

State of New York OFFICE OF MENTAL HEALTH OMH OFFICIAL POLICY MANUAL	Date Issued 5/29/07	T. L. 06-12	Section # PC-701
	Section Patient Care - Patient Management		
	Directive Seclusion and Restraint		

NOTE: This policy directive shall not preclude the application of security measures during transportation of patients who are committed to a facility pursuant to an order of a criminal court¹.

A. Policy Statement

The purpose of this policy directive is to set forth conditions and procedures for the use of seclusion and restraint in State-operated psychiatric inpatient facilities. The directive addresses both the use of seclusion and restraint for behavioral management purposes, as well as the use of restraints for medical and post- surgical care.

In this regard, the policy maintains the recent focus of requirements governing the use of restraints. Historically, requirements focused on the type of device or restraint being used, and the setting in which it was being employed. Under current federal regulations and JCAHO standards, requirements are tailored to the function or purpose of the restraint, i.e., is the restraint being used for medical or post-surgical purposes or for behavioral management purposes?

In medical or post-surgical care, a restraint may be necessary to ensure good medical outcomes when mechanical supports are not effective.. For example, restraints may be used to prevent an intravenous (IV) or feeding tube from being removed, or to prevent a patient who is temporarily or permanently incapacitated with a broken hip from attempting to walk before it is medically appropriate. In these circumstances, a medical restraint may be used to limit mobility or temporarily immobilize a patient in relation to a medical, post-surgical, or dental procedure.

For behavioral management purposes, seclusion and restraint are interventions to be used only as a measure of last resort to avoid imminent injury to the patient or others. The use of seclusion or restraint may be considered a treatment failure and serves as a prompt for treatment teams to review the appropriateness of the treatment approaches currently being used for individual patients. It is the goal of the Office of Mental Health to significantly reduce the incidence of situations that necessitate the use of seclusion and restraint, to make the use of seclusion and restraint a rare occurrence, and to continue efforts to reduce the rate of such rare occurrences.

Among the Office of Mental Health's purposes and goals are the provision of a safe and therapeutic environment, the reduction of danger, and the prevention of violent behavior. Episodes of violent behavior

are frequently associated with the use of seclusion and restraint for behavioral management purposes. While it is clear that violent behavior may lead to seclusion and restraint, in other instances violent behavior may begin or increase following the initiation of seclusion and restraint. Statistically, seclusion and restraint are associated with increased risk of injury to both patients and staff.

Seclusion and restraint also may have deleterious effects on patients, including survivors of sexual trauma and/or physical abuse, and patients with hearing impairments who are unable to communicate without the use of their hands. In assessing the need to use these interventions, therefore, the potential for any negative impact of the procedure on the particular patient shall be considered.

¹For purposes of this policy directive, "patients who are committed to a facility pursuant to an order of a criminal court" means and includes patients committed to the custody of the Commissioner pursuant to Section 330.20 or Article 730 of the Criminal Procedure Law, as well as those subject to subsequent retention orders following an initial commitment made under these statutes. This does not include: (1) persons who were initially admitted under Criminal Procedure Law Article 730 "Final Orders of Observation" whose original charges have been dismissed and who are, within 72 hours, converted to voluntary or involuntary status (Ritter vs. Surles); or (2) persons admitted under Criminal Procedure Law Article 730 who are converted to civil status as the result of a Court order issued pursuant to Jackson v. Indiana. Questions regarding applicability of this provision should be directed to Counsel's Office.

The use of seclusion and restraint for purposes of behavioral management can be reduced through the creation and maintenance of an environment which promotes the empowerment of patients, and which emphasizes the education and sensitization of staff regarding the appropriate use of restraint and seclusion. It is the goal of this policy to encourage this result.

Procedures for use of seclusion or restraint for behavioral management purposes are established in section E of this policy directive, while procedures for the use of restraints for medical or post-surgical care are set forth in section F.

B. Relevant Statutes and Standards

Mental Hygiene Law §33.04

14 NYCRR §27.7

42 C.F.R. §482.13

P.L. 106-310 (Children's Health Act of 2000)

Comprehensive Accreditation Manual for Hospitals (CAMH standards TX.7.1 through TX. 7.1.3.2)

C. Definitions

- 1) **Calming blanket** means a restraint consisting of a thick, stiff fabric comforter which encases a person's torso and limbs and is held in place by two persons.
- 2) **Chemical restraint**, or "Drug used as a restraint," means the use of a medication to control behavior or to restrict the patient's freedom of movement and is not standard treatment for the patient's medical or psychiatric condition². The use of medication to immobilize an individual is considered an inappropriate medical practice, is not an acceptable method of "drug used as a restraint," and is prohibited.
- 3) **Clinical director or designee** means the individual in charge of clinical services at the State-operated psychiatric facility, or a physician designated by that individual to carry out the responsibilities of the head of the clinical staff described in this directive.
- 4) **Comfort Wrap** means a lightweight blanket or sheet that a person may voluntarily use when they experience the need to feel safer and/or to provide an artificial boundary. When used in this manner, a comfort wrap is not a form of restraint.
- 5) **Five-point restraint** means a four-point restraint with the addition of a strap, which is placed over the person's upper torso and secured to the bed frame.
- 6) **Formal Debriefing** means a collaborative process among the treatment team, patient, and other involved parties, designed to rigorously analyze the use of a restraint or seclusion intervention in order to examine what occurred and to facilitate improved future outcomes by managing the event more effectively or preventing recurrence.
- 7) **Four-point restraint** means bracelets, encasing the wrists and ankles of a person lying on a bed, which are secured to the bed frame.

