Ohio Administrative Code

Rule 5122-26-16 Seclusion, restraint and time-out.

Effective: October 20, 2023

(A) This rule is applicable to all certified providers and licensed class one residential providers. The purpose of this rule is to state the general standards applicable to the use of seclusion, mechanical restraint, or physical restraint.

The provisions of this rule and rule 5122-26-16.1 of the Administrative Code are not applicable to forensic restrictions imposed by correction and law enforcement authorities for security (non-clinical care) purposes. The use of restraint or seclusion by correction, law enforcement or other staff for the purposes of clinical care is subject to the provisions of this rule.

A provider which prohibits the use of seclusion and restraint will develop a policy stating such.

(B) The provision of a physically and psychologically safe environment is a basic foundation and requirement for effective mental health and addiction services treatment. Adopting trauma informed treatment practices, creating calm surroundings and establishing positive, trusting relationships are essential to facilitating a person's treatment and recovery.

The goal of reducing and minimizing the use of seclusion and restraint is one that will be shared and articulated by the provider's leadership. The elevation of oversight by leadership of each use of seclusion or restraint in order to investigate causality, ascertain relevancy of current policies and procedures, and identify any associated workforce development issues, is core to the successful achievement of this goal.

Seclusion and restraint are intrusive techniques to be used by trained, qualified staff as a last resort in order to control dangerous and potentially harmful behaviors and to preserve safety. Best practices include careful early assessment of a person's history, experiences, preferences, and the effectiveness or ineffectiveness of past exposure to these methods. Best practices will be based on understanding and consideration of the individual's history of traumatic experiences as a means to gain insight into origins and patterns of the individual's actions.

Use of seclusion or restraint will be subject to performance improvement processes in order to identify ways in which the use of these methods can be decreased or avoided and more positive, relevant and less potentially dangerous techniques used in their place.

When individuals experience repeated or sustained use of these methods, leadership should evaluate all causative factors and consider alternative treatment interventions and possible transfer to or placement in a more structured treatment setting with the capacity to meet individual needs with reduced exposure to these intrusive interventions.

(C) The following definitions apply to rules 5122-26-16 to 5122-26-16.1 of the Administrative Code and are in addition to those contained in rule 5122-24-01 of the Administrative Code:

(1) "Advance directives" means a legal document used by an adult to direct in advance the mental or physical health treatment in the event the adult lacks the capacity to make such decisions. Two types of advance directives related to mental health treatment are: a "Declaration for Mental Health Treatment" subject to the requirements of Chapter 2135. of the Revised Code, and a "Durable Power of Attorney for Health Care" subject to the requirements of sections 1337.11 to 1337.17 of the Revised Code.

(2) "Behavior management" means the utilization of interventions that are applied in a systematic and contingent manner in the context of individual or group programs to change or manage behavior or facilitate improved self-control. The goal of behavior management is not to curtail or circumvent an individual's rights or human dignity, but rather to support the individual's recovery and increase the individual's ability to exercise those rights.

(3) "Comfort rooms," (formerly known as quiet or time-out rooms), are adapted sensory rooms that provide sanctuary from stress or can be places for persons to experience feelings within acceptable boundaries.

(4) "Individual crisis plan" means a written plan that allows the person to identify coping techniques and share with staff what is helpful in assisting to regain control of the person's behavior in the early stages of a crisis situation. It may also be referred to as a "behavior support plan."

(5) "Mechanical restraint" means any method of restricting a person's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

(6) "Physical restraint", also known as "manual restraint," means any method of physically restricting a person's freedom of movement, physical activity, or normal use of the person's body without the use of mechanical restraint devices. Transitional holds are not physical restraint.

(7) "PRN (pro re nata)" means as the situation demands.

(8) "Prone Restraint" means all items or measures used to limit or control the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a face-down position. Prone restraint may include either physical (also known as manual) or mechanical restraint.

(9) "Qualified person" means an employee or volunteer who carries out the agency's tasks under the agency's administration and/or supervision, and who is qualified to utilize or participate in the utilization of seclusion or restraint by virtue of the following: education, training, experience, competence, registration, certification, or applicable licensure, law, or regulation.

