Ohio Administrative Code

Rule 5122-2-17 Seclusion and restraint use in regional psychiatric hospitals.

Effective: December 3, 2020

(A) The provision of a physically and psychologically safe environment is a basic requirement for effective mental health treatment. Treatment environments free of coercive interventions and violence promote positive, trusting relationships and facilitate treatment and recovery.

Seclusion and physical restraint are emergency interventions intended to prevent patient and staff injury. They are not a form of therapy and may be traumatizing to a patient. We strive continually to minimize the use of seclusion and restraint. We recognize that these emergency interventions are to be used only by trained and competent staff and as a last resort in order to eliminate dangerous and potentially harmful behaviors and to preserve safety and dignity. All patients should be assessed for any past exposure to these emergency interventions along with possible alternative interventions based on patient preference and experience.

The fundamental goal of inpatient care is to facilitate recovery from serious mental illness, especially from acute exacerbation of illness that may affect judgment, perception, emotion, and behavior. Quality inpatient care includes a physically and psychologically safe environment for both patients and staff. The preference of the department is for the use of positive, supportive and less intrusive measures to engage patients in treatment, including the use of counseling, positive relationships, and a therapeutic environment that facilitates treatment and recovery.

To reduce incidents that may lead to injuries, staff should employ a multi-modal approach and an interdisciplinary, trauma-informed, proactive intervention perspective.

The experience of seclusion and restraint is stressful for both staff and patients, requiring debriefing and support for these individuals. The purpose of this rule shall be to define and establish uniform procedures governing the safe, humane, and appropriate use of seclusion and restraint consistent with this philosophy, standards of quality treatment and respect for the rights of patients.

(B) The provisions of this rule shall be applicable to all regional psychiatric hospital inpatient

settings operated by the department of mental health and addiction services (OhioMHAS).

(C) The following definitions apply to this rule in addition to or in place of those appearing in rule 5122-1-01 of the Administrative Code:

(1) "Chief clinical officer (CCO)" means the medical director of a regional psychiatric hospital (RPH) as defined in division (K) of section 5122.01 of the Revised Code.

(2) "Clear treatment reasons" means that permitting the patient to participate will present a substantial risk of physical harm to the patient or others or will substantially preclude effective treatment of the patient. If a restriction is imposed for clear treatment reasons, the patient's written treatment plan shall specify the treatment designed to eliminate the restriction at the earliest possible time.

(3) "Direct care personnel" means personnel with special training, competency and experience in assessing and treating persons with mental illness and whose primary responsibility is for such functions.

(4) "Emergency" means an impending or crisis situation which demands immediate action for preservation of life or prevention of serious bodily harm to the person or others as determined by a licensed physician, licensed practitioner, or registered nurse (RN).

(5) "Hospital services security personnel" means special police as defined in section 5119.08 of the Revised Code and security officers of the regional psychiatric hospital.

(6) Licensed practitioner means an individual who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with state law and specifically refers to advanced practice nurses (APN) and physician assistants.

(7) "Mechanical supports" means items used for the purpose of achieving proper body alignment, position and balance. Mechanical supports shall not be considered restraints under this rule when used in this manner. Examples include orthopedic-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.

(8) "Physical restraint" means any method, or device that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. For purposes of this rule, physical restraint refers to:

(a) "Manual restraint" means physically holding an individual to restrict an individual's ability to move his or her legs, arms, head, or body, freely.

(b) "Physical restraint with devices" means any method of restricting a persons freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

(c) "Prone restraint" means measures used to limit or control the movement of an individual's body while the individual is in a face-down position for an extended period of time. Prone restraint includes manual or physical restraint with devices.

(d) "Transitional hold" means a restraint involving a brief physical positioning of an individual face-down for the purpose of quickly and effectively gaining physical control of that individual in order to prevent harm to self and others, and enable the individual to be transported safely.

(9) "PRN order" means a practitioner's written order for a medication, treatment, or procedure which is only carried out when an individual patient manifests a specific clinical condition.

(10) "Quiet time" means a voluntary procedure through which a patient removes him/herself to an unlocked area from a situation which is too stimulating, in an effort to regain self-control.

(11) "Seclusion" means confinement of a patient alone in a room, locked or unlocked, in which that patient is physically prevented from leaving for any period of time.

(12) "Treatment plan" means a written statement of specific, reasonable and measurable goals and objectives for an individual established by the treatment team, in conjunction with the patient, with

specific criteria to evaluate progress towards achieving those objectives.