²If a drug is used as a restraint, all provisions governing the ordering, monitoring, and evaluation of restraint and seclusion apply. Federal CMS regulations define a drug used as a restraint (i.e., chemical restraint) as a "medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition" (42 CFR §482.13(f)). Federal guidance on this regulation provides that "the regulation is not intended to interfere with the clinical treatment of patients who are suffering from serious mental illness and who need appropriate doses of psychotropic medication to improve their level of functioning so that they can more actively participate in their treatment. Similarly, the regulation is not intended to interfere with appropriate doses of sleeping medication prescribed for patients with insomnia or anti-anxiety medication prescribed to calm a patient who is anxious. hence the notation that medications that are a standard treatment for a patient's medical or psychiatric condition are not subject to the requirements of the regulation." (CMS Interpretive Guidelines A-0063).

- 8) **Manual restraint** means the involuntary holding or pinning of an individual to restrict movement of the head, arms or body. Manual restraints include, but are not limited to, physical restraints required to facilitate the safe administration of court ordered or emergency medications administered over a patient's objection, physical "take downs," or other physical interventions that are designed to involuntarily hold or pin the individual to restrict movement.
- 9) **Mechanical restraint** means an apparatus which restricts an individual's movement of the head, limbs or body, and which the individual is unable to remove.³
- 10) **Mechanical support** means a device intended to keep a person in a safe or comfortable position or to provide the stability necessary for therapeutic measures such as immobilization of fractures, administration of intravenous solutions or other medically necessary procedures, which the patient can remove at will.⁴
- 11) **One-to-one constant observation** means a situation in which a staff member is responsible for maintaining continuous watch of a single patient, keeping the patient in view at all times, and, if clinically appropriate, attempting to initiate dialogue with the patient. In this situation, the staff member must remain in close enough proximity to the patient to be able to respond immediately if needed, and shall have no supervisory responsibilities for other patients.
- 12) **Restraint** means any manual method or physical or mechanical device that restricts freedom of movement or normal access to one's body, material, or equipment, attached or adjacent to the patient's body that he or she cannot easily remove⁵. For purposes of this policy directive, "restraint" means and includes manual restraint and mechanical restraint.
- 13) **Seclusion** means the placement of an individual alone in a room or area from which he or she cannot leave at will (or where the patient reasonably believes that he or she will be prevented from leaving), This includes restricting the patient's egress through the presence of staff, by coercion, or by imposing implicit or explicit consequences for non-compliance. However, it shall not mean confinement on a locked unit or ward where the patient is with others.
- 14) **Time-out** means a voluntary procedure used to assist the patient in regaining emotional control by providing access to a quiet area or unlocked quiet room away from his/her immediate environment. Time-out is not a form of restraint or seclusion. In order for an intervention to be considered time-out, the patient must be permitted to enter the area/room completely voluntarily. Exiting the time out area/room may not be restricted by any means. The room used for time-out should not be the same room that is used for seclusion.
- 15) **Wrist-to-belt restraint** means a belt, secured around a person's waist, with attached bracelets which encase the person's wrists. The tethers which secure the bracelets to the belt may be of adjustable lengths, which allow variation in the degree of restriction of the person's arms.

D. General Principles

- 1) The health and safety of the patient are the primary concerns of the Office of Mental Health at all times. Therefore, whenever a patient demonstrates a need for serious medical attention in the course of an episode of seclusion or restraint, medical priorities shall supersede psychiatric priorities, including the placement of the patient in restraint or seclusion.

³This term may apply to an apparatus not normally used for this purpose, such as a bed rail or bed sheet, if the patient is not able to release the mechanism. Restraint alternatives, such as chair or bed "sentinels," which patients themselves may release, may be useful in the treatment of, for example, elderly and confused patients who may otherwise injure themselves.

⁴Where the restraint is effectively equivalent to preventing a patient temporarily or permanently incapacitated by, e.g., a broken bone, from attempting prematurely to walk, the standard applicable to medical and post-surgical care, as identified in Section F of this directive, applies.

⁵A determination as to whether something is "easily removed" is based on a patient's physical and cognitive abilities to remove a restriction within a brief time span.

- 2) Seclusion or restraint for behavioral management purposes shall be employed only when necessary to prevent a patient from seriously injuring self or others, and less restrictive techniques have been tried and failed, or in the rare instance where the patient's danger is of such immediacy that less restrictive techniques cannot be safely applied.
- 3) Seclusion or restraint for behavior management is not a substitute for treatment. When it occurs, it indicates the need for a post-event analysis by the staff involved in the procedure, a debriefing by the treatment team and appropriate supervisory staff, and, in some cases, a formal treatment plan review. (See subdivision E)5)).
- 4) Seclusion or restraint shall not be used as punishment, for the convenience of staff, or as a substitute for treatment programs.
- 5) The criterion for release of a patient from seclusion or restraint for behavior management is achievement of a specific behavioral objective, which must directly relate to the situation that caused the seclusion or restraint episode. Examples that would satisfy this criterion include, but are not limited to, "the patient is no longer threatening to hurt staff"; or "the patient is able to verbalize that s/he is no longer intending to hurt self".
- 6) Simultaneous use:
 - (a) Seclusion and mechanical restraint shall never be used simultaneously.
 - (b) Two forms of restraint should not be used simultaneously, with the following exceptions:
 - (i) the use of mitts and helmets together;
 - (ii) the use of manual restraint while placing a patient in mechanical restraint; and
 - (iii) the use of chemical restraint with other forms of restraint.
- 7) The decision to utilize seclusion or restraint shall not be based on the individual's seclusion or restraint history or solely on a history of dangerous behavior.
- 8) Drug used as a restraint.
 - (a) The use of drugs as a restraint, while not prohibited, is not considered a standard practice. There may be rare instances where the degree of harm posed by a patient's behavior necessitates the use of medication to rapidly attenuate the behavior to ensure the safety of the patient and others.
 - (b) When medication is used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition, the use of the medication shall be deemed a restraint (i.e., "drug used as a restraint").
 - (c) Use of a drug as a restraint must be immediately reported to the facility's Clinical Director or designee and the facility Executive Director.
 - (d) All uses of drugs as a restraint can only be implemented following a written order of a physician.
 - (e) Monitoring and observation must include post-medication administration assessment by a registered nurse and shall include the same monitoring requirements as any other method of restraint, as set forth in this policy directive, provided, however, that monitoring of vital signs shall be done more frequently than with other forms of restraint, in accordance with good clinical practice and facility policy.
- 9) It is against Office of Mental Health policy to place objects on or over a patient's face during restraint procedures. In situations in which precautions need to be taken to protect staff against biting and spitting during restraint episodes, staff should wear bite gloves, masks or clear face shields when possible for purposes of infection control.

