

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)  
POLICY AND PROCEDURE

SUBJECT: RESTRAINT AND SECLUSION OF CONSUMERS

NUMBER: NN-RI-04

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APPROVAL: Cody L. Phinney, Agency Director

I. PURPOSE

To describe NNAMHS approach to the application of restraint and seclusion for consumers in a way that protects the consumer's health and safety, and preserves their dignity, rights and well-being.

II. POLICY

NNAMHS will ensure that all consumers are treated and managed in the least restrictive manner consistent with their clinical status and needs, and that seclusion and/or restraint will be used only in an emergency situation to insure safety of the consumer and others and when less restrictive interventions have been determined to be ineffective to protect the consumer or others from harm. The decision to use restraint is driven not by diagnosis, but by comprehensive individual assessment that concludes that for this consumer, at this time, the use of less intrusive measures poses a greater risk of using a restraint or seclusion.

The consumer has the right to be free from seclusion and/or restraints of any form that are imposed as a means of coercion, discipline, convenience, or retaliation by staff. Seclusion and/or restraint are never to be imposed for a particular period of time. Seclusion and/or restraint will be terminated when the behaviors that

necessitated the seclusion and/or restraint order are no longer occurring and documented behavioral release criteria are attained.

### III. REFERENCES

1. NNAMHS Policy NN-RI-08 Reporting the Denial of Consumers Rights.
2. NNAMHS Policy PC-SF-01 CPART – Crisis Prevention and Response Training.
3. MR131 Seclusion and Restraint Documentation Record.
4. MR 281 One Hour Face To Face Evaluation (MD or QRN).
5. Nevada Revised Statutes (NRS) 433.209 Person Professionally Qualified in the Field of Psychiatric Mental Health Defined.
6. NRS 433.545 through 433.551 Use of Restraints and Interventions.
7. Division of Public and Behavioral Health Policy 2.005 Restraint/Seclusion for Mental Health Inpatient Facilities.

### III. DEFINITIONS

1. Restraint: Includes either a physical restraint or a medication that is being used as a restraint.
2. Physical restraint: Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the consumer's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. Restraint is differentiated from mechanisms usually and customarily employed during medical or diagnostic procedures that are considered a regular and usual part of such procedures, (i.e., restraints to prevent a non-ambulatory or confused consumer from falling out of bed or out of a chair).
  - a. This policy may include the use of devices such as bed rails, tabletop chairs, mitts, wrist restraints, ankle restraints, 4-point, 5-point, or helmets when used as protective devices; any physician ordered item devised by personnel to prevent perpetual self-mutilators from inflicting injury to themselves, which inhibits the bending of the elbow, wrist, or fingers; or the use of orthopedic appliances, braces, and other appliances or devices used for postural support

of the consumer or to assist the consumer in obtaining and maintaining normal bodily functions if they are used for the purpose of restraining a consumer.

Physical restraint may be used on a consumer to conduct medical examinations or treatments on consumers that are necessary. In such cases, a Denial of Rights for Written Consent to Medical Treatment will be initiated.

3. Chemical restraint: Medication that is not a standard treatment for the consumer's medical or psychiatric condition and is used as a restraint to control behavior or to restrict the consumer's freedom of movement. The chemicals that comprise the resident's regular medication regimen are not considered chemical restraints, even if their purpose is to control ongoing behavior. When medications are used to solely manage a consumer's behavior in the absence of acute psychiatric symptoms it is considered a chemical restraint (i.e., when a typical antipsychotic medication is used for its sedative properties to manage acute violence that is not secondary to psychosis). When a consumer is given medication without previously signing written medication consent, a Denial of Rights for Written Consent to Medical Treatment will be initiated.
4. Seclusion: The involuntary confinement of a consumer in a locked room or a specific area from which the consumer is physically prevented from leaving. Seclusion does not include confinement on a locked unit or ward, where the consumer is with others. Seclusion is not just confining an individual to an area, but separating him or her from others. When a consumer is asked to remain in their room or the inpatient Comfort Room for de-escalation for safety reasons and complies voluntarily it is not considered seclusion.
5. Emergency: A serious, probable, or imminent threat of bodily harm to self or others where there is the real potential to effect such bodily harm. It may be an unanticipated situation where the consumer's behavior is violent or aggressive.
6. Imminent: Likely to occur any moment.