(10) "Seclusion" means the involuntary confinement of a person alone in a room where the person is physically prevented from leaving.

(11) "Sensory rooms" means appealing physical spaces painted with soft colors with the availability of furnishings and objects that promote relaxation and/or stimulation.

(12) "Time-out" means an intervention in which staff compel a person to remove themself from regular programming to a specified place for a specified period of time. Time-outs are allowed in areas away from activity, which may include time out rooms, other identified space in the facility, or the clients bedroom. Time-out is not seclusion or restraint.

(13) "Transitional hold" means a brief hold, without undue force, of a person in order to calm or comfort them; or holding a person's hand to safely escort them from one area to another. At no time

may a transitional hold be a prone, mechanical, or physical restraint as defined in this rule. Transitional holds are not seclusion or restraint.

(D) Policies and procedures

(1) The provider will establish policies and procedures that reflect the provisions of this rule and rule 5122-26-16.1 of the Administrative Code. The provider will document if and how the inclusion of clients and families in the development of such policies occurred.

(2) Policies and procedures governing the use of seclusion or restraint will include attention to preservation of the person's health, safety, rights, dignity, and well-being during use. Additionally:

(a) Respect for the person will be maintained when such methods are utilized;

(b) Use of the environment, including the possible addition of comfort, soothing and sensory rooms, will be designed to assist in the person's development of emotional self-management skills; and,

(c) The number of appropriately trained staff available to apply or initiate seclusion or restraint will be adequate to ensure safety. The use of non-agency employed law enforcement personnel, e.g., local law enforcement, to substitute for the lack of sufficient numbers of appropriately trained staff in such situations is prohibited.

(3) Policies and procedures will include the mailing address and toll-free phone number of disability rights Ohio.

(E) General requirements

(1) Seclusion or restraint will not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is identified.

(a) Seclusion and restraint will not be used as behavior management interventions, to compensate for the lack of sufficient staff, as a substitute for treatment, or as an act of punishment or retaliation.

(b) Absent a co-existing crisis situation that includes the imminent risk of physical harm to the individual or others, the destruction of property by an individual, in and of itself is not adequate grounds for the utilization of seclusion or restraint.

(2) The following will not be used under any circumstances:

(a) Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises;

(b) Any technique that restricts the individual's ability to communicate, including consideration given to the communication needs of individuals who are deaf or hard of hearing;

(c) Any technique that obstructs vision;

(d) Any technique that causes an individual to be retraumatized based on an individuals history of traumatic experiences;

(e) Any technique that obstructs the airways or impairs breathing;

(f) Use of mechanical restraint on individuals under age eighteen;

(g) A medication that is used as a restraint to control behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's medical or psychiatric condition or that reduces the individual's ability to effectively or appropriately interact with the world around the individual;

(h) The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers, other than the use of handcuffs or other devices used by corrections and law enforcement personnel for security purposes;

The presence of weaponry in an agency poses potential hazards, both physical and psychological, to clients, staff and visitors. Utilization by the agency of non-agency employed armed law enforcement personnel (e.g., local police) to respond to and control psychiatric crisis situations, will be minimized to the extent possible; and

(i) Prone restraint.

(3) Seclusion and restraint will be utilized in a manner that is safe, proportionate, and appropriate to the severity of the behavior.

(4) The choice of the least restrictive, safe and effective use of seclusion or restraint for an individual is determined by the person's assessed needs, including a consideration of any relevant history of trauma or abuse, risk factors as identified in paragraph (H)(3) of this rule, the effective or ineffective methods previously used with the person and, when possible, upon the person's preference.

(5) Each person will be informed of the agency's philosophy on the use of seclusion or restraint as well as of the presence of any agency policies and procedures addressing their use by the agency. This disclosure will occur upon admission or intake unless it is not clinically warranted; however the person will be provided the disclosure as soon as clinically warranted. The person's parent, custodian, or guardian will be provided these disclosures at admission or intake. This explanation will be in a language that the client and their parent, custodian or guardian understand, including American sign language if appropriate. A copy of the policies and procedures will be provided in writing to the person and to their parent, custodian or guardian when applicable . The agency will maintain written acknowledgment from the client or from their parent, custodian or guardian that they have been informed of the agencys policies and procedures on seclusion or restraint.