- 10) Mitts and helmets: The use of mitts and helmets as an emergency intervention to avoid imminent injury to the patient or others constitutes a restraint for behavioral management purposes and must follow the procedures set forth in section E of this policy directive.
- 11) When manual restraint is required to facilitate the safe administration of court ordered or emergency medications administered over a patient's objection, a physician's order for such manual restraint is required, and all provisions of this policy directive governing the use of manual restraint shall apply.
- 12) The use of manual restraint is the only form of restraint permitted with children less than 9 years of age in facilities operated by the Office of Mental Health. Other forms of restraint, as well as seclusion, shall be prohibited for this age group, except upon prior approval on a case-by-case basis by the Chief Medical Officer of the Office of Mental Health or his/her designee.
- 13) When manual restraint is used for the purpose of facilitating the placement of a patient in mechanical restraints or secluding a patient, a separate order is not needed for the manual restraint because an order will be written for the mechanical restraint or seclusion. The entire event must be documented in the patient's clinical record.
- 14) All clinical staff shall demonstrate competence in alternatives to, and the appropriate application of, seclusion and restraint prior to participating in the restraint or seclusion of a patient. Techniques sanctioned and taught by the Office of Mental Health must be employed. Excessive force shall not be used in initiating the use of seclusion or restraint. To enable staff to check the patient's airway and to prevent the possibility of positional asphyxia, care shall be taken to assure that patients are **not** placed in a face and chest down position.
- 15) In the case of patients who are known or reasonably believed to have a history of physical or sexual abuse, or in the case of patients with hearing impairments who would be unable to communicate without the use of their hands, an explanation of why restraint is the most appropriate intervention under the circumstances shall be included in the patient's case record when an order for the use of restraint is written pursuant to section E)3)).
- 16) The standard forms of mechanical restraint are the four-point restraint, five-point restraint, wrist-to-belt restraint, mitts, helmets, and calming blanket. No facility shall use these devices unless the related manufacturer and model have been approved by the Chief Medical Officer of the Office of Mental Health or his or her designee. Such approval shall be interpreted to allow facility-wide use. Mechanical restraints which employ a locking mechanism released by a key shall never be used or considered approved for use.
- 17) Facilities may use other types of mechanical restraints for specified patients for a specified period when so authorized by the Chief Medical Officer of the Office of Mental Health or his/her designee.
- 18) In choosing among the possible forms of intervention for a particular patient, staff shall utilize the least restrictive type which is appropriate and effective under the circumstances and shall only utilize restraint or seclusion as a last resort. Similarly, in cases where restraint or seclusion is used as a last resort, the least restrictive type which is appropriate and effective under the circumstances must be utilized. In determining whether or not a physical intervention rose to the level where it constitutes manual restraint, reasonable consideration must be given to the nature of the behavior of the patient that precipitated the intervention, the behavior of the patient subsequent to the intervention, federal guidance, clinical judgment, and common sense⁶.
- 19) The facility shall convey the intentions of OMH to make the use of restraint a rare occurrence, and to

⁶For example, if a staff member were to place his arm around a slightly agitated patient as he escorted him to a quiet room to regain control of his behavior, and the patient did regain control of his behavior and returned to the common area, such physical intervention would not constitute manual restraint. If an upset child was briefly held by staff to calm or soothe him, and the child soon quieted down, such physical intervention would not constitute manual restraint. If a patient erupted in violence and attempted to physically assault another patient or staff, and the patient had to be physically held prior to placing him in restraint or seclusion, such physical intervention would constitute manual restraint.

continue efforts to reduce the rate of such rare occurrences, to patients and to those families who, upon patient agreement, are involved in the patient's treatment planning process.

E. Procedures for Seclusion or Restraint for Behavioral Management Purposes

1) Individual Crisis Prevention Plans

- a) Within its assessment procedure for all patients, facilities must incorporate a patient interview, as clinically indicated, in which a number of specific inquiries are made regarding the patient's individual preferences and behaviors related to behavioral management interventions. These preferences or recommendations must be documented in the clinical record and used to develop an individual crisis prevention plan. In determining the appropriate intervention for a specific patient in response to an emergency situation which may warrant seclusion or restraint, any preferences or recommendations provided by the patient in the individual crisis prevention plan must be considered.
- b) Individual crisis prevention plans are designed to:
 - i) help patients during the earliest stages of distress or escalation before a crisis erupts;
 - ii) help patients identify practicable coping strategies;
 - iii) help staff plan ahead and know what to do with each person if a problem arises; and
 - iv) help staff use interventions that reduce risk and trauma to individuals.
- c) Individual crisis prevention plans should have at least three distinct sections which articulate triggers, early warning signs and coping strategies. The plans should encourage creativity and should be individualized to each patient's needs, linked to any personal history of trauma, and tailored to environmental resources.
 - i) "Triggers" are situations that may contribute to crisis for the patient under review (e.g., not being listened to, lack of privacy, feeling lonely, being teased, feeling pressured, people yelling, being touched, being isolated, loud noises, arguments, or not having control). The following questions should be conceptually utilized, as appropriate, to help articulate triggers:
 - (A) "What behaviors, situations or circumstances upset you?"
 - (B) "What makes you feel scared, upset or angry and could cause you to go into crisis?"
 - ii) "Early warning signs" are behaviors that a patient displays which indicate he or she may be upset or losing behavioral control (e.g., restlessness, agitation, pacing, shortness of breath, or sweating). The following questions should be conceptually utilized, as appropriate, to help articulate early warning signs:
 - (A) "What behaviors might you display as a result of what you are feeling or what might you or others notice just before you lose control?"
 - (B) "What subtle cues may you exhibit that indicate you are upset, frightened or angry?"
 - (C) "What are some things that you might say or do that would indicate that something was wrong?"
 - iii) "Coping strategies" are the patient's preferred strategies for managing and minimizing stress. (e.g., time away from a stressful situation, going for a walk, talking to someone who will listen, lying down, working out, or listening to peaceful music). The following questions should be conceptually utilized, as appropriate, to help articulate coping strategies:
 - (A) "What techniques, methods or tools help you control your behavior and thus prevent crisis situations, and what methods help you regain control when you are experiencing loss of

