

**A: Restraint/Seclusion for Mental Health Inpatient Facilities:**

**Policy:** The Division of Mental Health and Developmental Services (MHDS) no longer recognizes the use of seclusion and restraint as treatment options but as treatment failure. If seclusion and restraint are used on MHDS consumers they are to be used only as last resort and only if there is no alternative measure available to staff to maintain safety in the face of imminent harm (Attachment A contains definitions related to this policy).

**Purpose:** The goal of the Division of MHDS is to prevent, reduce, and ultimately eliminate the use of seclusion and restraint and to ensure that when such interventions are used, they are administered in as safe and humane a manner as possible by appropriately trained staff.

**Procedures:**

**I. Philosophy of Care:**

The Division of MHDS recognizes that seclusion and restraint are safety interventions of last resort and are not therapeutic treatment interventions. Seclusion and restraint will never be used for the purposes of discipline, coercion, active treatment, staff convenience, or as a replacement for adequate levels of staff.

The use of seclusion and restraint create significant risk for people with psychiatric disorders and developmental disabilities. These risks may include physical injury, including death, and the re-traumatization of people who have a history of trauma, loss of dignity, and other psychological harm. In light of these potential serious consequences, seclusion and restraint will be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible. When seclusion and/or restraints are applied they require the immediate implementation of necessary safety procedures, adequate documentation, physician's order review, physician's timely on site evaluation, and formal debriefing processes that must be followed by mental health inpatient facilities.

This goal can best be achieved by:

- A. Early identification and assessment of individual who may be at risk of receiving these interventions. During initial intake and ongoing assessment staff will assess whether or not an individual has a history of being sexually, physically, or emotionally abused, or has experience other trauma including trauma related to seclusion, restraint, or prior psychiatric treatment. Staff will also assess past and present violent behavior. Once assessed, staff will discuss with each individual strategies to reduce agitation that might lead to the use of seclusion or

restraint. Discussion will include what kind of treatment or intervention would be most helpful and least traumatic for the individual.

- B. In administering seclusion or restraint interventions, as well as in attempting to prevent the necessity for subsequent/recurrent use, staff shall recognize and use the treatment plan and its components as a specific intervention tool. Treatment plans need to address individual strengths, gender issues, history of trauma, age, and culture issues. In addition treatment plan need to identify staff and consumer identified alternatives to use in times of conflict and behavioral escalation.
- C. The development of high quality, treatment programs operated by trained and competent staff who effectively employ individualized alternative strategies to prevent and defuse escalating situations as well as who provide training and practice in communication skills and pro-social behaviors.
- D. Policies and procedures that clearly state that seclusion and restraint will be used only as emergency safety measures in situations of imminent danger to staff, consumers or others.
- E. Effective continuous performance improvement monitoring activities.

These approaches help to maintain an environment and culture of caring that will minimize the need for the use of seclusion and restraint.

In the event that the use of seclusion or restraint becomes necessary, the following standards will apply to each episode:

- The dignity, privacy, and safety of individuals who are secluded or restrained will be preserved to the greatest extent possible at all times during the use of these interventions;
- Seclusion or restraint will be initiated only in those individual situations in which an emergency need is identified. These interventions will be implemented only by competent, trained staff who have been credentialed or certified to perform them;
- Only licensed practitioners who are specially trained and qualified to assess and monitor the individual's safety and the significant medical and behavioral risk inherent in the use of seclusion and restraint will order these interventions;
- The least restrictive seclusion and restraint method that is safe and effective will be administered;
- Individuals placed in seclusion or restraint will be communicated with verbally and monitored at frequent appropriate intervals consistent with principals of quality care (see Safety Procedures section for appropriate intervals);

- All seclusion or restraint orders will be limited to a specific period of time (see Safety Procedures section); however, interventions will be ended as soon as it becomes safe to do so, even if the time-limited order has not expired; and
- Individuals who have been secluded or restrained, staff who have participated in these interventions, and appropriate other persons (see Consumer and Staff Debriefing section) will participate in debriefings following each episode in order to review the experience and to plan for earlier, alternative interventions.

Each treatment setting under the scope of this document establishes and adheres to the following value statements:

- It is recognized that a rich and caring therapeutic milieu, which strives to enhance patient choice and self-determination, is the most effective means to avoid the use of seclusion or restraint;
- Seclusion and restraint procedures may only be used as an intervention of last resort following a series of failed ongoing efforts by staff to promote more adaptive behavior by the patient and used only in emergency situations to prevent serious harm to anyone;
- Use of a seclusion or restraint intervention is viewed as an exceptional or extreme practice for any patient;
- Seclusion and restraint shall be as limited in time as possible. Staff and patients work together to lessen the incidence, duration, and induced trauma of these interventions;
- All clinical staff with a role in implementation of a seclusion or restraint intervention must be trained and demonstrate competency in their prevention and proper and safe usage;
- Leaders of the hospital, leaders of clinical departments, and leaders of wards/units are held accountable at all times for the initiation, usage, and termination of seclusion or restraint procedures. This accountability is demonstrated as a component of the hospital's Performance Improvement efforts and staff competency evaluations;
- All clinical staff will be trained in procedures that lead to elimination of the need for seclusion and restraint;
- The patient, family, and/or advocate of the patient's choice, as appropriate, are recognized members of the treatment team;
- The treatment plan shall address specific interventions for people identified as "at risk" to be used to avoid seclusion and restraint
- It is recognized that seclusion and restraint are interventions that inherently violate patient dignity, however, such dignity shall be maintained to the extent possible during implementation of each of these interventions; and
- In administering seclusion or restraint, as well as in attempting to prevent its use, staff shall recognize and use the strengths of the patient, and remain sensitive to issues of culture and trauma history.

