Seclusion and Restraint Policies
Protection of Residents

Restraint and Seclusion Policies are used for:

• Protection of residents
• Safety during an emergency situation and
• Only until the safety situation has ceased and the resident’s safety and the safety of others can be ensured

Emergency Safety Interventions must be safe and appropriate based on:

• Severity of behavior
• Chronological and developmental age
• Gender
• Physical, medical and psychiatric condition
• Personal history (including history of physical or sexual abuse)

*Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience or retaliation.
Notification of Restraints/Seclusions Policy

At the time of admission, the facility must:

• Inform the Resident and/or parent/legal guardian(s) of the Restraint and Seclusion policies

• Communicate the policy in a language and manner that the resident and parents/guardians understand—using interpreters or translators as needed.

• Obtain written acknowledgement of understanding from resident and parent/guardian and maintain documentation in the clinical record

• Provide a copy to the resident and/or parent/guardian

Facility’s Policies must include contact information for the appropriate State Protection and Advocacy organization

At the time a Restraint or Seclusion is used, the facility must:

• Contact the resident’s parent/guardian as soon as possible, but no later than 24 hours. If the parent/guardian cannot be reached, attempts are to be documented. If still unable to reach the parent or guardian within 24 hours, a letter can be mailed and documentation made that the letter of notification was sent.
Physician’s Orders for Restraint or Seclusion

Physician’s Orders Must:

• Be by a physician or other licensed practitioner permitted to order Restraint or Seclusion
• Be the least restrictive emergency safety intervention

Each Specific Order Must:

• Document the date and time the order was obtained
• Be specific to the acute incident requiring the use of restraint or seclusion-no standing PRN orders
• Not exceed
  4 hours for residents age 18-21;
  2 hours for residents age 9-17; or
  1 hour for residents under age 9
Examples of Physician Orders

Each Physician Order should:

- Include date and time
- Be specific to the acute incident-no PRN orders
- Follow age requirements
- Specify the emergency safety intervention ordered

Examples:

- “1/1/14 1305: Place resident in physical restraint for up to 30 minutes for physically aggressive behaviors displayed towards staff and peers. May discontinued physical restraint prior to the 30 minutes if emergency safety intervention is no longer required.”

- “12/2/13 1132: Place resident in seclusion for up to one hour for physically aggressive behaviors towards staff and others. May discontinue seclusion prior to one hour if emergency safety intervention is no longer required.”

- “7/4/12 1804: Place resident in a physical escort hold up to five minutes due to physically aggressive behaviors. May discontinue physical escort hold prior to the 5 minutes if emergency safety intervention is no longer required.”
Face to Face Intervention:

Within 1 hour of the initiation of the emergency safety intervention, a physician or other licensed practitioner trained in the use of emergency safety interventions and permitted by the State and the facility to assess the physical and psychological well being of residents must conduct a face-to-face assessment of the physical and psychological well-being of the resident, including but not limited to:

1. The resident's physical and psychological status,
2. The resident's behavior,
3. The appropriateness of the intervention measures, and
4. Any complications resulting from the intervention.

*If there is any harm or injury to the resident as a result of the safety intervention, medical treatment must be immediate.
Post Intervention Debriefings

Within 24 hours after the use of a restraint or seclusion there must be documentation of two (2) post intervention debriefings.

1. Staff debriefing including the resident:
   
   • A face to face discussion including staff involved in the use of the safety intervention as well as the resident. If the presence of a particular staff member may jeopardize the well-being of the resident, that staff can be excluded.
   
   • Both resident and staff (and parents/legal guardians when deemed appropriate) must be provided the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used to prevent any future use of restraint or seclusion.

*The staff must document in the resident's record that debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, the names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.
2. **Staff debriefing with supervisory and administrative staff:**

   Must include all staff involved in the safety intervention as well as appropriate supervisory and administrative staff. Discussion, at a minimum, must review:

   - The safety situation resulting in the required intervention including precipitating events
   - Alternative techniques that might have prevented the use of restraint or seclusion
   - Procedures that staff are to implement to prevent any future use of restraint and seclusion
   - The outcome of the intervention including any injuries that may have resulted from the intervention

   *The staff must document in the resident's record that debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, the names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.*
Documentation should be completed by the end of the staff’s shift.

- Each order for restraint or seclusion
- Start and stop times of the emergency safety intervention
- Time and results from the 1-hour post assessment
- Events of the emergency safety situation requiring the use of restraint or seclusion
- The name of staff involved in the emergency safety intervention.
“John was angry and placing staff and peers in danger. He was placed in a hold and escorted to time out.”

“John was in the dayroom and would not follow directions. He continued to be disruptive and told staff he was not going to leave the room. Staff placed him in a restraint and escorted him to time out.”

1. What was the emergency safety situation requiring restraint or seclusion?

2. What de-escalation techniques were used prior to the restraint or seclusion?

3. What were the specific behaviors?
“John was cursing all morning and became verbally aggressive. He threatened to fight peers and staff. John refused to follow staff directions while in the dining room. He began standing in an aggressive posture and attempted to charge at staff. Staff moved out of the way and he ran to exit door and began kicking and beating on the door while ignoring staff directions. Staff placed him in a physical restraint to escort him to the unit.”

