

## PURPOSE

The purpose of this policy is to assure that implementation of restraint, including physical management (manual hold) and seclusion with patients who exhibit violent/self-destructive behavior in state operated psychiatric hospitals and centers is consistent and complies with the provisions of applicable state and federal laws and regulations, whichever is the most stringent.

## REVISION HISTORY

Previously promulgated as Subpart U of Administrative Directive 07-C-1752/AD-00 (Use of Restraint) and Subpart V of Administrative Directive 07-C-1752/AD-00 (Use of Seclusion). Rescinds and replaces both. This policy rescinds and replaces Policy and Procedure 10.7.1 Use of Restraint and Physical Management and Policy and Procedure 10.7.2 Use of Seclusion both issued May 14, 2010.

## DEFINITIONS

**Anatomical support** means body positioning or a physical support ordered by a physician or occupational therapist for the purpose of maintaining or improving a patient's physical functioning. An anatomical support is not considered a restraint.

**Emergency situation** for purposes of this policy, means those occasions when unanticipated, severely aggressive or destructive behavior places the patient or others in imminent danger.

**Imminent risk** means a risk that is impending, on the point of happening, reasonably certain to occur.

**Less restrictive therapeutic intervention** means those professionally recognized strategies which are intended to recognize the early signs of impending dangerous behaviors, to identify and ameliorate the cause(s) of such behaviors and to implement non-aversive techniques to minimize the consequences of a patient's potentially harmful behavior.

**Physical management** means a technique approved by the hospital or center that is used by staff as an emergency intervention to restrict the movement of a patient by direct physical contact to prevent the patient from harming himself, herself or others. Physical management shall be considered a manual method of restraint.

**Prone immobilization** means a manual method of restraint of a patient in a prone (face down) position, usually on the floor, where force is applied to the patient's body in a manner that prevents him or her from moving out of the prone position.

**Protective device** means a device or physical barrier to prevent the patient from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective device as defined here and incorporated in the written individual plan of service shall not be considered restraint.

**Restraint** means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of the patient to move his or her arms, legs, body or head freely; or chemical restraint which is a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

- a. Restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- b. Physically holding a patient for forced medication is a restraint.

**Seclusion** means the temporary placement of a patient in a room, alone, where egress is prevented by any means and may only be used if essential to prevent the patient from physically harming others.

**Therapeutic de-escalation** means an intervention, the implementation of which is incorporated in the individualized written plan of service, wherein the patient is placed in a room, accompanied by staff who shall therapeutically engage the patient in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.

**Time-out** means a voluntary response to a therapeutic suggestion to a patient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous situation.

Violent/self-destructive behavior: means behavior that jeopardizes the immediate physical safety of the patient, staff or others.

## **POLICY**

It is the policy of the Department of Health and Human Services (MDHHS) that a patient has the right to be free from restraint or seclusion of any form imposed as a means of coercion, discipline, convenience or retaliation by staff and that restraint or seclusion shall only be imposed in a hospital or center to ensure the immediate physical safety of the patient and others. MDHHS believes that successful reduction in the use of restraint and seclusion requires a basic and profound respect for every patient and every staff person. Each hospital/center may develop patient care and treatment procedures for implementation of MDHHS policy.

## **STANDARDS**

### ***Implementation of Restraint or Seclusion***

1. A patient shall not be placed in any manual (such as physical management), mechanical or chemical restraint or seclusion except in the circumstances and under the conditions set forth in this policy or in other state or federal law, rules or regulations, whichever is the more stringent.
2. Restraint or seclusion shall only be used for the management of violent/self-destructive behavior.
3. In the case of an emergency situation, restraint or seclusion use shall be based solely on the immediate care environment, not on the patient's history of dangerous behavior or previous response to physical intervention.
4. Restraint or seclusion shall not be used if the patient's physician has determined that restraint or seclusion is clinically contraindicated for the individual. This determination shall be clearly documented in the patient's record.
5. Prone immobilization of a patient for the purpose of behavior control is prohibited unless implementation of other manual methods of restraint other than prone immobilization is medically contraindicated and documented in the patient's record.