- 7 Time Out: Allowing the consumer to voluntarily be alone in an unlocked room for up to 30 minutes. The purpose of this quiet time is to promote calm so the consumer may return to the therapeutic milieu. Time out is not seclusion.
8. Qualified Registered Nurse (QRN): A registered Nurse who has received training and demonstrated competency to provide the 1 hour face-to-face assessment of patients in seclusion or restraint. Training for an RN to conduct the 1 hour face-to-face assessment includes:
  - a. All the training for all direct care staff described herein.
  - b. Additional content for evaluating the consumer's immediate situation, reaction to the intervention, medical and behavioral condition, and the need to continue or terminate the restraint or seclusion. Training content for the medical condition evaluation includes, but is not limited to, review of systems, history, medications, most recent labs, or other factors that may be contributing to the consumer's violent behavior.

## V. PROCEDURE

### SECLUSION AND RESTRAINT

#### 1. PRINCIPLES GOVERNING THE USE OF SECLUSION AND/OR RESTRAINT:

This section of the policy and procedure includes the principles for initiating and/or providing care for consumers in seclusion and/or restraint.

- a. All staff that have direct consumer contact must have ongoing education and training in the proper and safe use of seclusion and restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion.
  - i) Direct care personnel permitted to employ manual restraint, physical restraint, seclusion, and mechanical support are those who have successfully completed the Mental Health Developmental Services' training program and are certified to do so. Other uncertified personnel

who may be present should immediately help redirect other consumers and remove themselves from the confrontation scene.

- ii) Staff training shall focus on identifying the earliest precipitant of aggression for consumers with a known or suspected history of aggressiveness, and on developing treatment strategies to prevent exacerbation or escalation of these behaviors.
- iii) Training will also emphasize how staff behavior can affect consumer behavior. Consumer involvement in the identification of precipitants is paramount.
- iv) Training shall emphasize the primary importance of consumer safety, at all times, during the seclusion and restraint process. This shall include the time preceding the placement of a consumer into seclusion or restraint as well as the time spent in the seclusion area.
- v) Training shall be provided to all inpatient nursing staff during employment orientation, on an annual basis, and when performance improvement activities identify staff education needs.
- vi) All staff training regarding the use of seclusion and/or restraint as an adjunct to treatment shall embody the philosophy that seclusion and/or restraint results only after all less restrictive interventions have been appropriately considered, implemented and the consumer continues to present a clear and present danger to self and/or others, and will emphasize the use of de-escalation, mediation, self-protection, and other less restrictive techniques such as time-out.
- vii) Staff training shall also include the nature and identification of the possible negative psychological effect seclusion may have upon some individuals and offer positive therapeutic strategies to combat such effects. Training shall also emphasize the importance of the debriefing process, which shall take place after the consumer is no longer in seclusion or restraint and may include the consumer's family and staff involved in the episode.

- viii) NNAMHS assures that each direct-care employee is apprised of this policy within ten (10) days of hire. All direct-care employees must receive annual training and certification on the use of restraint/seclusion. All training needs to be documented in the employee personnel file.
- b. Staff responsible for implementing this policy includes all clinical, administrative and treatment staff.
- c. The use of seclusion and/or restraint shall require clinical justification and shall be used only to prevent a consumer from injuring self or others.
- d. Only authorized restraint materials shall be used by competent clinical personnel.
- e. Seclusion and/or restraint shall be used in such a manner as not to cause any undue physical discomfort, harm, or pain, and shall not be employed as punishment or for the convenience of staff.
- f. Seclusion and/or restraint shall be utilized only in cases of emergency and imminent danger when other less restrictive methods have failed. Alternatives must be tried prior to the use of seclusion and/or restraint.
- g. Clinical staff shall make all efforts to preserve the privacy, safety, human dignity, and the physical and emotional comfort of the consumer at all times.
- h. The duration of the seclusion and/or restraint episode shall be the shortest time possible to reasonably assure the safety and protection of the consumer and the safety of others.
- i. At the onset of seclusion and/or restraint and throughout the course of the procedure, the consumer shall be given a clear explanation of the reason(s) for using seclusion and/or restraint, the monitoring procedure, the desired outcome, and the criteria the consumer must meet in order for the episode to be terminated.
- j. At the onset of seclusion and/or restraint the consumers Kardex and medical record are reviewed to ID history of trauma, medical conditions, and positive interventions that may decrease the negative impact and/or duration of the