control?"

(B) "What are some things that help you calm down when you start to get upset?"

(C) "Are you able to communicate with staff when you are having a hard time? If not, what can staff do at these moments to help, essentially what can staff do to assist you?"

(D) "What does not help when you are upset; moreover, what should staff not do or what actions should staff avoid?"

(E) "Would you like your family to play a role when you are having trouble controlling your behavior? Is there anyone else you would like to have involved?"

(F) "What medications do you prefer (including dosages if known)? Do you prefer medication by mouth or by injection? Would it be helpful if someone held your hands and did not restrain your body?"

(G) "As a last resort in a crisis situation, when you are unable to maintain control and there is an imminent potential for you or others to be injured, do you have a preference for seclusion or a particular form of restraint?"

(H) "If seclusion or restraint is used as a last resort, do you want us to notify your family or a patient advocate of your choice?"

- d) Each facility shall develop a mechanism to be sure that all staff on all shifts, as well as floating staff, are aware of the patients' individual crisis prevention plans. At a minimum, the crisis plans should be attached to the patient's treatment plan and appear in condensed form which is readily accessible by staff. The information may also be included in other places where patient alerts are noted.
 - e) A copy of the individual crisis prevention plan should be given to the patient and routinely reviewed and updated throughout his/her inpatient admission when changes are warranted. Once the specific coping strategies are identified, they should be incorporated into the patient's individual crisis prevention plan. To provide an opportunity for the patient to build proficiency and increase the probability that they will be effective during times of crisis, the patient should be given an opportunity to "practice" the identified coping strategies at times when he/she is not in crisis.
 - f) Any preferences expressed by the patient regarding the gender of and/or languages spoken by the observing staff person shall be honored when practicable and clinically appropriate.
- 2) Strategies to Reduce the Use of Seclusion and Restraint
- a) Appropriate staff shall be made aware of patients' individual crisis prevention plans and shall be instructed to implement these plans in the early stages of patient crisis.
 - b) In addition, consistent with OMH's emphasis on recovery, facilities shall demonstrate commitment to reduction of the use of restraint and seclusion, through hiring practices, training and hands on involvement of executive, administrative and supervisory staff. Such commitment can be demonstrated by assuring that all staff are encouraged and trained to utilize clinical intervention strategies that contribute to therapeutic communication, negotiation, problem solving, prevention of power struggles between patients and staff, and proactive prevention and management of crisis behavior through use of de-escalation strategies, trauma informed interventions, and least restrictive measures.
 - c) Each State operated facility is required to develop and have in operation a plan to become violence and coercion free, the progress of which must be monitored regularly by the Facility Director or his or her designee.
- 3) Initiating Seclusion or Restraint
- a) Except as provided in section E)3)j), the implementation of seclusion or restraint shall only be pursuant

to a physician's written order, based on the results of a documented personal examination of the patient by the physician.

- b) The examination of the patient conducted by the physician shall include an assessment of the patient's mental status and physical condition, as well as a review of the clinical record for any pre-existing medical diagnosis and/or physical condition which may contraindicate the use of seclusion and/or restraint⁷.
 - i) The mental status assessment shall include an assessment of the patient's behavior, thought content, actual dangerousness to self or others, level of consciousness, and any other assessments which are clinically necessary. NOTE: The only reason that can justify the use of seclusion or restraint is imminent danger.
 - ii) The physical assessment shall include an assessment of the patient's general condition and vital signs, and any other examinations which are clinically necessary.
 - iii) The results of the examination shall be documented in the patient's clinical record, along with the inadequacies of less restrictive interventions and the specific behaviors that necessitated seclusion or restraint.
 - iv) Whenever any elements of the examination cannot be performed due to the condition of the patient, an explanation for the omission and the physician's clinical observations of the patient shall be recorded.
 - v) Any prior medical diagnoses, conditions, or behaviors which may serve as relative contraindications to the use of seclusion or restraint, including but not limited to a history of physical or sexual abuse or hearing impairment, should be documented, as well as the physician's rationale for ordering such an intervention at this time.
- c) The physician shall review the patient's existing medication orders and shall assess the need for modifying such orders during the period of restraint or seclusion. Documentation of this medication review shall be included in the patient's clinical record.
- d) The physician must document the time at which he or she personally examined the patient in the patient's clinical record.
- e) The physician's written order shall:
 - i) be written on the Order Sheet and included in the patient's clinical record;
 - ii) specify the facts and behaviors justifying the intervention and set forth the time of initiation and expiration of the authorization;
 - iii) specify the type of intervention to be used. If a physician orders the use of restraint, the written order shall specify the type of restraint to be used;
 - iv) identify the behavioral criteria for release; and
 - v) include any special care or monitoring instructions.
- f) The maximum time period of orders of seclusion or restraint shall be in accordance with the following:
 - i) one hour for adults;
 - ii) 30 minutes for patients ages 9 to 18, or for patients over age 18 in a children's facility or unit;

⁷For example, patients who are survivors of sexual assault should not be placed in restraints that position them in the "spread eagle" position.