(a) Adult clients will be offered the opportunity to give consent for the notification of their use to a family member or significant other.

(b) For minor clients, the agency will obtain contact information in order to notify the parent, custodian or guardian. The agency may allow the parent, custodian or guardian to specify certain hours during which they do not want to be notified.

(6) The inclusion of clients (including children), families, and external advocates in various roles and at all provider levels to assist in reducing the use of seclusion or restraint will be considered.

(F) Staff training. The provisions of this paragraph are applicable to all staff whose normal duties are to interact with those persons served by the provider and any other staff involved in the use of seclusion and restraint.

Staff will be trained and demonstrate competency before participating in any seclusion or restraint intervention.

(1) The agency will mandate staff to have ongoing education and training. Staff training will include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency situations. Staff will have training in and demonstrated knowledge of:

(a) Techniques to identify staff and individual behaviors, events, and environmental factors that may trigger seclusion or restraint.

(b) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, as alternatives to the use of seclusion and restraint.

(c) The safe use of restraint and seclusion

(d) The ability to recognize and respond to signs of physical distress in individuals who are restrained or in seclusion, including attention to vitals, and certification in cardiopulmonary resuscitation and first aid. After initial certification, staff will be recertified either according to the time frame of a national first aid certifying body, e,g, the American red cross, or annually.

(e) Recognize signs of distress in youth to help reduce the use of seclusion and restraint through the use of trauma assessments, detection of early warning signs, and the development of calming/soothing plans and other strategies to help youth self-regulate. The calming/soothing plans will be documented in the individualized treatment plan.

(2) Individuals providing staff training will:

(a) Be qualified to do so by education, training, and experience.

(b) Document that staff received training and demonstrated competency. This will occur before staff participate in any seclusion or restraint intervention, and on an on-going basis:

(i) Staff will be certified and recertified in cardiopulmonary resuscitation. Staff certified by programs approved by the American red cross or the American heart association will be recertified in accordance with time frames established by the certifying entity.

(ii) Staff will be certified and recertified in first aid. Staff certified by programs approved by the American red cross or the American heart association will be recertified in accordance with time frames established by these entities. Staff certification under other programs will be recertified at least once every twelve months unless a longer time frame is approved by the department.

(iii) Non psychiatric residential treatment facility (PRTF) staff will demonstrate all other competencies as in paragraph (F)(1) of this rule at least once every twelve months. PRTF staff will demonstrate competencies as in paragraph (F)(1) of this rule at least once every six months.

(3) The agency will document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation will include the date training was completed and the name of persons certifying the completion of training.

(4) All training programs and materials used by the agency will be available for review by the department.

(G) Documentation.

(1) The presence of advance directives or client preferences addressing the use of seclusion or restraint will be determined and considered, and documented in the ICR. If the provider will be unable to utilize seclusion or restraint in a manner in accordance with the person's directives or

preferences, the provider will notify the individual, including the rationale, and document such in the ICR.

(2) In conjunction with the person's active participation, an individual crisis plan will be developed at the time of admission and incorporated in the person's ITP for each child or adolescent resident of a department licensed residential facility or psychiatric residential treatment facility, for each client known to have experienced seclusion or restraint, for an individual who is at risk of harming themselves, and when otherwise clinically indicated.

The plan will be based on the initial behavioral health assessment, and will include and be implemented, as feasible, in the following order:

(a) Identification of the methods or tools to be used by the client to de-escalate and manage his or her own aggressive behavior;

(b) Identification of techniques and strategies for staff in assisting the person to maintain control of his or her own behavior; and

(c) Identification, in order of least restrictive to most restrictive, of the methods or tools to be used by staff to de-escalate and manage the client's aggressive behavior.