event. The information is transferred to the MR 131 Seclusion and Restraint Documentation record to alert monitoring/intervening staff.

- k. When voluntary consumers are placed in seclusion and/or restraint, an application for involuntary commitment will be initiated as per NRS 433.
  - l. A room designated for use as seclusion and/or restraint shall be designed and maintained so as to preserve the safety, privacy, human dignity, and the physical and emotional comfort of the consumer.
  - m. The initial assessment of each consumer at the time of admission shall include an attempt to obtain information that may help minimize the use of restraint or seclusion and any historical information, such as triggers to violence, preferred interventions to decrease anger/anxiety and prior traumatic events that may prevent the use of seclusion or restraint or indicate other nonrestrictive strategies that can decrease the potential of psychological trauma.
  - n. When seclusion or restraint is initiated, family members or others involved in the consumer's care will be notified when the consumer has consented to such notification.
2. SAFETY PROCEDURES: This section of the policy and procedure includes safety procedures for initiating and/or providing care for consumers in seclusion and/or restraint.
- a. All potentially dangerous items shall be removed from the consumer and the room prior to placement in seclusion and/or restraint.
  - b. Sufficient staff shall be present to accomplish placement in seclusion and/or restraint in the safest manner possible.
  - c. No physical or mechanical restraint or body positioning of a consumer shall place excessive pressure on the chest or back of the consumer or inhibit or impede the consumer's ability to breathe.
  - d. Consumers are to be restrained in a manner to minimize potential medical complications. Staff must be aware of the possibility of consumer injury in the application and/or utilization of restraints. This includes, but is not limited to,

the danger of aspiration of vomitus, impaired circulation and/or respiration, and damage to nerves and skin breakdown.

- e. Staff must consider the potential negative impact of seclusion/restraints likely to occur in those consumers with a history of trauma such as physical or sexual abuse and be particularly sensitive to the needs of these consumers. Nursing will maintain the following information on each consumer admitted to the inpatient unit: consumer name, age, diagnosis, medical problems, and history of trauma or abuse. This information card will be provided to and utilized by direct care staff involved in episodes of secluding or restraining any individuals to assure that staff is aware of relevant medical and psychiatric history. This information is maintained on the MR 131.
- f. While the consumer is in seclusion he/she will be on constant, uninterrupted in-person observation for the first hour. After the first hour, in-person observation can be replaced by uninterrupted observation using audio and visual equipment in close proximity to the consumer. The use of video and audio equipment does not eliminate the need for assessment of the consumer's needs and status.
- g. Consumers in seclusion and restraint simultaneously will be on constant one-to-one (1:1), uninterrupted observation, which includes face-to-face evaluation.
- h. The condition of the restrained consumer must be continually assessed, monitored, and re-evaluated. The assigned registered nurse will assess the consumer's physical, behavioral, and emotional status at no less than every 15 minutes. Increased frequency of monitoring will be determined on an individual basis, reflecting consideration of the individual's medical needs and health status. The rationale for this decision as to the needed frequency of assessment/monitoring must be documented in the medical record.
- i) The consumer in seclusion and/or restraint will have his/her vital signs taken as early to the onset of the event as possible and repeated at a minimum of every two (2) hours, this is documented on the patients vital signs log and on the MR 131. Any concerns including the consumer's

medical and/or emotional status will be referred to the physician by the registered nurse (RN).