(13) "Treatment team" means a team comprised of the patient, patient's family as defined and authorized by the patient, psychiatrist, licensed practitioner, or physician so privileged by the facility, RN, social worker, and other appropriate personnel (such as activity therapist, CPST worker, interpreter, dietitian, occupational therapist, pharmacist, psychologist, counselors, and others as appropriate) based on patient needs and requests, and standard-setting agency requirements.

(D) It is the policy of the department that seclusion and restraint shall be applied in a safe and humane manner as measures of last resort. The goal of seclusion and restraint use is to assist the patient in regaining self-control and maintaining dignity while reducing the risk of injury to patients and staff. The use of seclusion and restraint shall be consistent with nationally recognized standards for quality treatment and applicable laws.

(1) RPH policies for seclusion or restraint must require that these measures shall:

(a) Only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible. time;

(b) Not employ 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;

(c) Be employed as a last resort when lesser restrictive measures aimed at assisting a patient to control his or her behavior have failed;

(d) Not be used as coercion, discipline, or punishment; for the convenience of staff; or longer than clinically necessary;

(e) Be employed using the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff or others.

(f) Not cause injury to the patient;

(g) Not be used in place of more appropriate treatment interventions;

(h) Be used in a manner that best protects and maintains the dignity and individuality of each patient, and considers:

(i) Gender;

(ii) Age;

(iii) Developmental issues;

(iv) Ethnicity;

(v) History of physical or sexual abuse, or other trauma;

(vi) Medical conditions;

(vii) Physical disabilities; and

(viii) If individual is deaf, hard-of-hearing, or has a primary spoken language is other than English.

(i) Be ordered only by physicians or a licensed practitioner;

(j) Be used in a manner to provide for the greatest possible comfort of the patient; and

(k) Be vigorously supervised and monitored using individual medical record reviews and aggregate data reviews as part of an ongoing and systematic quality improvement program.

(2) Position in restraint. RPH policies and procedures shall ensure that:

(a) The use of prone restraint is prohibited.

(b) A patient shall be placed in a position that allows airway access and does not compromise respiration, regardless of the method of restraint utilized.

(c) The use of a transitional hold shall be:

(i) Applied only in a manner that does not compromise breathing; and,

(ii) Only for the brief amount of time necessary to bring the patient under control and ensure safe patient transport.

(3) RPH restraint and seclusion policies shall incorporate the following:

(a) Restraint shall be applied with concern for good body alignment and comfort of the patient, and recognition of any medical conditions;

(b) Seclusion may be employed only in rooms which contain proper temperature control, ventilation and lighting; a visual panel of safety glass for staff to make observations; a safe and sanitary environment with no wall/ceiling fixtures and sharp edges or electrical outlets. The room must include a bed, mattress, bed sheets, and pillow unless the patient's condition warrants their removal. Removal of these items requires a physician's or licensed practitioner's written order and documentation of rationale for removal, however, a nurse may initiate their removal and then obtain the physician's or licensed practitioner's order within sixty minutes after the removal.

(4) Steel cuffs or other restraining devices used by security staff for custody, detention, and public safety reasons are not considered behavioral restraints. The use of steel cuffs to restrain a patient on a unit is prohibited.

(E) Standards

(1) RPHs may distinguish between manual or physical restraint with devices in policy consistent with regulating and accrediting authorities and this rule.

(2) Approved restraints are indicated below and are to be used in accordance with the limitations

stated in this rule.

(a) Physical restraints with devices:

(i) Padded leather cuffs, vinyl flexicuffs, waist/wrist cuffs (pads), and two- and four-point belts and cuffs;

(ii) Mittens securely fastened around the wrist with a tie;

(iii) Helmets only if the helmets are of an approved type and affixed in such a manner that removal or choking cannot be easily accomplished by patients;

(iv) Mechanical supports used for restraint rather than support purposes (e.g., soft ties, geri chairs, and tie jackets) shall be considered physical restraint devices under this rule.

(v) Items used for medical, surgical or dental procedures shall not be considered restraints under this rule.

(b) Manual restraint. May be utilized in either an emergency situation to prevent injury to the patient or others until appropriate physical restraint devices may be applied, or to control for transporting. Manual restraint is typically applied for only a brief time period (less than ten minutes).

(3) Quiet time shall not be considered restraint or seclusion.

(4) Personnel designated below shall be the only individuals permitted to implement seclusion and restraint if they have been trained and are competent to do so:

(a) Direct care and nursing personnel shall be permitted to implement seclusion and restraint;

(b) RPH security personnel shall assist in the use of these interventions only when requested to do so by direct care or nursing personnel; and,

(c) Other employees who have successfully completed training programs on the use of restraint or

seclusion shall be permitted to assist in their application.