(3) The provider will conduct an initial or comprehensive assessment for each child or adolescent resident of a department licensed residential facility, for each client known to have experienced seclusion or restraint, for an individual who is at risk of harming him/herself, and when otherwise clinically indicated for the following which may place the person at greater risk of physical or psychological injury as a result of the use of seclusion or restraint:

(a) Gender;

(b) Chronological and developmental age;

(c) physical body size;

(d) Culture, race, ethnicity, and primary language;

(e) History of physical or sexual abuse, or psychological trauma;

(f) Medical and other conditions that might compromise physical well-being, e.g., asthma, epilepsy, obesity, lung and heart conditions, an existing broken bone, pregnancy, and drug or alcohol use;

(g) Physical disabilities; and

(h) Psychiatric condition.

(H) Logs and notifications.

(1) A log will be maintained for department review of each incident of mechanical restraint, seclusion, and physical restraint, and for time-outs exceeding sixty minutes per episode. The log will include, at minimum, the following information:

(a) The person's name;

(b) The date, time and type of method or methods utilized, i.e., seclusion, mechanical restraint, physical restraint , or time-out. The log of mechanical restraint will also include the type of mechanical restraint device used;

(c) The duration of the method or methods; and

(d) The outcome of the intervention.

(2) Pursuant to rules 5122-26-13 and 5122-30-16 of the Administrative Code, the provider will notify the department of each:

(a) Instance of physical injury to a client or resident that is restraint-related, e.g., injuries incurred when being placed in seclusion or restraint or while in seclusion or restraint, with the exception of injury that is self-inflicted, i.e. a client or resident banging their own head;

(b) Death that occurs while a person is restrained or in seclusion;

(c) Death occurring within twenty four hours after the person has been removed from restraints or seclusion, and

(d) Death where it is reasonable to assume that a person's death may be related to or is a result of such seclusion or restraint.

(I) Episode review and performance improvement.

(1) Each incident of seclusion or restraint will be clinically and administratively reviewed. Such review will be documented.

(2) The provider will collect the following data on all instances of the use of seclusion or restraint and integrate the data into performance improvement activities.

(a) Staff involved, including staff member who initiated the seclusion or restraint;

(b) Duration of the method;

(c) Date, time and shift each method was initiated;

(d) Day of week;

(e) Type of method, including type of physical hold or mechanical restraints utilized;

(f) Client age, race, gender and ethnicity;

(g) Client and staff injuries;

(h) Number of episodes per client; and

(i) Use of psychotropic medications during an intervention of seclusion or restraint.

(3) Data will be aggregated and reviewed at least semi-annually by providers and at least quarterly by department licensed residential facilities or certified addiction treatment residential/withdrawal management providers. The results of the review will be maintained in writing. Data will be reviewed:

(a) For analysis of trends and patterns of use; and

(b) To identify opportunities to reduce the use of seclusion or restraint episodes per client.

(4) The results of data reviews and performance improvement activities will be shared with staff at least semi-annually with the goal of reducing the use of seclusion or restraint.

(J) Plan to eliminate seclusion or restraint.

(1) A provider which utilizes seclusion or restraint will develop a plan designed to reduce its use. The plan will include attention to the following strategies:

(a) Identification of the role of leadership;

(b) Use of data to inform practice;

(c) Workforce development;

(d) Identification and implementation of prevention strategies;

(e) Identification of the role of clients (including children), families, and external advocates; and

(f) Utilization of the post seclusion or restraint debriefing process.

(2) A written status report will be prepared annually, and reviewed by leadership.

(K) Staff actions commonly known as therapeutic, supportive or directional touch, utilized to direct an individual to another area without the use of force and which do not restrict an individual's freedom of movement, are not considered restraint and are not subject to the provisions of this rule.

(L) Each provider utilizing seclusion or restraint is responsible for identifying and adopting systems of seclusion and restraint techniques; and will assure that chosen systems meet all standards set forth in rules 5122-26-16 and 5122-26-16.1 of the Administrative Code and that staff that perform seclusion or restraint are trained in the proper use of those systems.