- iii) 15 minutes for the use of calming blankets, which are not intended for use as ongoing restraints;
 - iv) up to 15 minutes for manual restraint of patients of any age, and
 - v) seclusion or mechanical restraint shall not be used for patients under the age of 9, except upon prior approval on a case-by-case basis by the Chief Medical Officer of the Office of Mental Health or his/her designee.
- g) Seclusion shall not be used with persons with a sole diagnosis of mental retardation or a sole diagnosis of any other developmental disability. However, seclusion shall be permitted for persons with a dual diagnosis of mental illness and mental retardation or any other developmental disability, only if performed in accordance with the requirements of this policy directive which govern seclusion interventions, in order to ensure compliance with 14 NYCRR Section 27.7.
- h) PRN orders shall not be used to authorize the use of seclusion or restraint.
- i) Continuous use of seclusion or restraint.
- (i) The use of seclusion or restraint beyond a continuous 4-hour period requires prior approval by the clinical director or his/her designee. Continuous use shall not exceed 24 hours without notification of the Chief Medical Officer of the Office of Mental Health, or his or her designee.
 - (ii) The clinical director or his/her designee shall immediately be notified of the issuance of 2 or more separate orders for the use of seclusion or restraint on any patient within any 12 hour period.
- j) It is the expectation of the Office of Mental Health that staff will immediately interact/intervene to prevent a patient from seriously injuring him/herself or others. When patients display antecedents to aggressive behavior and a potential crisis appears to be evolving, the registered nurse or nurse practitioner and physician should be immediately notified. Seclusion or restraint may be initiated in the absence of a physician's written order if a patient presents an imminent danger to self or others and a physician is not immediately available to examine the patient. The procedure shall be employed in accordance with the following directives:
- i) The procedure shall be initiated at the direction of a registered nurse, nurse practitioner, or physician's assistant.
 - ii) A physician must be called immediately to conduct a personal examination of the patient. The registered nurse, nurse practitioner, or physician's assistant shall note in the patient's clinical record the time of the call and the name of the physician contacted. All actions taken must be recorded on the Restraint or Seclusion Monitoring Form.
 - iii) If the physician's arrival exceeds 20 minutes from the time called:
 - (a) the registered nurse, nurse practitioner, or physician's assistant shall record the delay in the patient's clinical record, in addition to a description of the patient's behavior which requires seclusion or restraint, the type of procedure used, any condition for maintaining the seclusion or restraint pending the arrival of the physician, the reasons why alternative interventions were not used, and a description of the steps taken to assure the patient's comfort and safety; and
 - (b) the physician shall record in the patient's clinical record the explanation for his or her delay in arrival.
 - iv) In no event shall seclusion or restraint be applied for longer than 30 minutes without the written order of a physician.
 - v) If, based on the results of the physician's examination, the physician determines that the use of seclusion or restraint was and/or continues to be indicated, he or she shall write an order for the procedure consistent with the requirements of section E)3). The order shall commence from the

time at which the patient was initially placed in seclusion or restraints. The combined duration of the period specified in the physician's written order and the period of seclusion or restraint initiated by the registered nurse, nurse practitioner, or physician's assistant shall not exceed the time period allowed pursuant to section E)3)f).

- vi) If, based on the physician's examination, it is determined that seclusion or restraint are not needed, the physician shall document his rationale in a progress note. This should not be interpreted as a reflection of the judgment of the registered nurse, nurse practitioner, or physician's assistant, as the crisis may have passed. In addition, the physician must write an order to cover the period of time in which the patient was in restraint or seclusion prior to the physician's examination.
- k) Prior to placing a patient in seclusion or restraints pursuant to section E)3)a) or E)3)j), he or she shall be searched for potentially dangerous objects, and such objects shall be removed. If such search cannot safely be conducted, the reason for the delay shall be documented in the patient's clinical record. However, such search shall be conducted at a later time, as soon as it can be completed safely. In no event shall a patient be placed in seclusion or restraint in a nude or semi-nude state.
- l) Implementation of the seclusion or restraint order shall be consistent with the techniques sanctioned and taught by the Office of Mental Health.
- m) To enable staff to check the patient's airway and prevent positional asphyxia, care shall be taken to assure that patients are **not** placed in a face and chest down position. In cases where the patient moves, or is inadvertently moved, to a face or chest down position, he or she shall be immediately repositioned.
- n) Immediately after the application of the seclusion or restraint, a physician or registered nurse shall conduct an assessment of the patient to ensure that the intervention was safely and correctly applied without undue harm or pain to the patient.
- o) If the patient has granted permission for notification of his/her family and/or a patient advocate of the initiation of seclusion or restraint, a professional staff member shall promptly make such notification. If the seclusion or restraint is applied during the night, such notification may occur the following morning.

If a family has submitted a written request not to be notified of instances of seclusion and restraint, the facility shall honor this request.

- p) If, at any time after application of seclusion or restraint, clinical assessment indicates that the patient has met the behavioral criteria for release, release shall be immediate.

4) Monitoring Persons in Seclusion or Restraint

- a) A patient in seclusion or restraint shall be monitored and assessed to ensure that his or her physical needs, comfort and safety are properly cared for.
 - i) A patient in seclusion or restraint shall receive one-to-one constant observation and assessment by a staff member who is trained and competent in Office of Mental Health policies and procedures regarding seclusion and restraint with demonstrated skills in minimizing the use of seclusion and restraint, assisting patients in meeting behavior criteria for the discontinuation of seclusion or restraint, assisting patients in meeting their physical needs (e.g., nutrition and hydration, hygiene and elimination, circulation and range of motion in the extremities, and vital signs), assessing physical and psychological signs of distress or injury of patients who are in seclusion or restraint, and recognizing readiness for the discontinuation of these interventions.
 - ii) A written assessment of the need for seclusion or restraint and of the general comfort and condition of the patient shall be done at the time of the initial application of the seclusion or restraint and every 15 minutes thereafter, or at more frequent intervals as directed by the physician. The assessment shall be recorded on the Restraint and Seclusion Monitoring Form.