- ii) At a minimum of every fifteen (15) minutes, the staff will document their ongoing assessment of the consumer's hydration needs, level of distress and agitation, mental status, cognitive functioning, skin integrity, position, circulation, respiration, and safety. Any observed changes or problems will be referred to the physician by the RN.
  - iii) Any changes in gait or coordination shall be documented and referred to the physician by the RN.
- i. Staff will offer the consumer's fluids, toileting and comfort measures every fifteen (15) minutes. Meals and snacks will be offered at regular times. Staff will assist with the consumer's washing of hands after toileting and before meals. Bathing will be provided at least once daily. Any exception to the above procedures must be clinically justified and noted in the medical record.
  - j. Range of motion and movement of limbs will be provided for at least ten (10) minutes and at least every two (2) hours. Relief from mechanical restraint will occur as long as it is deemed to be safe. If consumer has not regained sufficient control of his/herself to be considered safe, this must be documented in the progress note. During relief periods, the staff shall insure proper positioning of the consumer and provide movement of limbs as necessary.
  - k. No matter how long the prescribed treatment order allows, the seclusion and/or restraint will be terminated when the behaviors that necessitated the seclusion and/or restraint order are no longer in evidence and the behavioral release criteria are attained. If the consumer is falling asleep or falls asleep, an immediate assessment of the consumer and the release criteria will be made. Consumers who are sleeping in seclusion and/or restraint must be evaluated and removed from seclusion and/or restraint if they meet release criteria.
  - l. In the event of any emergency requiring unit evacuation, the consumer shall be removed from seclusion and/or restraint, and staff will stay with the consumer on a 1:1 basis.

- m. Precautions shall be taken to assure the protection of the consumer in restraints from being mistreated or harmed by other persons.

### 3. NURSING FUNCTIONS:

This section of the policy and procedure includes the nursing staff procedures for initiating and/or providing care for consumers in seclusion and/or restraint.

- a. An RN must be notified immediately if a consumer exhibits threatening or harmful behavior. The emergency use of seclusion and/or restraints requires an RN assessment to determine whether an emergency situation exists.
  - i) The RN assessment will include whether alternatives to the use of seclusion and/or restraint were adequately attempted or considered including, but not limited to:
    - 1) Consumer's verbalization of feelings
    - 2) Verbal reassurance/redirection given to consumer
    - 3) 1:1 interaction for the consumer with staff
    - 4) Reduction in stimuli
    - 5) Environmental changes for the consumer
    - 6) Limit setting
    - 7) Time out offered to the consumer
    - 8) Medication offered to the consumer
- b. Upon determination by an RN that seclusion or restraint is necessary, a physician order is obtained. The RN notifies the physician of the consumer's behavior, and his/her assessment of same.
- c. Order to seclude and/or restrain:
  - i) Orders should be written on the Seclusion and Restraint Order Form no more than fifteen (15) minutes after employment of these measures. Verbal orders to a staff RN are acceptable. The RN shall record the details on the Seclusion and Restraint Order Form and place the form in sequence in the order section of the consumer's medical record.

- ii) No application of restraint or seclusion shall occur without a physician's order, including the clinical assessment and justification for seclusion and/or restraint.
- iii) The order will include the method of seclusion and/or restraint to be utilized and the clinical reason for seclusion and/or restraint (e.g. danger to self or others). The order must include the behavioral criteria the consumer must meet to be removed from seclusion and/or restraint.
- iv) Neither restraint nor seclusion orders shall be written PRN orders.
- v) The physician must perform a face-to-face evaluation within one (1) hour of the initiation of the episode/intervention regardless of the duration of the seclusion and/or restraint.
- vi) Restraint/seclusion orders are time limited and are valid for no longer than eight (8) consecutive hours.
  - 1) The original order is only good for a maximum of four (4) hours and the continuation order (which must be included in the original order) is only good for four (4) hours; this is a total of eight (8) hours maximum for one order.
  - 2) If, in the original order, the physician stated that the order could be extended once, not to exceed four (4) additional hours, the RN MUST document a FACE-TO-FACE reassessment of the consumer's current behavior that warrants the extension of the restraint/seclusion.
  - 3) The RN must contact the physician and review this reassessment prior to the extension of the original order.
  - 4) If restraints or seclusion are discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating seclusion or reapplying the restraints and the requirements restart.
- vii) Chemical restraint: When medications are given solely to manage aggressive and dangerous behavior that is not secondary or related to acute psychiatric symptoms.