II. Creating A Violence Free Treatment Milieu (see Attachment B for examples of forms for this section)

There are many factors that lead to a safe and violence-free environment and each agency is responsible for developing a culture of recovery that values these goals. This culture will include individualized treatment options that are tailored to the needs of the person served and reduce the risk of future violence. In developing a culture of recovery:

- Agency Leadership needs to ensure a culture of respect (not power by hierarchy) by empowering staff at all levels to be to make day-to-day treatment decisions while sensitizing staff about the misuse of power
- Training on Recovery Models of care (including skills for self-monitoring and self-control);
- Clinical paradigm that addresses history of violence or trauma as part of the clinical picture - proper individualized assessment at intake that include past occurrences of violence behavior or trauma (agencies are to develop specific sections within current forms or develop tools to be used in conjunction with current assessment forms). This assessment will serve as a safety precaution in the prevention of seclusion or restraint;
- Individualized treatment plans that include information from the assessment about violence and trauma;
- Advanced Directives tailored to the people served by the agency and include information about Alternative Dispute Resolution to avoid future violence/conflict (please see attached Personal Safety Form as an example);
- Array of treatment options that are available at all times from which the consumer chooses; and
- Ongoing training that is constantly evolving - based on changing situations and type of people being served. This training will be developed in collaboration of consumers/survivors/ex-consumers, as appropriate (see training section below).

III. Notification:

With the consumer's consent, upon admission of the consumer, the consumer's family shall be informed of the policies and procedures regarding the use of seclusion and restraint. With the consumer's consent, as documented in the medical record, designated family members shall be informed of their opportunity to be notified of each occurrence of seclusion or restraint within the timeframe agreed to by the family and to participate in the consumer's debriefing as appropriate. If there is no family member available, the office of Nevada Disability Advocacy & Law Center (NDALD) may be used upon consent of the consumer.

IV. Staff Training:

A. Restraint/Seclusion Training:

Staff training shall focus upon the development of skills and abilities needed to assess risk and trauma, identify escalating behaviors, and effectively assist patients to maintain control and learn safer ways of dealing with stress, anger, fear, and frustration.

Staff training shall include the primary importance of patient safety, at all times, during the restraint or seclusion process. Training shall be provided to all clinical staff regarding the philosophy of and the Division/Agency policy for reduction and elimination of restraint and seclusion. This training shall be provided at the time of orientation and annually thereafter.

B. Conflict Prevention and Response Training (CPART):

Staff training for competency in restraint and seclusion techniques shall be completed before direct care personnel complete the Agency orientation. In addition, MHT staff (and other direct care staff as designated by each agency) must complete an Initial Certification Course for certification in Crisis Prevention and Response Training (CPART). Retraining, recertification and demonstration of competency must occur bi-annually.

C. Additional Staff Training:

Training in safe physical intervention techniques shall be provided only by approved/certified instructors using methodologies approved by the Division of Mental Health and Developmental Services Training Committee. Specific training components shall include:

1. Agency and Division policies and procedures relating to the use of, documentation and monitoring of seclusion and restraint.
2. Assessment skills needed to identify those persons who have a history of trauma (e.g., abuse, assault, etc.).
3. Assessment skills needed to identify those persons who are at risk of violence to self or others.
4. Treatment interventions that will reduce the risk of violence and increase the patient's capacity to benefit from psychosocial rehabilitation and educational programs.
5. Skills in developing a patient education program that will assist patients in learning more adaptive ways of handling the stress, frustration or anger that precipitates aggressive behavior.
6. Conflict resolution, mediation, therapeutic communication, de-escalation, and verbal violence prevention skills that will assist staff

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to diffuse and safely resolve emerging crisis situations without resorting to seclusion or restraint.

7. The nature and identification of the possible negative psychological effects these measures have upon individuals, and positive therapeutic strategies to combat such effects.
8. Trauma, gender, and culturally informed consent.
9. Use of safe physical intervention techniques and restraint techniques and devices.
10. Use of alternative adaptive support or assistive devices and care strategies in lieu of protective restraints for body positioning and falls prevention.
11. Recognition and management of signs of patient physical and psychological distress during seclusion and restraint, and appropriate follow-up.
12. Recognition of the behaviors that indicate when restraint/seclusion may be safely terminated.
13. How to conduct a post procedure debriefing.
14. Appropriate documentation.

V. Safety Procedures (Attachment C contains seclusion and restraint reporting forms):

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. In general the person's face will always be maintained in view of staff to assure immediate identification of physical distress such as pain or breathing difficulties.
- 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.

- F. While the consumer is in seclusion he/she will be on constant, uninterrupted monitoring by staff either face-to-face or by using both video and audio equipment. The consumer will receive face to face assessment at a minimum of at least every 15 minutes during seclusion.
- G. The condition of the restrained consumer must be continually assessed, monitored and re-evaluated. Frequency of monitoring must be made 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.
  - 1. The consumer in seclusion and/or restraint will have his/her vital signs taken and documented at a minimum of every 30 minutes for the first hour and then on the hour afterwards. Any concerns will be referred to the physician by the registered nurse.
  - 2. At a minimum of every 15 minutes the staff will document their ongoing, face-to-face, continual 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 associated with the consumer's hydration needs, level of distress and agitation, mental status, cognitive functioning, skin integrity, position, circulation, respiration, and safety will be referred to the registered nurse immediately and then to the physician.
  - 3. Any changes in gait or coordination shall be documented and referred to the physician by the registered nurse.
- H. Staff will offer the consumer fluids, toileting and comfort measures every fifteen (15) minutes. Meals and snacks will be offered at regular times. Staff will assist the consumer with hand washing after toileting and before meals. Any exception to the above procedures must be clinically justified and noted in the medical record.
- I. 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.
- J. Despite the length that 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.