- b) Although audiovisual monitoring may be useful for time-out, one-to-one constant observation shall be used to monitor persons in seclusion or restraint. Staff members assigned to provide one-to-one constant observation may not have other assigned responsibilities during the time period that they are assigned this supervision responsibility.
- c) In order to reduce the possibility of choking, unless clinically indicated, patients shall not be fed while in restraints. If a patient has been restrained and not fed during mealtime, immediately after release from restraints, he or she shall be offered food and fluids.
- d) In order to assess the patient's physical status during the use of seclusion or restraint, vital signs, consisting of blood pressure, temperature, pulse and respiratory rate⁸, shall be taken and recorded on the Restraint and Seclusion Monitoring Form according to the following guidelines:
 - i) For patients in restraint, vital signs should be taken immediately after application of restraint, hourly thereafter, and upon release, or more frequently as ordered by the physician.
 - ii) For patients in seclusion, vital signs should be taken immediately after placement in seclusion and upon release if the patient's behavior is such that vital signs can be taken safely.
 - iii) If a patient is in seclusion beyond a period of 1 hour, vital signs should be taken every two hours or more frequently as specified by the physician, if the patient's behavior is such that vital signs can be taken safely.
 - iv) If vital signs of a patient in seclusion or restraint cannot be taken safely at the frequency required, the reason for each omission shall be documented in the patient's clinical record.
- e) A patient shall be released from seclusion or restraint as soon as he or she has achieved the behavioral criteria for release. Unless the nurse, doctor, or physician's assistant determines that the patient is obviously dangerous, an attempt should be made to release the patient at least once every 30 minutes. Patients who are sleeping are deemed not to be a danger to themselves or others.
 - i) If a patient, upon this attempt to release him/her from seclusion or restraint, is determined to be a continued danger to self or others, the intervention may be continued, unless the order pursuant to section E)3) has expired.
 - ii) If the order has expired, a subsequent episode of seclusion or restraint can only be initiated in accordance with the procedures set forth in section E)3).
 - iii) If a patient, upon being released from seclusion or restraint, makes no overt gestures or verbalizations that would indicate a threat of serious harm or injury to self or others, the procedure shall not be reimposed and a physician shall be immediately notified.
- a) It is the responsibility of the physician who has ordered seclusion or restraint to be accessible to staff in the event of an emergency. Accordingly, the physician shall advise appropriate staff how to contact him or her, or a relief physician, during the period of the order.
- g) Each State-operated psychiatric facility shall develop and implement written procedures to assure that physicians are accessible to staff on all shifts when the physician who has ordered seclusion or restraint is off duty after writing the order. These procedures shall include mechanisms for communication among shifts regarding the names of patients in seclusion or restraint, the condition of the patients, changes in medication and any complications or problems encountered during the period of seclusion or restraint.

5) Reviewing the Use of Seclusion or Restraint

⁸It is recommended that assessment of vital signs include, in addition to assessing temperature, blood pressure, and pulse and respiration rate, observation and documentation of status of respiration, skin color, and appearance of nail beds.

- a) Patient Evaluation. Upon the patient's release, the registered nurse, nurse practitioner, or physician's assistant shall conduct an in-person re-evaluation of the patient and write a progress note that includes a description of the patient's response to the use of seclusion or restraint.
- b) Post Acute Event Analysis. Immediately following the episode of seclusion or restraint, the key individuals involved in the procedure, including the staff who authorized and ordered the restraint or seclusion shall conduct and document a post acute event analysis. The scope and depth of the post acute event analysis shall be commensurate with the nature and duration of the intervention utilized, provided minimum JCAHO and CMS requirements are met. When possible, the immediate post acute event analysis should be led by the on-site supervisor, and an individual from outside the treatment team should be invited to participate. The input of the patient placed in restraint or seclusion shall also be sought, when clinically appropriate. The focus of the immediate post acute event analysis shall include the following:
 - i) to assess patient and staff members' immediate needs (e.g., survival, safety/security, injury or medical concerns);
 - ii) to identify steps that need to be taken to return to the pre-crisis milieu;
 - iii) to assure communication regarding the event between the administration, unit staff, the family and the patient; and
 - iv) to begin to evaluate the need for emotional support, including, if necessary, treatment of trauma, for the patient, witnesses/observers and the staff involved.
- c) Formal Debriefing. No later than the next working day following the use of seclusion or restraint, or sooner if practicable, a senior manager shall conduct a formal debriefing designed to separately delineate what happened, how the participants feel about the events that happened, and what operational and training issues need to be addressed. The scope and depth of the formal debriefing shall be commensurate with the nature and duration of the intervention utilized, provided minimum JCAHO and CMS requirements are met. At a minimum, participants in the formal debriefing should include the treatment team and appropriate supervisory staff, including the clinical lead; and, whenever practicable, an executive staff representative and one or more consumer advocates. The restrained or secluded patient should be encouraged to participate, as well as family members, if the patient so indicates.
 - i) Goals. The goals of the formal debriefing process include the following:
 - A). to reverse or minimize the negative effects of the use of seclusion and restraint;
 - B) to evaluate the physical and emotional impact on all involved persons;
 - C. to identify any need for, and then to provide, counseling or support for the patients (and staff) involved for any trauma that may have resulted (or emerged) from the incident;
 - D. to prevent the future use of seclusion and restraint by assisting the patient and staff in identifying what led to the incident and what could have been done differently; and in determining whether or not all alternatives to seclusion and restraint were considered; and
 - E. to address organizational problems and make appropriate changes by determining what organizational barriers may exist to avoiding seclusion and restraint in the future; and by recommending changes to the organization's philosophy, policies and procedures, environments of care, treatment approaches, staff education and training.
 - ii) Process. The Formal Debriefing should include inquiries designed to evaluate and understand the escalation of the crisis and the restraint/seclusion process.
 - A) The focus of the formal debriefing must be to identify opportunities for process improvement,

rather than to attribute fault or blame. The following inquiries may be conceptually included to achieve this result:

- 1) Had a treatment environment been created where conflict was minimized (or not)?
- 2) Could the trigger for conflict (disease, personal, environmental) have been prevented (or not)?
- 3) Did staff notice and respond to events (or not)?
- 4) Was there an Individual Crisis Prevention Plan, was it followed, and was it useful?
- 5) Did the interaction/intervention occur at the earliest opportunity?
- 6) Did staff choose an effective intervention (or not)?
- 7) If the intervention was unsuccessful was another chosen (or not)?
- 8) Were all pertinent members of the treatment team involved in the de-escalation process (or not)?
- 9) Did staff order seclusion or restraint only in response to imminent danger (or not)?
- 10) Was seclusion or restraint applied safely (or not)?
- 11) Was the individual monitored safely (or not)?
- 12) Was individual released as soon as behavioral release criteria were met (or not)?
- 13) Did immediate post-acute event activities occur (or not)?
- 14) Did learning occur and was it integrated into the treatment plan and practice (or not)?

B) During the Formal Debriefing, inquiries that are designed to assist staff in analyzing the situation should be explored. The following are sample questions for staff which conceptually capture these content areas, which should be addressed, as applicable to the specific situation:

- 1) What were the first signs that a crisis might be developing?
- 2) What de-escalation techniques were used?
- 3) What worked and what did not?
- 4) What could you do differently next time?
- 5) How could seclusion or restraint be avoided in this situation in the future?
- 6) What emotional impact does putting someone in restraints have on you?
- 7) What was your emotional state at the time of the escalation?

C) During the Formal Debriefing, inquiries that are designed to assist the patient in analyzing the situation should be explored. The patient should first be provided with a copy of his or her individual crisis prevention plan (if any). The following are sample questions for the patient which conceptually capture these content areas, which should then be addressed, as clinically appropriate and applicable to the specific situation:

- 1) Did we fail to understand what you needed?

- 2) What upset you most?
- 3) What did we do that was helpful?
- 4) What did we do that got in the way?
- 5) What can we do better next time?
- 6) Is there anything that you could have done differently; could you do something differently next time?
- 7) What could we have done to make the restraint/hold (or seclusion) less traumatic?

- iii.) Application of information gained. The information gathered should be used to identify, evaluate and modify facility policies and procedures, unit environments, rules, practices, staff interactions, individual crisis prevention plans, individual treatment plans, training needs and other areas, as appropriate. Any recommended solutions or intervention preferences offered by the patient during the debriefing or at any other time shall be noted in the patient's clinical record. Such information shall be considered in future situations, and implemented whenever clinically appropriate.
- d) It shall be part of the ward psychiatrist's responsibilities upon coming on duty to review the clinical record of any patients for whom he or she is responsible who have been in seclusion or restraint since he/she was last on duty, and to ascertain their current status.
- e) A report which indicates the utilization of seclusion or restraint shall be sent to the clinical director or designee on a daily basis. The report shall, at a minimum, include:
 - i) the patient's name and ward;
 - ii) the type of seclusion or restraint used;
 - iii) the length of time that the patient was in seclusion or restraint for each written order;
 - iv) the behavior(s) necessitating the intervention; and
 - v) any less restrictive techniques attempted and a statement of why they were found inadequate.
- f) The clinical director or designee shall review the use of seclusion and/or restraint daily, and shall immediately investigate unusual or unwarranted patterns of utilization. Each episode of seclusion or restraint involving patients under the age of 18 shall be reviewed by the clinical director or designee no later than the next working day.
- g) Multiple episodes of seclusion or restraint with an individual patient shall be reviewed by the patient's treatment team and the clinical director or his or her designee. At a minimum, such reviews, which shall include a review of the patient's treatment plan, shall be conducted whenever three or more orders are written for a given patient every 30 days. The review team shall include a senior psychiatrist and, if available, at least one peer specialist.
- h) As part of the facility's quality management program, the incidence of violent behavior and the associated use of seclusion and/or restraint shall be monitored. Data regarding each order of seclusion and/or restraint shall be collected, analyzed, and reported to Central Office. These data shall be integrated into facility and Office of Mental Health performance improvement activities.
- i) Injuries and deaths related to the use of seclusion and/or restraint shall be reported as incidents pursuant to the mandates of Part 524 of Codes, Rules and Regulations of the State of New York and the Office of Mental Health clinical risk management and incident management plans policy (QA-510). Staff injuries shall also be reported, pursuant to employee accident reporting policies.

- j) The Office of Mental Health shall report to the Center for Medicare and Medicaid Services (formerly HCFA) any death that occurs while a patient is secluded and/or restrained, or in which it is reasonable to assume that the death is a result of seclusion and/or restraint. This notification will be made by the Office of Mental Health Director for Quality Management after consultation with the Associate Commissioner for State Psychiatric Center Management and the Chief Medical Officer or his/her designee and will occur by the next business day following the patient's death.