1. What was the emergency safety situation requiring restraint or seclusion?

2. What de-escalation techniques were used prior to the restraint or seclusion?

3. What were the specific behaviors?
Example

“John was in the day room and refused to follow staff directions. He continued to be disruptive and threatened to leave the room. He attempted to pick up a chair and hold it over his head as if he was going to throw it at staff. He refused to put the chair down while demanding to leave the room. Staff had to intervene and place him in a physical restraint to remove the chair and reduce safety risks to staff and peers.”

1. What was the emergency safety situation requiring restraint or seclusion?

2. What de-escalation techniques were used prior to the restraint or seclusion?

3. What were the specific behaviors?
The following definitions apply:

A. Drug used as a restraint means any drug that:
   1. Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others,
   2. Has the temporary effect of restricting the resident's freedom of movement and
   3. Is not a standard treatment for the resident's medical or psychiatric condition.

B. Emergency safety intervention means the use of restraint or seclusion as an immediate response to an emergency safety situation.

C. Emergency safety situation means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.
D. *Mechanical restraint* means any device attached or adjacent to the resident's body that he or she cannot easily remove and that restricts freedom of movement or normal access to his or her body.

E. *Minor* means a minor as defined under State law and, for the purpose of this subpart, includes a resident who has been declared legally incompetent by the applicable State court.

F. *Personal restraint* means the application of physical force without the use of any device for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him or her or holding a resident's hand to safely escort a resident from one area to another.

G. *Psychiatric Residential Treatment Facility* means a facility other than a hospital that provides psychiatric services, as described in subpart D of part 441 of Title 42 of the Code of Federal Regulations, to individuals under age 21 in an inpatient setting.
H. Restraint means a “personal restraint,” “mechanical restraint” or “drug used as a restraint” as defined in this section.

I. Serious injury means any significant impairment of the physical condition of the resident as determined by the provider’s qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

J. Staff means those individuals with responsibility for managing a resident’s health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time, or contract basis.
A. Restraint and seclusion policy for the protection of residents.

1. Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

2. An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.

3. Restraint or seclusion must not result in harm or injury to the resident and must be used only:
   
   a) To ensure the safety of the resident or others during an emergency safety situation and

   b) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.

4. Restraint and seclusion must not be used simultaneously.
B. Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe and proportionate and that is appropriate to the severity of the behavior and to the resident's chronological and developmental age, size, gender, physical, medical, and psychiatric condition, and personal history (including any history of physical or sexual abuse).

C. Notification of facility policy. At admission, the facility must:

1. Inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;

2. Communicate its restraint and seclusion policy in a language that the resident or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and, when necessary, the facility must provide interpreters or translators;
(continued)

3. Obtain an acknowledgment, in writing, from the resident or, in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and

4. Provide a copy of the facility policy to the resident and, in the case of a minor, to the resident's parent(s) or legal guardian(s).

D. Contact information. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.
Orders for restraint or seclusion must be by a physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and who is trained in the use of emergency safety interventions.

If the resident's treatment team physician is available, only he or she can order restraint or seclusion.

A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
D. If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff, such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion must be available to the staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

E. Each order for restraint or seclusion must:

1. Be limited to no longer than the duration of the emergency safety situation and

2. Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9.
Within 1 hour of the initiation of the emergency safety intervention, a physician or other licensed practitioner trained in the use of emergency safety interventions and permitted by the State and the facility to assess the physical and psychological well-being of residents must conduct a face-to-face assessment of the physical and psychological well-being of the resident, including but not limited to:

1. The resident's physical and psychological status,
2. The resident's behavior,
3. The appropriateness of the intervention measures, and
4. Any complications resulting from the intervention.
G. Each order for restraint or seclusion must include:

1. The name of the ordering physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion;

2. The date and time the order was obtained; and

3. The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion authorized its use.
H. Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

1. Each order for restraint or seclusion as required in paragraph G of this section.
2. The time the emergency safety intervention actually began and ended.
3. The time and results of the 1-hour assessment required in paragraph F of this section.
4. The emergency safety situation that required the resident to be restrained or put in seclusion.
5. The name of staff involved in the emergency safety intervention.
I. The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.

J. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.
If a physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion orders the use of restraint or seclusion, that person must contact the resident's treatment team physician unless the ordering physician is in fact the resident's treatment team physician. The person ordering the use of restraint or seclusion must:

A. Consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion and

B. Document in the resident's record the date and time the team physician was consulted.
A. Clinical staff trained in the use of emergency safety interventions must be physically present and continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.

B. If the emergency safety situation continues beyond the time limit of the order for the use of restraints, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion to receive further instructions.

C. A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and who is trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.
A. Clinical staff trained in the use of emergency safety interventions must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement.