- K. In the event of any emergency requiring unit evacuation (including drills), the consumer shall be removed from seclusion and/or restraint, and staff will stay with the consumer on a 1:1 basis.
- L. Precautions shall be taken to assure the protection of the consumer in restraints from being mistreated or harmed by other persons.

VI. 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. A registered nurse must be notified immediately if a consumer exhibits threatening or harmful behavior. The emergency use of seclusion and/or restraints requires an RN assessment.
  - 1. The RN assessment will include alternatives used prior to the use of seclusion and/or restraint. These may include, but are not limited to:
    - a. Consumer's verbalization of feelings;
    - b. Verbal reassurance/redirection given to consumer;
    - c. 1:1 interaction for the consumer with staff;
    - d. Redirection in stimuli;
    - e. Environmental changes for the consumer;
    - f. Limit setting;
    - g. Time Out offered to the consumer;
    - h. Medication offered to the consumer;
    - i. Antecedent behaviors or events which triggered the escalation;
    - j. Determining the point of conflict and deciding why the person cannot "win" or get his/her way
      - (1) Upon determination by a registered nurse 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.
- B. Order to seclude and/or restrain:
  - 1. Orders will 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 Registered Nurse 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.

2. No application of restraint or seclusion shall occur without a Division Mental Health and Developmental Services physician's order, stating the reason for use.
  3. 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).
  4. Neither restraint nor seclusion orders shall be written PRN orders.
  5. 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.
  6. Restraint/seclusion orders are time limited and are valid for no longer than eight (8) consecutive hours.
    - a) The original order shall be for a maximum of four (4).
    - b) If continued seclusion or restraint is needed, the physician must be contacted. The RN must contact the physician and review this reassessment prior to the extension of the original order.
    - c) 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.
  7. The Nursing Supervisor, or charge nurse on duty, must be notified immediately of all applications and removals of restraints and/or seclusions. The Nursing Supervisor must come to that unit to assist/observe and provide senior clinical assistance (treat seclusion or restraint like you would a cardiac arrest).
- C. The RN must document the clinical rationale for the use of seclusion and/or restraint. This documentation shall include, but not be limited to:
1. An assessment 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. (past history of violent assaultive behavior is a significant consideration and therefore will be included in the assessment, i.e., punched several consumer's, with severe injury, in the past two days, etc.)
  2. The treatment techniques attempted prior to using seclusion and/or restraint (e.g., administration of medication, counseling, quiet time).
  3. 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. This shall include the behavior that will determine their readiness for release from seclusion and/or restraint.

4. A description of interventions implemented to assist the consumer in meeting the release criteria.
  5. A summary of the consumer's current physical assessment, including vital signs.
- VII. The consumer must be continuously 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:
  - A. Mental Status and behaviors consumer is exhibiting at the moment justifying continuation of seclusion and/or restraint.
  - B. Why less restrictive alternatives are not appropriate.
  - C. The consumer's physical condition including vital signs and circulation.
  - D. 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.
  - E. Review with consumer criteria necessary for release from seclusion and/or restraint and any additional counseling and/or education needed.
- VIII. The person must be able to demonstrate calm behavior(s) and/or be able to state that they are calm (release criteria). Other actions as documented by the physician and nursing staff are considered interventions to assist the consumer in accomplishing the emergency behavioral plan. Modifications of the original plan of care are not necessary.
- IX. If a consumer remains in seclusion or restraint when a nursing shift ends, the RN going off duty and the RN coming on duty must assess the consumer together. This will be documented in a progress note.
- X. All progress notes and observation report entries on each consumer shall be in chronological order in the medical record.
- XI. Ensuring that the consumer understands that they are not to "blame" for the seclusion or restraint, a licensed mental health professional will, when clinically appropriate, meet with the consumer following release from seclusion or restraint.

This must be done prior to any shift change, but no later than 8 hours. The purpose of this meeting will include:

- A. 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.
- B. Assisting the consumer to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized if similar situations/emotions/thoughts re-occur.
- C. Developing and documenting a specific plan of interventions for inclusion in the treatment plan for the purpose of reducing or eliminating seclusion and restraint.
- D. The mental health professional shall document the consumer interview process in the consumer's medical record.

XII. Physician Functions:

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

- A. The physician must assess the consumer and shall document in the medical record:
  - 1. Clinical reason for seclusion and/or restraint, which includes an assessment of risks and benefits to consumer.
  - 2. The type of external control (e.g., seclusion, seclusion and restraint).
  - 3. An on site assessment of the consumer's behavior necessitating the use of seclusion and/or restraint within one hour of the event. The justification shall clearly specify the nature of the dangerous behavior.
  - 4. Alternative interventions attempted.
  - 5. Treatment recommendations.
  - 6. Medical or other contraindications to seclusion and/or restraint.
  - 7. The maximum length of time seclusion or restraint is to be employed.
  - 8. A statement of the **SPECIFIC** desired behavior for discontinuation for seclusion or restraint.
- B. Only upon completion of a face-to-face clinical assessment by the 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.

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- C. If a consumer who is restrained for aggressiveness or violence quickly recovers and is released before the physician arrives to perform the assessment, the physician must still see the consumer face-to-face to perform the assessment.
- D. The on-call psychiatrist is responsible for all seclusion/restraint on site timely (within one hour) evaluations and orders on Saturdays, Sunday, 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.
- E. Continuation of seclusion and/or restraint beyond four (4) hours requires a new physician order and progress note as outlined above as well as a face-to-face by the RN or Nursing Supervisor.
- F. All progress notes and observation report entries on each consumer shall be in chronological order in the medical record.

