint: any involuntary method of physically restricting a client's freedom of movement, physical activity, or normal access to his or her body (from JCAHO standards). Restraints used for security purposes during transport of a client out of the building or off the premises to receive therapeutic services or to participate in activities directly related to the client's illness (such as court proceedings or appointments necessary to acquire human services) are not to be reported. Also, restraint devices employed for medical purposes (Geri-chair, posey, etc..) or as personal protective devices (helmets, bed rails, etc..) should not be reported.

Begin and End Times - an "episode" of restraint or seclusion is an event that begins when an individual goes into seclusion or restraint ("Event Begin Time") and ends when the individual is released ("Event End Time"). It is possible for one event to be associated with multiple orders. For example, if an order for restraint is renewed and the client never exits the restraints between the original order and the renewal, only one event has occurred. Also, cases may exist in which a client has multiple seclusion or restraint events associated with a single order. For example, this would occur if an individual is removed from seclusion within the time limits of the initial seclusion order and staff are allowed to reapply