B. A room used for seclusion must:
   1. Allow staff a full view of the resident in all areas of the room and
   2. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

C. If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion to receive further instructions.
D. A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.
If the resident is a minor as defined in this subpart:

A. The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

B. The facility must also notify the resident’s parent(s) or legal guardian(s) as soon as possible and in no case later than 24 hours after the serious occurrence.

C. The facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.
A. A resident in time out must never be physically prevented from leaving the time out area.

B. Time out may take place away from the area of activity or from other residents, such as in the resident's room (exclusionary), or in the area of activity or other residents (inclusionary).

C. Staff must monitor the resident while he or she is in time out.
A. Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.
B. Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of:

1. The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;

2. Alternative techniques that might have prevented the use of the restraint or seclusion;

3. The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

4. The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.
C. The staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, the names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.
221.710 Medical Treatment for Injuries Resulting From an Emergency Safety Intervention

A. Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

B. The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid Program that reasonably ensure that:

1. A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

2. Medical and other information needed for care of the resident in light of such a transfer will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

3. Services are available to each resident 24 hours a day, 7 days a week.
Medical Treatment for Injuries Resulting from and Emergency Safety Intervention

221.710 Medical Treatment for Injuries Resulting From an Emergency Safety Intervention

(continued)

C. The staff must document in the resident's record all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

D. The staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.
Federal regulations regarding facility reporting and survey activity are located at 42 CFR Part 483, Subpart G §§483.374 – 483.376.
Each psychiatric residential treatment facility that provides inpatient psychiatric services to individuals under age 21 must attest, in writing, that the facility is in compliance with the Centers for Medicare and Medicaid Service (CMS) standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

A. Current Medicaid Providers

A facility with a current provider agreement with the Medicaid agency must provide a letter of attestation no later than July 21st of each year. Attestations must be sent to each state Medicaid agency (SMA) where the PRTF has established a provider agreement.

Exceptions:

1. If July 21st occurs on a weekend or holiday, the attestation is due on the first business day following the weekend or holiday and

2. If the letter of attestation is not received by the due date, the provider will be given 30 calendar days to submit it. If it is not received by the 30th day after the due date, the provider will be terminated from participation in the Arkansas Medicaid Program.

Attestation letters must be sent to the Medicaid Provider Enrollment Unit. View or print the contact information for the Medicaid Provider Enrollment Unit.
New Medicaid Provider Applicants

A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.
A federal provider identification number is assigned to each provider who meets the attestation requirement. The identification numbers for PRTFs will have five digits and one letter. The first two digits identify the state in which the facility is located. This number is then followed by the letter L and then by three digits and is numbered according to the order in which a facility was identified.

A. Federal provider numbers are assigned by the State Medicaid agency (SMA).

B. A provider number is coded based on where the PRTF is physically located.
Roles and Responsibilities for the Reporting of Deaths, Serious Injuries, and Attempted Suicides

The interim process for reporting deaths will follow a similar process as currently in place for the death reporting process for hospitals. The roles and responsibilities of the appropriate entities are outlined below.

A. PRTFs

1. Report to the SMA, no later than close of business the next business day, all deaths, serious injuries, and attempted suicides at (501) 682-6173.

2. Report to the CMS regional office (RO) all deaths no later than close of business the next business day after the resident's death. Death reporting information should be reported to CMS at (214) 767-4434.

3. Document in the resident's record that the death was reported to the CMS regional office.
Roles and Responsibilities for the Reporting of Deaths, Serious Injuries and Attempted Suicides

(continued)

B. CMS Regional Office (RO)

1. The regional office should receive the report directly from the PRTF. Pursuant to 42 CFR 483.374(b)(1), the report must include the name of the resident, a description of the occurrence, and the name, street address, and telephone number of the facility.

2. The CMS regional office should make sure the survey agency (SA) has received the report. The SA is responsible for carrying out the investigation in conjunction with instructions from the State Medicaid agency.

3. Since the PRTF is responsible for reporting to the agencies listed previously in addition to the CMS RO, the regional office should obtain the completed investigation from the SA.

4. The report should be received from the PRTF, according to 42 CFR 483.374(c)(1), no later than close of business the next business day after the resident's death.

5. The CMS regional office will send the death report to the CMS central office (CMS CO).
221.803 Roles and Responsibilities for the Reporting of Deaths, Serious Injuries and Attempted Suicides

(continued)

C. CMS Central Office (CO)

- The CMS CO is responsible for maintaining a central log of the death information reported from the CMS RO.
The facility must require staff to have ongoing education, training, and demonstrated knowledge of:

A. Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;

B. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and
C. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

1. Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

2. Individuals who are qualified by education, training, and experience must provide staff training.

3. Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

4. The staff must be trained and demonstrate competency before participating in an emergency safety intervention.

5. The staff must demonstrate their competencies as specified in paragraph A of this section on a semiannual basis and their competencies as specified in paragraph B of this section on an annual basis.
6. The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

7. All training programs and materials used by the facility must be available for review by CMS, the SMA, and the State SA.
Questions?
Please watch for a survey following this webinar. We appreciate your feedback.
Thank you