All chemical restraint events require completion of the MR 191, MR 131, MR 211, and staff debriefing form. The MD face-to-face assessment within 1 hour is required. All the instances listed below constitute a chemical restraint.

1) A one time "Now" order for the medication is obtained from the attending physician or on call designee. The order will include parameters for monitoring the consumer post administration of the medication if not placed in a restrictive intervention

2) The consumer is given the option to accept the medication voluntarily via the medication consent process MR 126.

OR

The consumer declines consent but is then given the medication. A denial of rights to refuse medications is completed

OR

A restrictive procedure is required to administer the medication.

- viii) The Nursing Supervisor must be notified within one (1) hour of all applications and removals of restraints and/or seclusions.
- d. The RN must document the clinical rationale for the use of seclusion and/or restraint. This documentation shall include, but not be limited to:
- i) An appraisal of the consumer's behavior and clinical justification necessitating the use of seclusion and/or restraint. The justification shall clearly specify the nature of the dangerous behavior. The use of seclusion and/or restraint may not be based on past history, criminal behavior, convictions, or commitment status.
  - ii) The treatment techniques tried attempting to quiet or control the consumer's behavior prior to using seclusion and/or restraint (e.g., administration of medication, counseling, quiet time).
  - iii) The reason for the use of seclusion and/or restraint and the criteria for termination of seclusion and/or restraint will be explained to the

- consumer, including their behavior that will determine their readiness for release from seclusion and/or restraint.
- iv) A description of interventions implemented to assist the consumer in meeting the release criteria.
  - v) A summary of the consumer's current physical assessment, including vital signs.
- e. The consumer must be assessed, monitored, and re-evaluated as to the need for seclusion and/or restraint. This review and assessment will be documented within one hour following the initiation of seclusion and/or restraint and every two hours, anytime there is a change in the consumer's physical status and at shift change by the RN coming on duty. The review will address the following:
- i) Mental Status and behaviors consumer is exhibiting at the moment justifying continuation of seclusion and/or restraint.
  - ii) Why less restrictive alternatives are not appropriate.
  - iii) The consumer's physical condition including vital signs and circulation.
  - iv) If there is evidence of any potential injury, restraints must be readjusted, repositioned, padded, or removed if necessary. If there is evidence of actual injury, the appropriate physician must be notified, proper treatment initiated including readjustment, repositioning, padding, or removal of restraints and/or any other medical treatment that may be necessary. Complete documentation in the medical record is required.
  - v) Review the criteria necessary for release from seclusion and/or restraint with the consumer and provide any additional counseling and/or education needed.
- f. The action recorded on the seclusion and restraint order form will be considered an emergency plan of care with the release criteria established as the immediate goals for the consumer to accomplish. Other actions as documented by the physician and nursing staff are considered interventions to assist the consumer in accomplishing the emergency behavioral plan. Modification of the original plan of care is not necessary.

- g. If a consumer remains in seclusion or restraint when a nursing shift ends, the RN coming on duty will make a new assessment of the consumer's condition. The RN going off duty and the RN coming on duty must assess the consumer together. This should be documented in a progress note.
- h. All progress notes and observation report entries on each consumer shall be correlated and sequential in the medical record.
- i. When the consumer is released from seclusion or restraint a mental health professional shall meet with the consumer for the purpose of:
  - i) Assisting the consumer to develop an understanding of the precipitants, which may have evoked the behaviors necessitating the use of seclusion and/or restraint and discussing the consumer's perception and observation of the episode and to provide feedback to the staff.
  - ii) Assisting the consumer to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations/emotions/thoughts present themselves again.
  - iii) Developing and documenting a specific plan of interventions for inclusion in the Comprehensive Individualized Treatment Plan, with the intent to avert future need for seclusion or restraint.
  - iv) The mental health professional shall document the consumer interview process in the consumer's medical record.
- j. In the event that the consumer has consented to have the family informed regarding his or her care and the family has agreed to be notified staff attempts to contact the family promptly to inform them of the restraint or seclusion episode.