(F) Procedures

(1) RPH policies shall

(a) Allow a patient, as part of treatment planning, the opportunity to identify techniques that would help control his or her behavior; and

(b) Consider a patient's advance directive addressing special safety and treatment if seclusion or restraint is warranted.

(2) Orders

(a) Any application of seclusion or restraint of a patient shall require an order by a physician or another licensed practitioner. This order is obtained beforehand, as much as possible, but in emergent situations, a (RN) can direct the use of seclusion or restraint (either a physical restraint with devices or a manual restraint) and obtain the order as soon as possible afterward in accordance with paragraph (F)(2)(e) of this rule. The order must specify the use of seclusion and restraint separately. Each order shall be documented to include parameters for discontinuation of the intervention (seclusion and/or restraint) and placed in the patient's medical record.

(b) With the exception of orders for the use of mittens and helmets for patient who exhibit self-injurious behavior, each order for seclusion or restraint shall be in force for no longer than one hour for an initial order, or up to four hours for a renewal. A physician, licensed practitioner, or registered nurse trained in accordance with the requirements specified by CMS shall personally examine a patient being physically restrained and/or placed in seclusion and substantiate the need for continuing the use of seclusion or physical restraint with devices prior to order.

(3) Examinations/assessments

The patient shall be given an explanation of the reason for the restraint or seclusion, and which would indicate sufficient behavioral control to discontinue the intervention. The examination shall

include the following unless clinically contraindicated and documented in the patient's record:

(a) An assessment of any physical problems or an unstable medical status that might contraindicate the use of seclusion or restraint. If there are none, the evaluator shall document in the patient's medical record that there are no known contraindications to this seclusion or restraint procedure;

(b) Vital signs including temperature, pulse, respiration, and blood pressure, or documentation if not done, and why;

(c) A review of current medications if the evaluation is conducted by a physician or licensed practitioner;

(d) Documentation to substantiate the clinical indication for seclusion or restraint use, and that the evaluator considered both the benefits and risks of these measures; and

(e) If the one hour face-to-face evaluation is conducted by a physician other than the attending physician, the attending physician or other licensed practitioner responsible for the care of the patient must be consulted as soon as possible.

(4) Rationale for the release from seclusion or restraint shall be documented by the registered nurse or licensed practical nurse in the patient's medical record.

(5) The treating physician or licensed practitioner shall be contacted as soon as possible if the restraint or seclusion was ordered by another physician or licensed practitioner.

(6) Patient care and documentation standards.

(a) All prior interventions used before seclusion or restraint shall be documented in the patient's medical record.

(b) To ensure proper safety, body comfort, and circulation of a patient placed in restraints, checks of the patient's condition shall be made by direct care personnel.

(i) Patients placed in restraints or seclusion shall be continuously monitored. Observations of the condition of the patient shall be made and documented in the patient's medical record at least every fifteen minutes or more often if the patient's condition so warrants.

(ii) Appropriate assessments of a patient in restraint or seclusion shall be conducted every fifteen minutes by trained and competent staff, and documented in the patient's medical record. The fifteen minute assessments shall include, as applicable: signs of any injury; nutrition/hydration; circulation and range of motion in the extremities; vital signs; hygiene and elimination; physical and psychological status and comfort; and readiness for discontinuation of restraint or seclusion.

(iii) When a patient is removed from physical restraint with devices, nursing staff shall continue to monitor the progress of the patient and make at least one entry, including vital signs, within two hours in the patient's medical record concerning the patient's status. More frequent monitoring may be necessary if warranted by the patient's condition.

(c) All patients placed in restraint or seclusion shall be visited by a registered nurse or licensed practical nurse no less than every hour to assess the patient. These visits shall be documented in the patient's medical record. This contact may be modified by a physician's or licensed practitioner's order if the patient's need for reduced stimulus outweighs the need for continued medical assessment.

(d) A patient placed in restraint or seclusion shall be provided the opportunity for motion and exercise for at least ten minutes during each two hour period in which these devices are employed. This shall be documented in the patient's medical record.

(e) The patient's medical record shall include documentation of fluids being offered and monitoring for fluid intake and output. Monitoring may be modified by a physician's or licensed practitioner's order if the patient's condition warrants reduced monitoring. The physician's order shall include rationale for the reduction in monitoring of fluid intake and output.

(f) The rationale for each episode of seclusion or restraint shall be clearly documented in the patient's medical record by the physician or licensed practitioner who examined the patient.

(g) The physician or licensed practitioner shall specify criteria for discontinuation of seclusion and/or

restraint.

(h) With the patient's consent, the patient's family is notified of the initiation of restraint or seclusion.