XIII. Consumer and Staff Debriefing (see Attachment D for a debriefing form):

An initial staff debriefing shall occur immediately after the seclusion or restraint but prior to any shift change. This shall be done by a licensed mental health professional and, where applicable, Consumer Assistance staff. The purpose of this debriefing will be to elicit feedback information from the consumer about the intervention. Findings from the staff debriefing and proposed administrative changes or strategies to prevent reoccurrence shall also be documented on the seclusion and restraint form and forwarded to the Division's Medical Director and Agency Director for their review and action. A second full debriefing process shall be initiated within 24 hours of the end of each incident or seclusion or restraint, unless further delay is clinically indicated. This information shall be available to the treatment team prior to its next meeting with the consumer.

After each incident of seclusion or restraint, a licensed mental health professional and members of the treatment team shall meet with the consumer for the purpose of:

- A. Exploring with the consumer to develop an understanding of the precipitant which may have evoked the behaviors necessitating the use of the restrictive technique(s).
- B. Exploring with the consumer to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized if similar situations/emotions/thoughts recur.

- C. Assisting to identify stress reduction methods and teaching identification of antecedent trigger events which may cause stress.
- D. Using admission forms, treatment plans, and any other agency forms when discussing what might have occurred (“went wrong”) that led to an initiation of seclusion or restraint and what changes need to occur that would lessen future occurrences.
- E. Developing and documenting a specific plan of intervention for inclusion in the comprehensive individualized treatment plan, for the purpose of reducing or eliminating the need for restrictive techniques. The team member shall document the debriefing process in the progress notes in the consumer’s medical record. Documentation of the new intervention to be used shall be included in the comprehensive individualized treatment plan the first working day after termination of the seclusion or restraint and shall be reviewed with the consumer.

XIV. Continuous Improvement Monitoring:

- A. The Agency Director and the leadership staff of each inpatient facility shall maintain a performance improvement program designed to continuously review, monitor and analyze the use of those measures shall be employed.
- B. The Agency Director and Medical Director are responsible for insuring that ongoing documentation and monitoring of consumers placed in seclusion or restraints are maintained. Monitoring shall consist of reviewing the necessity for use or continuation of these measures based upon documentation of unsuccessful, less restrictive alternatives, attempts at patient education of stress reduction behaviors and trigger identification, as well as appropriate rationale and justification. Consumer “debriefing” health teaching, clinical response to seclusion, treatment plan revisions, and incidents of failure to meet timelines as outlined in this policy.

**Notification to the on-call executive needs to be immediate.**

- C. For incidents of seclusion or restraint that exceed 12 hours, or experiences two or more separate episodes of restraint and/or seclusion within a 12 hour period, Agency Administration and clinical leadership shall be notified within 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.

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- D. A formal interdisciplinary Treatment Plan Review will be held for all consumers placed in seclusion or restraints within 48 hours. This shall be documented in the medical record.
  - E. All events of seclusion and/or restraint must be reported within one hour to the Agency Director/designee, Medical Director/designee and to the Director of Nursing/designee.
  - F. The Director of Nursing, Medical Director and Agency Director will review copies of all seclusion orders and restraint orders daily or on the next working day.
  - G. The Agency Director/designee will forward the order copies (without consumer names) and reviews to the MHDS Administrator daily for review. Copies of all documents are maintained in the medical record.
  - H. A monthly uniform summary of all reports of seclusion and restraint shall be compiled by the Nursing Director, or designee. Copies shall be submitted to the agency Performance Improvement Department and to the Division of MHDS.
  - I. The MHDS Administrator will review and report seclusion and restraint orders to the Mental Health and Developmental Services Commission.
  - J. Leadership staff of each state psychiatric hospital will include the review of seclusion and restraint data in the facility performance improvement program.
  - K. The data will be systematically aggregated and analyzed on an ongoing basis by Leadership staff at each agency.
  - L. Ongoing efforts to reduce the utilization of seclusion and restraint shall be employed by each facility.
  - M. The facility Chief Executive Officer of each state psychiatric hospital is responsible for assuring that ongoing documentation and monitoring of consumers placed in seclusion and/or restraint is maintained.
- XV. The hospital will report to the MHDS Administrator, the Center for Medicare/Medicaid Services (CMS) and the State of Nevada, Division of Health Bureau of Licensure and Certification any death that occurs while a consumer is restrained or in seclusion or where it is reasonable to assume that a consumer's death is a result of restraint and/or seclusion.

**B: Restraint/Seclusion for Developmental Services Residential Programs:**

**Policy:** When addressing the needs of the people we serve, Developmental Services provides values-based treatment and support. Support planning is driven by an understanding of the individual's personal goals. For individuals with severe behavioral problems, treatment is built on prevention through positive and supportive interventions that make problem behavior irrelevant or less effective or efficient compared to proactive, adaptive alternatives. Treatment of severe behavior disorders in Developmental Services is based on the personal and organizational outcomes of The Council and on positive behavioral support strategies and values.

**Purpose:** Within this context, restraint and other intrusive interventions are viewed as interventions of last resort to be used only in an emergency (as defined in N.R.S. 433.5466) to prevent harm to the individual or others. Restraint is considered by the Division of MHDS to be an emergency and safety intervention, and not a therapeutic technique. Restraint procedures shall never be initiated or maintained as a substitute for treatment, as punishment, or for the convenience of staff.