4. PHYSICIAN FUNCTIONS: This section includes the function of the physician:
  - a. The physician is contacted for the order for seclusion and/or restraint, this contact includes information from the nurse assessment as listed in nursing functions.
  - b. The physician will be contacted for continuation of orders. This contact will include assessment of the patient's current physical condition, mental status and behavior.
  - c. If the 1 hour face-to-face assessment was performed by a QRN, the physician will be contacted to discuss the findings of the face-to-face assessment as soon as possible, in no case longer than 24-hours.
  - d. If the face-to-face assessment process, performed by the QRN, results in any concern about the consumer's safety or medical condition the physician will be contacted immediately.
  - d. If the 1 hour face-to-face assessment was performed by a QRN, the physician must examine the consumer within 24 hours following the initiation of the seclusion or restraint, review and sign the completed QRN assessment, and document their assessment on the seclusion and restraint record.
5. ASSESSMENT FUNCTIONS (PHYSICIAN OR QRN):
  - a. The QRN or physician must provide a face-to-face assessment of the consumer within one (1) hour of the initiation of seclusion or restraint, and shall document in the medical record:
    - i) Clinical assessment and justification for seclusion and/or restraint, which includes an assessment of risks and benefits to consumer.
    - ii) The type of external control (e.g., seclusion, seclusion, and restraint).
    - iii) An appraisal of the consumer's behavior necessitating the use of seclusion and/or restraint. The justification shall clearly specify the nature of the dangerous behavior.
    - iv) Alternative interventions attempted.
    - v) Treatment recommendations.
    - vi) Medical or other contraindications to seclusion and/or restraint.
    - vii) The maximum length of time seclusion or restraints is to be employed.

- viii) A statement of the desired behavior for discontinuation for seclusion or restraint.
  - b. Only upon completion of a face-to-face clinical assessment by the QRN/physician may the consumer be secluded and/or restrained beyond one hour. The physician order will include the length of time (up to four (4) hours) and the method of seclusion and/or restraint to be utilized. The physician will be contacted for any continuation of the order for seclusion and/or restraint.
  - c. If a consumer who is restrained for aggressiveness or violence quickly recovers and is released before the QRN/physician arrives to perform the assessment, the QRN/physician must still see the consumer face-to-face to perform the assessment.
  - d. The on-call psychiatrist is responsible for all seclusion/restraint orders on Saturdays, Sundays, holidays, and after-working hours on all non-holiday weeknights (5:00 p.m. to 8:00 a.m.). The treating physician will be consulted as soon as possible if the treating physician did not order the seclusion and/or restraint.
  - e. Continuation of seclusion and/or restraint beyond eight (8) hours requires a new face-to-face assessment by the physician, a new physician order, and progress note as outlined above.
  - f. All progress notes and observation report entries on each consumer shall be correlated and sequential in the medical record.
6. ADMINISTRATOR FUNCTIONS: Administration is expected to review all seclusion and restraint episodes with the goal of reducing the use of seclusion/restraint through oversight and elevate the visibility of every seclusion and restraint event.
- a. Organizational leadership ensures oversight and accountability by assigning specific duties and responsibilities to multiple levels of staff.
  - b. Onsite Nursing Supervisor responds immediately to any potential conflict situation.

- c. On-call executive provides twenty-four (24) hour/seven (7) day on call supervision. Specific responsibilities include:
    - i) Respond to onsite supervisor when called.
    - ii) Obtain details of the event.
    - iii) Ask which staff were involved.
    - iv) Ask about use of de-escalation techniques.
    - v) Ask about past history of violence.
    - vi) Ask about any injuries to consumer or staff.
    - vii) Verify that risk assessment information regarding past history of violence and antecedents were put into treatment plan and the kardex.
    - viii) Remind staff that CISM debriefing is available if it would be helpful.
  - d. The on-call executive directs the onsite Nursing Supervisor to provide the information learned from the event to the treatment team and the Director of Nursing as a follow-up the next day.
  - e. Information learned from the events should be used to review and revise procedures and educate staff. The Director of Nursing or designee will report lessons learned to the Core Leadership Committee biannually
7. ADDITIONAL PROCEDURES FOR MONITORING SECLUSION AND/OR RESTRAINT:
- a. For instances in which the consumer remains in restraint or seclusion for more than twelve (12) hours or experiences two or more separate episodes of restraint and/or seclusion within a twelve (12) hour period, the Agency Director and the Medical Director shall be notified within one (1) hour. For episodes in excess of twelve (12) hours, daily administrative review and clinical rationale to continue seclusion and/or restraint shall be provided by a non-treating psychiatrist or designee of the Medical Director.
  - b. A formal interdisciplinary Treatment Plan Review will be held for all consumers placed in seclusion or restraints. This shall be documented in the medical record.