(7) Conduct debriefings after an incident. (See MHAS policy MED-19 "Proactive Positive Intervention Treatment and Safety").

(a) The goals of debriefing are to: (i) minimize the negative effects of the incident on all involved individuals; and (ii) identify alternatives strategies to prevent or minimize future occurrences.

(b) Each patient shall be given the opportunity to debrief each episode of seclusion or restraint, unless specifically contraindicated in the treatment plan for clear treatment reasons. As part of the debriefing, the patient shall be given the opportunity to identify techniques that would assist the patient to control his or her behavior. In addition, patient debriefing provides an opportunity to minimize trauma and reestablish the therapeutic staff-patient relationship. Families may also participate in the debriefings at the patient's request.

(c) Each RPH shall develop procedures to debrief staff after an episode of restraint. Conduct a staff debriefing when a physical intervention occurs to:

(i) Assess for any injury;

(ii) Plan next steps for the patient's care and protection for the remainder of the shift;

(iii) Determine how management of the situation could have been handled differently;

(iv) Provide information to patient's treatment team to assist in treatment plan revisions;

(v) The following are examples of questions that may be included in a staff debriefing:

(a) Were there alternative actions that could have been taken to prevent the incident?

(b) Could some intervention earlier have prevented the outcome?

(c) In the case of restraint, could seclusion have been an alternative?

(d) Would it be possible to achieve a better outcome if an assist team were called?

(e) Are we medicating optimally? Is the patient adherent? How do we respond to possible non-adherence?

(f) What environmental changes might minimize the risk of further dangerous behaviors (e.g., room changes, roommate changes, ambient noise, light, or congestion on the unit, access to exits, response to visitors, etc.)?

(8) Monitoring and quality improvement requirements

(a) Each unit shall be responsible for preparing a daily log indicating name of patient, patient number, living unit, time of day in, time of day out, for each episode of seclusion or restraint.

(b) The regional psychiatric hospital CCO or his/her designee and the director of nursing/nurse executive and/or his or her designee shall review, daily, all uses of seclusion or restraint.

(c) The quality improvement review of restraint and seclusion shall include, at a minimum, the following:

(i) A review of the aggregate monthly totals of the use of restraint or seclusion by type, ward, time of day, and other data required in paragraph (F) of this rule;

(ii) The review of any major incidents that resulted in the use of seclusion or restraint;

(iii) Within one business day, the treatment team shall conduct a review of any patient who required any seclusion or restraint. During this review the current treatment plan shall be assessed and revised as needed to contain specific elements that are aimed at reducing the use of seclusion or restraint. All prior interventions shall be reviewed. If successive treatment plan revisions are not successful in reducing the use of seclusion or physical restraint with devices in a clinically

reasonable amount of time, consultation from outside the treatment team must be obtained. The department or regional psychiatric hospital behavior therapy committee, the CCO, other treatment teams, private consultants etc. may be sources utilized to conduct a consultation; and

(iv) The findings from the activities under paragraph (F) of this rule shall be reviewed monthly. This review shall identify any trends, increases, and problems. The need for additional training, consultations, or corrective action will be noted in the minutes of that review and forwarded to the CCO for possible action.

(v) The data collected in paragraph (F) of this rule and other related quality improvement review information shall be available to central office.

(d) Each patient, unless specifically contraindicated in the treatment plan for clear treatment reasons, shall be given the opportunity to debrief each episode of seclusion or restraint. As part of the debriefing, the patient shall be given the opportunity to identify techniques that would assist the patient to control his or her behavior. This shall be documented in the patient's medical record.

(e) Each regional psychiatric hospital shall develop procedures to debrief staff after an episode of restraint.

(G) Orientation and training

(1) Each chief executive officer shall be responsible for ensuring that orientation and training programs regarding the use of seclusion and restraint are provided. These programs shall be provided and conducted by appropriate personnel.

(2) Training shall emphasize the use of non-physical crisis intervention, behavioral and other treatment strategies to prevent exacerbation of aggression, and other techniques that will reduce the use of restraints. Special attention shall be placed on the humane use of any restraint technique.

(a) All personnel shall have appropriate training during employee orientation.

(b) All new and existing direct care personnel and regional psychiatric hospital security personnel

shall receive training in behavioral and other techniques to reduce the use of seclusion or restraint, and the proper use of physical restraint, manual restraint, and seclusion. This training will be conducted at least annually or more often if indicated by quality improvement reviews.

(c) Upon successful completion of each orientation or training program, a record of this training shall be documented and maintained in each employee's personnel folder.

(H) Implementation

The chief executive officer of each RPH shall be responsible for implementation of this rule.