**Procedures:**

**I. Philosophy of Care:**

Use of a restraint procedure is viewed as an exceptional or extreme event for any person. Except for unforeseen emergencies, restraint may only be incorporated into a crisis plan if the person's support team has developed and implemented a positive support plan (a) that is based on a functional assessment of the problem behavior(s), and (b) that incorporates setting event, antecedent, response building, and consequence support strategies. All decisions to incorporate restraint in an approved crisis plan shall be based on a thorough assessment of the person which addresses factors contraindicating restraint use (e.g., history of sexual/physical abuse or other violence; medical or psychiatric issues; cultural issues, etc.).

All staff with a role in implementing restraint procedures must be trained and demonstrate competence in preventive strategies as well as the proper and safe use of specific restraint procedures as approved by the Division of MHDS Training Committee.

Individuals in leadership roles either within campus- or community-based service programs or agencies are held accountable at all times for the proper initiation, usage, termination, and documentation of restraint procedures. Each agency's

quality improvement and staff evaluation procedures shall reflect this accountability.

A. If restraint is used:

1. Restraint shall be implemented in a manner designed to protect the person's safety, dignity and emotional well-being and that of others.
2. Restraint procedures must provide only the minimum amount of restriction necessary as a protective measure and shall only be applied until the individual no longer poses a danger to him/herself or others.
3. As determined by the individual's support team, post-procedure debriefing and discussion shall occur that focuses on how future situations may be prevented or de-escalated by employing alternative preventive problem-solving measures. As appropriate, the person restrained or his/her advocate or guardian shall be involved in these discussions. On an on-going basis, the individual's support team (including the person and/or advocate/guardian) shall review and revise the support plan as necessary. Agency-level oversight and review of all approved crisis plans employing restraint will occur at least annually.

II. Usage, Tracking and Reporting:

A. Physical and Mechanical Restraints may be used, per NRS, for the following reasons:

1. For protection of the person or others in an emergency that necessitates the use of restraint.
2. Other situations:
  - a. Physical Restraint to:
    - ❖ Assist in completing a task or response if there is no or minimal resistance.
    - ❖ Escort or carry the person to safety.
  - b. Mechanical Restraint to:
    - ❖ Treat the medical needs of the person.
    - ❖ Protect a person from injury because of lack of coordination or frequent loss of consciousness.
    - ❖ Body alignment or positioning as described in a plan of treatment.

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- B. All uses of chemical, physical and/or mechanical restraints will be reported using the Restraint and Denial Form (RAD) approved by the Commission for MHDS. The original of the RAD is considered part of the individual's permanent record and will be maintained as such by each agency. *(Mechanical Restraints for body alignment or positioning do not need to be reported using a RAD.)*
- C. The agency will report each use of the following as a Denial of Rights by indicating it as denial of rights on the RAD and forwarding a copy of the front page of the RAD to Division MHDS. Division MHDS will forward the RAD to the Commission for review.
1. Physical Restraint used on a person in an emergency.
  2. Mechanical Restraint used on a person in an emergency.
  3. Chemical Restraint.
- III. Each agency of the Division, which is regulated by the Center for Medicare/Medicaid Services, shall develop and implement their own written procedures to implement the provisions of this policy.
- IV. All other agencies of the Division shall develop written procedures to meet the requirements of state law with respect to consumer restraints.



Administrator

ATTACHMENT A: Restraint and Denial Form (RAD)

ATTACHMENT B: Seclusion/Restraint Review Form

ATTACHMENT C: Joint Commission Definitions

ATTACHMENT D: Personal Safety Plan

ATTACHMENT E: Debriefing Form

Effective Date: 4/30/98

Date Revised: 12/21/98, 2/4/99, 2/17/00, 1/15/02, 3/11/03, 08/01/04, 06/23/05; 11/7/07

Date Approved by MHDS Commission: 01/30/98

<input type="checkbox"/> D.R.C.
<input type="checkbox"/> Rural
<input type="checkbox"/> S.R.C.
<input type="checkbox"/> Other (specify)
_____

**Restraint and Denial Form (RAD):**

*Commission MHDS Developmental Services Restraint Report Form and Denial of Rights for Restraint Form per NRS 433*

**Case # \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ (Identifying information on side 2 only.)**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date of Restraint      Time Start      Time End (AM/PM)      Total Time**

**1. Type(s) of Restraint (Check all that apply.)**

- Physical Restraint** “. . .the use of physical contact to limit a person’s movement or hold a person immobile.”
- Mechanical** Is this a one time report for a continuing restraint w/Physician’s orders?  Yes  No
- Chemical Restraint**  
(the administration of drugs for the **specific** and **exclusive** purpose of controlling an acute or episodic aggressive behavior . . .)

**2. Reason(s) for use of restraint (Check all that apply.)**

- Aggression toward others  Harmful to self  Property destruction (**Emergency use of restraint**)

Briefly describe incident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Details of restraint:**

- a. Is this part of approved treatment plan?  Yes  No
- b. Number of staff assisting in restraint \_\_\_\_\_ (Staff names on reverse)

**c. Physical Restraint**

What type  Prone  Basket-hold  Carry  Physical Escort (resistive)  
 Other (specify) \_\_\_\_\_

**d. Mechanical restraint:**

What type:  Reciprocal Wrist  Waist/wrist  Chair posey  Bed Posey  Mitts  
 Other (specify) \_\_\_\_\_

**4. Methods used to avoid restraint (Check all that apply.)**

- Redirection/Counseling  One-to-one supervision  Physical Escort (minimal resistance)
- Other (please specify) \_\_\_\_\_

Briefly describe actions \_\_\_\_\_  
\_\_\_\_\_

**5. Are there any team directed limits or modifications to the use of restraint?**  Yes  No **If Yes**  
describe the limits or modifications: \_\_\_\_\_

**6. Were there any injuries to the client as a result of the restraint?**  Yes  No **If Yes**, briefly describe the injury:  
\_\_\_\_\_

**7. Was a nurse or physician contacted during or following the use of restraint?**  Yes  No

a. Was there any medical treatment?  Yes  No **If yes**, describe \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature/title of staff completing form      Date      Signature of witness      Date  
*Denial of Rights for Restraint form (Administrative use only.) If checked, forward to the Commission on MH/MR*

**Reviewed by:** (Note: All signatures may not be required by individual agency policies.)

\_\_\_\_\_  
PC/Case Mgr.      Res./Comm. Dir.      Q.A.      Other  
Administrative comment and suggested action, if any.