6) Training

- a) The facility shall assure that clinical staff, including professional staff, as well as any staff that may be involved in the seclusion and restraint, receive orientation and instruction in alternatives to both seclusion and restraint, the appropriate techniques of applying both seclusion and restraint, the potentially traumatic impact of seclusion and restraint, and the laws, regulations, policies and procedures governing the use of seclusion and restraint. The training shall also address the sensitization of staff regarding the use of seclusion and restraint and shall allow each staff member the opportunity to experience at least one of these interventions. When appropriate, persons who have experienced seclusion and restraint as patients shall be included as providers of training. If such persons are not available as trainers, the viewpoints of persons who have experienced seclusion or restraint shall be presented using written or audiovisual material, as available. A written record of training shall be maintained.
- b) Such training must be provided to all staff working in an inpatient setting who interact with patients as follows: a 2-day minimum training program should be provided initially, with one-day review programs provided on an annual basis.
- c) Staff must initially demonstrate competency in all of the training areas identified in paragraph a) of this subdivision prior to their participation in the seclusion or restraint of a patient, and shall further be required to demonstrate such competence on an annual basis.

7) Use of Mechanical Supports

- a) The requirements of this directive do not preclude the use of mechanical supports.⁹ For devices intended to keep a person in a safe or comfortable position, however, the patient must be able to release the device at will; otherwise, the procedure needs to be defined and handled as a restraint.
- b) The use of mechanical supports shall be ordered by a physician as part of the patient's treatment program in accordance with facility policy. Such order shall be documented in the patient's clinical record.
- c) As a matter of policy, mechanical supports shall not be used as a substitute for restraint or seclusion. In those rare events in which they are used as a form of restraint, such use shall only be implemented following the prior approval of the Chief Medical Officer of the Office of Mental Health or his/her designee and in accordance with the provisions of Section F, below.

F. Procedures for Use of Restraints for Medical or Post- Surgical Care

As with all restraints, risks associated with restraints for medical or post-surgical care must be considered in the ongoing loop of assessment, intervention, evaluation, and re-intervention. The greater the risks associated with an intervention, the more careful and thorough the assessment must be. The following guidelines apply to restraint of a patient in a facility operated by the Office of Mental Health when used for purposes of medical or post-surgical care:

- 1) A restraint for medical or post-surgical care shall not serve as a substitute for adequate staffing to monitor patients.

⁹Each facility should have in place a separate policy that governs the use of mechanical supports. The statements in this section are intended to clarify the relationship between mechanical supports and restraints.

- 2) The use of restraints for medical or post-surgical care shall be implemented in accordance with a written modification of the patient's treatment plan.
- 3) The implementation of medical or post-surgical restraint shall be pursuant to a physician's written order, based on the results of a documented personal examination of the patient by the physician.
- 4) The examination of the patient conducted by the physician shall include an assessment of the patient's mental status and physical condition, as well as a review of the clinical record for any pre-existing medical diagnosis and/or physical condition which may contraindicate the use of restraint.
 - a) The assessment shall include an evaluation of the patient's general condition and vital signs, and any other examinations which are clinically necessary.
 - b) The results of the examination shall be documented in the patient's clinical record, along with the inadequacies of less invasive interventions, the specific circumstances that necessitated the restraint, and the purpose that the intervention is to serve.
- 5) The physician's written order shall:
 - a) be written on the Order Sheet and included in the patient's clinical record;
 - b) specify the facts and circumstances justifying the intervention and set forth the time of initiation and expiration of the authorization;
 - c) specify the specific type of restraint to be used; and
 - d) include any special care or monitoring instructions.
- 6) The maximum time period for each order of restraint for medical or post-surgical care shall be 24 hours.
- 7) Implementation of the restraint order for medical or post-surgical care shall be consistent with standard techniques to ensure safety and efficacy. The facility shall assure that clinical staff, including professional staff, receive orientation and annual instruction in all techniques commonly used in the facility for restraining patients in medical and post-surgical care.
- 8) A patient in restraint shall be monitored to ensure that his or her physical needs, comfort and safety are properly addressed, including administration to the patient's limbs of range of motion exercises at least every 2 hours, when the patient is awake.
- 9) When utilizing four point or five point methods of mechanical restraint for medical or post-surgical care, written assessment of the need for the restraint of the general comfort and condition of the patient shall be done at the time of the initial application of the restraint and every 15 minutes thereafter, or at more frequent intervals as directed by the physician. The assessment shall be recorded on the Restraint and Seclusion Monitoring Form. Such patients shall be continually monitored on a one-to-one basis. For all other forms of mechanical restraint used for this purpose, written assessment of the need for the restraint of the general comfort and condition of the patient shall be done at the time of the initial application of the restraint and every hour thereafter, or at more frequent intervals as directed by the physician. The assessment shall be recorded on the Restraint and Seclusion Monitoring Form.
- 10) When utilizing four point or five point methods of mechanical restraint for medical or post-surgical care, in order to assess the patient's physical status during the use of restraint, vital signs, consisting of blood pressure, temperature, pulse and respiratory rate, shall be taken and recorded immediately after application of restraint, hourly thereafter, and upon release, or more frequently as ordered by the physician. For all other forms of mechanical restraint used for this purpose, such vital signs shall be taken and recorded immediately upon application of the restraint and thereafter on a daily basis, or at more frequent intervals as directed by the physician.
- 11) It is the responsibility of the physician who has ordered the medical post-surgical restraint to be accessible to

staff in the event of an emergency. Accordingly, the physician shall advise appropriate staff how to contact him or her, or a relief physician, during the period of the order.

- 12) The clinical director or designee shall review the use of medical or post-surgical restraint daily, and shall immediately investigate unusual or unwarranted patterns of utilization.
- 13) Injuries and deaths related to the use of medical or post-surgical restraint shall be reported as incidents pursuant to the mandates of Part 524 of Codes, Rules and Regulations of the State of New York and the Office of Mental Health incident management policy (QA-510).
- 14) The Office of Mental Health shall report to the Center for Medicare and Medicaid Services (formerly HCFA) any death that occurs while a patient is restrained, or in which it is reasonable to assume that the death is a result of restraint. This notification will be made by the Office of Mental Health Director for Quality Management after consultation with the Associate Commissioner for State Psychiatric Center Management and the Chief Medical Officer or his/her designee and will occur by the next business day following the patient's death.