6. A patient may be restrained or secluded only after less restrictive therapeutic interventions have been determined to be ineffective to protect the patient or others from harm. This determination shall be documented in the medical record.
7. A patient may be temporarily restrained or secluded without an order in an emergency situation. Immediately after imposition of the temporary restraint or seclusion, a physician shall be contacted.
  - a. If, after being contacted, the physician does not order restraint or seclusion, the restraint or seclusion shall be discontinued.
  - b. If the patient's violent/self-destructive behavior resolves and the restraint or seclusion is discontinued before the physician arrives to perform the 1 hour face-to-face evaluation, the physician is still required to see the patient face to face and conduct the evaluation within 1 hour after the initiation of the restraint or seclusion.
8. A patient may be restrained or secluded pursuant to an order by a physician made after personal examination of the patient. An order for restraint or seclusion shall continue only for that period of time specified in the order or for up to the following limits, whichever is less:
  - a. 4 hours for adults 18 years of age or older.
  - b. 2 hours for children and adolescents 9 to 17 years of age.
  - c. 1 hour for children under 9 years of age.
9. When restraint or seclusion is used for the management of violent or self-destructive behavior, the patient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician to evaluate:
  - a. The patient's immediate situation.
  - b. The patient's reaction to the intervention.
  - c. The patient's medical and behavioral condition.
  - d. The need to continue or terminate restraint or seclusion.
10. If the face-to-face evaluation specified in subsection 9 is conducted by a physician who is not the patient's attending physician, that physician must consult the patient's physician as soon as possible after the completion of the 1-hour face-to-face evaluation.

11. Before writing a new order for the use of restraint or seclusion, a physician must see and assess the patient not more than 30 minutes before the expiration of the expiring order.
12. A restrained or secluded patient shall continue to receive food, shall be kept in sanitary conditions, shall be clothed or otherwise covered, shall be given hourly access to toilet facilities, shall be given the opportunity to sit or lie down and shall have the opportunity to bathe or shower or shall be bathed as often as needed, but at least once every 24 hours.
13. Each instance of restraint or seclusion requires full justification for its application, and the results of each periodic examination shall be placed promptly in the record of the patient.
14. If a patient is restrained or secluded repeatedly, the patient's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of seclusion.
15. The use of restraint or seclusion must be:
  - a. In accordance with a written modification to the patients plan of service.
  - b. Implemented in accordance with safe and appropriate restraint or seclusion techniques as determined by hospital procedures in accordance with state law and regulations.
16. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).
17. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
18. The condition of the patient who is restrained or secluded must be monitored by a physician or trained staff that have completed the training criteria specified in this policy at least once every 15 minutes.
19. Restraints shall be removed every 2 hours for not less than 15 minutes unless medically contraindicated or whenever they are no longer essential in order to achieve the objective which justified their initial application.

20. All hospital and center physicians must have a working knowledge of this policy regarding the use of restraint or seclusion.
21. All requirements specified under this subsection are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored:
  - a. Face-to-face by an assigned, trained staff member.
  - b. By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient. The patient shall be seen live for the 15 minute monitoring if the patient is restrained or viewed through the seclusion room window if the patient is secluded.
22. When restraint or seclusion is used, there must be documentation in the patient's record of the following:
  - a. The 1-hour face-to-face medical and behavioral evaluation.
  - b. A description of the patient's behavior and the intervention used.
  - c. Alternatives or other less restrictive interventions attempted (as applicable).
  - d. The patient's condition or symptom(s) that warranted the use of the restraint or seclusion.
  - e. The patient's response to the restraint or seclusion, including the rationale for continued use of restraint or seclusion.
23. The hospital or center shall ensure that a restrained or secluded patient is given an explanation of why he or she is being restrained or secluded and what he or she needs to do to have the restraint or seclusion order removed. The explanation shall be provided in clear behavioral terms and documented in the record.