\_\_\_\_\_  
\_\_\_\_\_

CLIENT Age \_\_\_\_\_ Sex \_\_\_\_\_

\_\_\_\_LCC \_\_\_\_NNAMHS \_\_\_\_SNAMHS \_\_\_\_DWTC

**Rationale for seclusion and/or restraint:**

- harmful to self  harmful to others

PRIVATE \_\_\_\_\_  
(SPECIFY HOSPITAL)

**Methods used to avoid restraint and seclusion:**

- ventilation of feelings  verbal reassurance/redirection  1 - 1 interaction with staff  reduction in stimuli  
 environmental change  limit setting  time out  
 medication(s) name/dosage: \_\_\_\_\_  P.O.  I.M.

RN narrative: \_\_\_\_\_  
\_\_\_\_\_

**Is the patient medically compromised?**  Yes  No **If yes, check all that apply:**

- morbid obesity  spinal injury  current or history of cardiac or respiratory disease  
 recent vomiting  pregnant  on seizure precautions  other: \_\_\_\_\_

**Physician's clinical assessment justifying use of seclusion or restraint:** \_\_\_\_\_

**Behavioral criteria necessary for release:**

**Patient to be:**

**Adults:**

- secluded and restrained for up to 4 hours  secluded for up to 4 hours  restrained for up to 4 hours

**Children and Adolescents ages 9 – 17:**

- secluded and restrained for up to 2 hours  secluded for up to 2 hours  restrained for up to 2 hours

**Children under 9:**

- secluded and restrained for up to 1 hour  secluded for up to 1 hour  restrained for up to 1 hour

RN may extend order once, up to the maximum allowable hours.  Yes  No

**Place patient in:**

- seclusion  locked seclusion  cuff/belt  legs  wrists  4-point  5-point  mitts  geri chair  
 physical intervention required (i.e. hand-holding, escort)

**Placed in seclusion/restraint** Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Released from seclusion/restraint** Date: \_\_\_\_\_ Time: \_\_\_\_\_

**CONTINUATION OF ORDER**

The RN evaluation and documentation for continuation of orders must include a face-to-face reassessment of the patient's current behavior that warrants the extension of the restraint/seclusion.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Discussed with physician: \_\_\_\_\_ / \_\_\_\_\_  
R.N. Signature Date/Time

Verbal/phone order by Dr. \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
R.N. signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Order noted by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**COMMISSION ON MHDS REPORT FORM**

**SECLUSION AND RESTRAINT ORDERS**

**INSTRUCTIONS**

*List client number only. Client's name, initials, date of birth, social security number, etc. should not appear anywhere on this front page.*

**CLIENT RECORD NUMBER** \_\_\_\_\_

# SECLUSION/RESTRAINT REVIEW

DON REVIEW:

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Signature

Date

MEDICAL DIRECTOR REVIEW:

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Signature

Date

AGENCY DIRECTOR REVIEW:

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Signature

Date

DIVISION MHDS REVIEW:

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Signature

Date

**CLIENT RECORD NUMBER** \_\_\_\_\_

## Attachment C

### DEFINITIONS

SUGGESTION: JOINT COMMISSION has the following definitions –

**Seclusion:** The involuntary confinement of an individual served alone in a room, which the individual served is physically prevented from leaving, for any period of time. Seclusion does not include involuntary confinement for legally mandated but nonclinical purposes, such as confining a person facing serious criminal charges, or serving a criminal sentence, to a locked room.

**Restraint:** The direct application of physical force to an individual served, with or without the individual's permission, to restrict his/her freedom or movement. The physical force may be human, mechanical devices, or a combination thereof.

**Time-out:** A procedure used to assist the individual to regain emotional control by removing the individual to a quiet area of unlocked quiet room. (The standard that references time-out also states that the use of time-out is limited to use of no more than 30 minutes.)

- A. "Restraint" includes either a physical restraint or a medication that is being used as a restraint. A physical restraint is 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).

This policy may include the use of devices such as bed rails, tabletop chairs, protective nets, mitts, or helmets when used as protective devices; any physician ordered item devised by personnel to prevent perpetual self-mutilators from inflicting injury to them-selves, 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. Medications that comprise the resident's regular medical regimen are not considered chemical restraints, even if their purpose is to control ongoing behavior. Medications shall not be used as chemical restraints (N.R.S. 433.5503 and 433.5456 allows use of chemical restraint. Many times Haldol may be given on an emergent basis, where the routine antipsychotic would

- be some other medication). Medications are only to be used to treat the symptoms of the consumer's psychiatric condition. When a consumer is given medication without previously signing a written medication consent, a Denial of Rights for Written Consent to Medical Treatment will be initiated.
- B. Seclusion: The involuntary confinement of a consumer in a locked room or a specific area from which the consumer is physically prevented, or psychologically coerced, from leaving. Seclusion does not include confinement on a locked inpatient treatment unit or ward, where the consumer is with others receiving inpatient care.
- C. Emergency: Emergency is defined as a serious, probable, or imminent threat of bodily harm to self or others where there is the real potential to cause bodily harm. It may be an unanticipated situation where the consumer's behavior is violent or aggressive.
- D. Imminent: Likely to occur immediately.
- E. Time Out: Allowing the consumer to voluntarily be alone in an unlocked room for 30 minutes or less for quiet time purposes and to promote a calming effect so they may return to the therapeutic milieu. Time out is not seclusion (see facility policy on time out).
- F. Mental Health Professional: A person professionally qualified in the field of Mental Health (N.R.S. 433.209).
- G. Consumer: The individual defined as "consumer" in statute will hereinafter be referred to as "consumer."