- c. Staff shall regularly evaluate the environment of care provided to the consumers and consider factors other than the individual patient in determining the causes for need of seclusion or restraints.
- d. All events of seclusion and/or restraint must be reported each business day to the Medical Director/designee as well as to the Director of Nursing/designee.
- e. The Director of Nursing, Medical Director, and Agency Director will review copies of all seclusion orders and restraint orders.
- f. NNAMHS Agency Director/designee will forward the order copies (without client names) and reviews to the MHDS Administrator bimonthly for review.
- g. A monthly uniform summary of all reports of seclusion and restraint shall be compiled by the Director of Nursing. Copies shall be submitted to the agency Quality Improvement Department and to the Local Governing Body.
- h. Review of seclusion and restraint data will be included in the facility performance improvement program.
  - i) The data will be systematically aggregated and analyzed on an ongoing basis.
  - ii) Ongoing efforts to reduce the utilization of seclusion and/or restraint shall be employed by each facility.
- i. NNAMHS Agency Director is responsible for assuring that ongoing documentation and monitoring of consumers placed in seclusion and/or restraint is maintained.

### TIME OUT

1. Time out shall be employed under circumstances and conditions in which a consumer cannot be intruded upon by other consumers or inadvertently locked into a room.
2. The consumer's room can be used for time out as long as the door stays unlocked and the rights of the roommate(s) are not violated.
3. The consumer may request that they be allowed to go into time out. Staff will help the consumer find an appropriate quiet room.

4. It may be suggested to the consumer by staff that they voluntarily go to time out.  
Staff will help the consumer find an appropriate quiet room.
5. Staff aware of excessive or unusually frequent use of time out for a consumer will refer to the nurse on duty.

## VI. REPORTING SECLUSION AND RESTRAINT ASSOCIATED DEATHS

- A. Any seclusion and restraint associated death requires an immediate serious incident report (SIR) and notification of the Agency Director and the Performance Improvement Coordinator.
- B. The Agency Director, Performance Improvement Coordinator, or designee will report any seclusion and restraint associated death to the Division of Public and Behavioral Health (DPBH) Administrator, and the DPBH Bureau of Health Care Quality and Compliance.
- C. The Agency Director, Performance Improvement Coordinator, or designee will report any seclusion and restraint associated death to the Centers for Medicare and Medicaid Services (CMS) Regional Office in San Francisco by telephone, no later than close of the next business day following the day in which the consumer's death is known.
- D. In cases involving death within one week after use of seclusion and restraint where the intervention may have contributed to the consumer's death, the death might occur outside the hospital and not become known to the hospital, or there might be a delay in the hospital's learning of the consumer's death.
- E. The following parameters are to be followed when reporting to CMS:
1. Any death that occurs while a consumer is in restraints.
  2. Any death that occurs within 24 hours after a consumer has been removed from restraints.
  3. Any death that occurs within one week after the use of restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the consumer's death.
- F. The date and time that the death was reported to CMS will be documented in the consumer's medical record.
- G. The Performance Improvement Department will maintain an internal tracking system of any seclusion and restraint associated deaths.
- H. The tracking system will include the consumer's name, date of birth, date of death, name of attending physician or other licensed independent practitioner who

is responsible for the care of the patient, medical record number, and primary diagnosis(es).

I. The information in the tracking system will be made available in both written and electronic form to CMS immediately upon request.