### ***Post-Restraint or Seclusion Debriefings***

1. Following are the goals of post event debriefing:

- a. To reverse or minimize the negative effects of the use of restraint and seclusion.
    - i. Evaluate the physical and emotional impact on all involved individuals.
    - ii. Identify need for and provide counseling or support for the patient and staff involved for any trauma that may have resulted or emerged from the event.
  - b. To prevent the future use of restraint and seclusion.
    - i. Assist the patient and staff in identifying what led to the incident and what could have been done differently.
    - ii. Determine if all alternatives to restraint and seclusion were considered.
  - c. To address organizational problems and make appropriate changes.
    - i. Determine what hospital/center barriers may exist to avoiding restraint and seclusion in the future.
    - ii. Recommend changes to the hospital/center philosophies, procedures, and environment of care, treatment approaches, staff education and training.
2. Post-Event Debriefing.
- a. This debriefing occurs within the next 1 to 2 working days with the patient, staff who participated in the event, patient's treatment team leader and appropriate supervisory staff. The purpose of this debriefing is:
    - i. To assist the treatment team to determine how to more effectively assist the patient and staff in understanding what precipitated the event.
    - ii. To develop appropriate coping skills.
    - iii. To develop interventions designed to avoid future need for restraint or seclusion.
  - b. Following are debriefing questions for staff who participated in the event:

- i. What were the first signs the patient exhibited?
    - ii. What de-escalation techniques were used?
    - iii. Was the patient's Safety Plan considered?
    - iv. What worked and what did not?
    - v. What would you do differently next time?
  - c. Following are debriefing questions for the patient involved in the event:
    - i. How did we fail to understand what you needed?
    - ii. What upset you the most?
    - iii. What did we do that was helpful?
    - iv. What did we do that got in the way?
    - v. What can we do better next time?
  - d. Documentation related to the post event formal debriefing that includes the above information shall be placed in the patient's record. Documentation shall include the names of staff who were present for the debriefing, names of staff who were excused from the debriefing, and any changes to the patient's treatment plan that result from the debriefing.

***Staff Training Requirements.***

1. The patient has the right to safe implementation of restraint or seclusion by trained staff.
2. Staff must be trained and able to demonstrate competency in the use of restraint or seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion :
  - a. Before performing any of the actions specified in this procedure.
  - b. As part of orientation.
  - c. Subsequently on a periodic basis no less than annually.
3. The hospital or center must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:
  - a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger the need for restraint or seclusion.

- b. The use of nonphysical intervention skills.
  - c. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition.
  - d. Recognizing and respond to signs of physical and psychological distress
  - e. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
  - f. Monitoring the physical and psychological well-being of the patient who is restrained or secluded,
  - g. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
4. **Trainer requirements.** Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.
  5. **Training documentation.** The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.
  6. **Standard:** Death reporting requirements: Hospitals and centers must report deaths associated with the use of restraint or seclusion.
    - a. The hospital must report the following information to the Bureau of State Hospitals and Behavioral Health Administrative Operations and to other state and federal regulatory bodies as required:
      1. Each death that occurs while a patient is in restraint or seclusion.
      2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
      3. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or seclusion contributed directly or indirectly to a patient's death. **Reasonable to assume** in this

context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

## CONTACT INFORMATION:

**Center for Medicare/Medicaid Services (CMS) Region V: FAX**  
443-380-8952

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- b. Each death referenced in this paragraph must be reported to the bureau and to CMS or federal regulatory bodies by telephone no later than the close of business the next business day following knowledge of the patient's death.
- c. Staff must document in the patient's record the date and time the death was reported to CMS.

## REFERENCES

- Michigan Mental Health Code, MCL 330.1752
- Michigan Mental Health Code, MCL 330.1740
- Michigan Mental Health Code, MCL 330.1742
- MDHHS Administrative Rule 330.7243
- 42 CFR 482.13
- State Operations Manual, Interpretive Guidelines, A-0154 through A-0214
- Debriefing Activities: A Core Strategy©, A Tertiary Prevention Tool, Goetz and Huckshorn, 2003

## CONTACT

For additional information concerning this policy, contact the Director of the Office of Recipient Rights at (517) 373-2319.