**ATTACHMENT D**

<b>NAME:</b>	<b>Date:</b>
<b>(print)</b>	<b>Facility:</b>

**PERSONAL SAFETY PLAN**  
**(For Advance Crisis Planning to be used in Inpatient Facility Only)**

**This form will allow you to suggest calming strategies in advance of a crisis. It will allow you to list things that are helpful when you are under stress or are upset. It will also allow you to identify things that make you angry. Staff and individuals receiving services can enter into a “partnership of safety” using this form as a guide to assist in your treatment plan. The information is intended only to be helpful; it will not be used for any purpose other than to help staff understand how to best work with you to maintain your safety or to collect data to establish trends. This is a tool that you can add to at any time. Information should always be available from staff members for updates or discussion. Please feel free to ask questions.**

1. Calming Strategies: It is helpful for us to be aware of things that help you feel better when you’re having a hard time. Please indicate (5) activities number then 1 (most helpful) through 5 (least helpful) that has worked for you or that you believe would be most helpful. You can then check other boxes as well or add any at the bottom in the box marked “Other”. We may not be able to offer all of these alternatives, but we would like to work together with you to determine how we can best help you while you are here.

<input type="checkbox"/> Listen to music	<input type="checkbox"/> Exercise	<input type="checkbox"/> Read a book
<input type="checkbox"/> Wrap up in a blanket	<input type="checkbox"/> Have a hug (with my consent)	<input type="checkbox"/> Drink a beverage
<input type="checkbox"/> Write in a journal	<input type="checkbox"/> Calling friend/family member	<input type="checkbox"/> Watch TV
<input type="checkbox"/> Be in a dark room	<input type="checkbox"/> Hugging a stuffed animal	<input type="checkbox"/> Medication
<input type="checkbox"/> Take a shower	<input type="checkbox"/> Talk with peers on unit	<input type="checkbox"/> Do artwork
<input type="checkbox"/> Talk with staff	<input type="checkbox"/> Take walk with staff	<input type="checkbox"/> Other (specify below)

2. What are some of the things that make you angry, very upset or cause you to go into crisis? What are your “triggers”?

<input type="checkbox"/> Being touched	<input type="checkbox"/> Called names/made fun of	<input type="checkbox"/> Security in uniform
<input type="checkbox"/> Yelling/loud noises	<input type="checkbox"/> Physical force	<input type="checkbox"/> Being isolated
<input type="checkbox"/> Contact with person who is upsetting	<input type="checkbox"/> Being forced to do something	<input type="checkbox"/> Someone lying about my behavior
<input type="checkbox"/> Being Restrained	<input type="checkbox"/> Being threatened	<input type="checkbox"/> Other (specify below)

3. Gender Preference: Do you have a preference regarding the gender of staff assigned to you during a time when you are upset or angry?

- female staff       male staff       no preference

4. Signals of Distress: Please describe your warning signals. For example, what you know about yourself, and what other people may notice when you begin to lose control. Check those things that are most applicable to you. This information will be helpful so that together we can create new ways of coping with anger and stress:

<input type="checkbox"/> Sweating	<input type="checkbox"/> Crying	<input type="checkbox"/> Breathing hard	<input type="checkbox"/> Yelling
<input type="checkbox"/> Hurting self	<input type="checkbox"/> Injuring self/others	<input type="checkbox"/> Pacing	<input type="checkbox"/> Pacing
<input type="checkbox"/> Running	<input type="checkbox"/> Clenching teeth	<input type="checkbox"/> Not taking care of self	<input type="checkbox"/> Swearing
<input type="checkbox"/> Not eating	<input type="checkbox"/> Throwing objects	<input type="checkbox"/> Being rude	<input type="checkbox"/> Other (specify below)

5. Seclusion and Restraint: This facility is trying to eliminate the use of seclusion and restraint, therefore, it would be helpful to know if you have ever been placed in a seclusion room or restrained. This information will be used only for collecting data and for training purposes, not to predict any future behaviors.

- Have you ever been placed in a seclusion room?       YES       NO  
 Have you ever been restrained?       YES       NO

6. In Extreme Emergencies: In extreme emergencies seclusion and restraint may be used as a last resort. Is there anything you find helpful in emergency situations that could prevent these interventions from being used?

- A. Medical Conditions: Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc., that we should be aware of when caring for you during an emergency situation?
- B. Physical Contact Preferences: We would like to know about your preferences regarding physical contact. For example, you may not like to be touched at all or you may find it helpful to have a hug or be touched appropriately when you are upset. Do you find it helpful to be hugged or touched appropriate when you are upset?       YES       NO

Comments:

- C. Helpful Medications: We may be required to give medications if other measures do not help you to calm down. In this case, we would like to know what medications have been especially helpful to you?

10. Not Helpful Medications: Are there any medications that are not helpful?

11. Room Checks: Room checks are done at night to make sure you are okay. In

order to make room checks as non-intrusive as possible is there anything that would make room checks more comfortable for you?

12. Trauma History: Do you have any issues regarding abuse such as sexual or physical abuse that you would like to talk about with staff, or with a counselor?

YES

NO

Would you like more information on these issues in classes or support groups?

YES

NO

13. Anything Else? Is there anything else that would make your stay easier and more comfortable/ For example do you have any special issues such as cultural, dietary, sexual preference, appearance, etc. that you think could contribute to misunderstandings? Please describe:

The Personal Safety Form Information should be presented to the treatment team and incorporated into the treatment plan for this individual. Each individual shall receive a copy.

This form has been adapted from an original form created by the Massachusetts Department of Mental Health.

### **Guidelines for Person Safety Form**

1. The Personal Safety Form should be completed within 24-72 hours.
2. It is preferable that this form not be included in the initial admission packet. Persons who are newly admitted are required to sign multiple legal forms and must be able to understand certain policies and procedures. It would be very difficult for an individual to focus on questions related to personal safety preferences when they are already in some degree of stress.
3. It would be helpful to administer the form in small group settings. Individuals may feel safer to answer sensitive questions while sitting in a group with other peers as a group setting is more informal than a clinical setting. If given during a group session, there should be several staff members present to help individuals who need support or assistance with reading, understanding, or answering the questions.
4. Careful consideration should be given as to who will administer the form. Ideally, it should always be the same person, someone who is both familiar and comfortable with the material. A peer advocate employed by the hospital would be ideal, because peers are often less threatening. It must be understood by the person administering the form that the form is not presented as treatment or therapy, but as helpful information that can be included in the treatment plan.
5. To effectively provide information, person administering the form should be knowledgeable about how this material pertains to treatment. It would be helpful for them to learn and know about efforts being made at the facility to reduce seclusion and restraint and how this information will be used as part of that process. Facilitators should also be able to answer questions or provide clarification. For

example, it is important that information about touching at the facility is presented as promoting appropriate, not inappropriate, touching.

6. When individuals are not communicative enough to answer questions, they may be provided an opportunity to answer the questions at another time, if they so desire.
7. Individuals must always be given the option of decline answering any or all questions.
8. the form, when completed, should be placed in the individual's file where it is known and used effectively by staff. It is recommended that a means of ready-reference, such as a tickler file, be kept at the desk in the nurses' station for easy availability in potential emergency situations.
9. Individuals should be told how the form is to be used. They shall be offered a copy of the form to keep.
10. It may be helpful for the facility to collect data on answers to some of these questions to identify patterns that are important to individuals receiving services that can be used to determine how to improve treatment and programming.

## ATTACHMENT E

### DEBRIEFING - FOR THOSE WHO WERE PUT IN RESTRAINTS OR SECLUSION

I would like to talk with you about your experience of being put in seclusion/restraint. Would you be willing to do this?

**If yes:**

How do you feel about being put in seclusion/restraint?

Are you angry that this was done?

Are you scared that this might happen again?

Are there things that we could have done better that could have prevented this from happening?

Were you upset about something prior to being put into seclusion/restraint?

Would you like to talk about that?

Do you know why you were upset?

Do you think you could have done things differently?

Is there anything else you would like to talk about?

**If no or unresponsive:**

Would you like me to sit with you for awhile?

**If yes or unresponsive:**

Sit with person for awhile. Wait a few minutes (at least) before asking any questions. Maintain dialog if person begins speaking. Gradually ask above questions, giving the person plenty of time.

**If answer is no:**

Tell him/her that you will be around for a while (if true) and if they change their mind you will be available to talk with them. Provide them a copy of the questions. Check back with them after awhile.

### DEBRIEFING FOR THOSE WHO HAVE WITNESSED AN ACT OF SECLUSION/RESTRAINT (EITHER GROUP OF INDIVIDUAL)

Was anyone scared about what was happening?

What were you feeling?

Are you afraid that something like that might happen to you?

Do you feel that what was done was appropriate?

Why or why not?

Do you think we could have handled anything differently?

What could we do to avoid things like that happening again?

Does anyone have anything else to say?

In case anyone thinks of anything later, I would like to hear it so please let me know.

SECLUSION/RESTRAINT DEBRIEFING

TYPE OF EVENT: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

DEBRIEFING DATE/TIME:

WHAT LED TO THE EVENT?       Harmful to self       Harmful to others

What methods were used to avoid seclusion/restraint?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Ventilation of feelings | <input type="checkbox"/> Environmental change       | <input type="checkbox"/> Verbal assurance/redirection |
| <input type="checkbox"/> Limit setting           | <input type="checkbox"/> 1:1 interaction with staff | <input type="checkbox"/> Time out                     |
| <input type="checkbox"/> Reduction in stimuli    | <input type="checkbox"/> Medication                 |   |

Did staff address your:

- |                        |                              |                             |
|------------------------|------------------------------|-----------------------------|
| Physical well-being:   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Psychological comfort: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Right to privacy:      | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Have you ever been secluded or restrained before:       YES       NO

Did you experience any pain or discomfort:       YES       NO  
If yes, please describe pain: \_\_\_\_\_

Did you receive any injury during seclusion/restraint:       YES       NO  
If yes, please describe: \_\_\_\_\_

Did you understand the reason for the use of seclusion/restraint?       YES       NO

Did staff counsel you for any trauma that may have resulted from the incident:       YES       NO

What can you and our staff do to avoid seclusion/restraint in the future?  
\_\_\_\_\_

Recommendations for improvement in care:  
\_\_\_\_\_

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE      DATE      TIME

STAFF SIGNATURES:

\_\_\_\_\_  
SIGNATURE      DATE      TIME

\_\_\_\_\_  
SIGNATURE      DATE      TIME

SECLUSION/RESTRAINT STAFF DEBRIEFING

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ SHIFT: \_\_\_\_\_ DAY OF WEEK: \_\_\_\_\_

