

Attachment J

CAMHD Seclusion and Restraints Policy & Procedures

**CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL**

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REFERENCE: Child Health Act, Public Law No. 106-310; 42 CFR Parts 441 and 483; CMS; American Academy of Child and Adolescent Psychiatry Policy Statement; AHA, "Guiding Principles on Restraint and Seclusion for Behavioral Health Services," Feb.'99; CAMHD Sentinel Event Policy.	APPROVED:	
	<i>Signature on File</i>	03/13/07
	Chief	Eff. Date

PURPOSE

To provide a uniform set of standards and guidelines, conducive with Centers for Medicare and Medicaid Services (CMS) requirements, for the use of restraint or seclusion for youth in out-of-home placements in Child and Adolescent Mental Health Division (CAMHD)-contracted programs.

DEFINITIONS

Emergency safety situation: when unanticipated youth behavior places the youth or others at serious threat of violence or injury if no intervention occurs and calls for an emergency safety intervention as defined in this section.

Emergency safety intervention: Intervention or action performed in a manner that is safe, proportionate, appropriate to the severity of the behavior, and the youth's chronological and developmental age, size, gender, physical, medical, psychiatric condition and personal history (including any history of physical or sexual abuse) to ensure the safety of the youth and others.

Seclusion: The *involuntary* confinement of a youth in a locked and/or secure room to ensure the safety of the youth or others. Any such isolation in a secure environment from which the youth is not potentially free to leave is considered seclusion (*e.g.*, having a staff member block the exit from the unlocked seclusion room).

Serious occurrence: A youth's death, serious injury or suicide attempt.

Restraint: The restriction of freedom of movement through personal, drug or mechanical means in order to protect the individual from injury to self or to others. There are no distinguishing time limits among any form of restraint.

Mechanical Restraint: Any device attached or adjacent to the youth's body (*e.g.*, four-point bed restraint) that restricts a youth's movement.

Personal (Physical) Restraint: Involves any use of physical force to restrict a youth's freedom of movement. Personal escorts where the youth is willfully cooperating with the escort is not considered a restraint until such time as the youth no longer intends to follow or be escorted (*e.g.*, youth struggles with staff).

Drug (Chemical) Restraint: Any drug that:

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1. Is administered to manage a youth’s behavior in a way that reduces the safety risk to the youth or others;
2. Has the temporary effect of restricting the youth’s freedom of movement; and
3. Is not a standard treatment for the youth’s medical or psychiatric condition.

Time Out: The removal of youth from peers or rewarding situations that does not involve seclusion. Time Out is not used as a primary purpose to confine the youth, only to separate the youth from others. Such a restriction requires constant monitoring by staff. The individual is not physically prevented from leaving the designated time-out area.

Serious Injury: Any significant impairment of the physical condition of the youth as determined by qualified medical personnel, including, but not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Sentinel Event: An occurrence involving serious physical or psychological harm to anyone or the risk thereof, as defined under the categories of sentinel event codes and definitions. A sentinel event includes:

- any inappropriate sexual contact between youth, or credible allegation thereof;
- any inappropriate, intentional physical contact between youth that could reasonably be expected to result in bodily harm, or credible allegation thereof;
- any physical mistreatment of a youth by staff, or credible allegation thereof;
- any accidental injury to the youth or medical condition requiring attention by a medical professional or transfer to a medical facility for emergency treatment or admission;
- medication errors and drug reactions;
- any fire, spill of hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or
- any incident of elopement by a youth.

POLICY

1. Each client has the right to be free from restraint or seclusion of any form that is used as a means of coercion, discipline, convenience, or retaliation. For CAMHD-contracted providers providing intensive home and community-based intervention services, the CAMHD recognizes that seclusion and restraint are not available or practicable at these

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levels of care and therefore, are not generally used in such settings. Mental health professionals providing intensive home and community-based intervention services who might encounter potentially dangerous or otherwise unsafe situations in the community should be knowledgeable about resources and be sufficiently trained to recognize when police, mobile outreach, or emergency services are needed and then be able to assist in accessing the appropriate intervention.

2. Non-aversive interventions and positive behavioral supports shall be the ***absolute first course of action*** to ensure the safety of the youth and others. These strategies must be part of a programmatic plan to anticipate and manage a youth's unsafe behavior and must be clearly documented that such non-aversive strategies were the first course of action.
3. Evidence of the use of non-aversive interventions and positive behavior supports is the expectation of all levels of care.
4. Uses of restraint or seclusion are safety interventions ***of last resort*** and only in situations where risk of danger to the youth or others is reasonably imminent. Restraint or seclusion:
 - A. Is not used as a treatment intervention.
 - B. Must terminate when the emergency safety situation has ended and the safety of all can be ensured, even if the order has not expired.
 - C. Is prohibited from the simultaneous use.
 - D. May not exceed four (4) hours for 18-21 year olds, two (2) hours for 9-17 year olds, and one (1) hour for children under 9 years of age.
 - E. Must not involve the use of mouth coverings.
 - F. Must not result in harm or injury to the youth.
 - G. Standing orders and as-needed (PRN) orders are prohibited.

PROCEDURE

1. CAMHD shall contractually require that each contracted provider agency must have policies and procedures regarding the use of restraint or seclusion. The policies and procedures must include, but are not limited to, the following:
 - A. The training that staff must receive prior to using restraint or seclusion with an emphasis on the serious potential for restraint or seclusion to cause injury or death;
 - B. Reviewing and updating restraint and seclusion policies and procedures regularly based on clinical outcomes;

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- C. Agency-wide priority to use restraint or seclusion appropriately, safely and in accordance the agency’s restraint and seclusion policies and procedures;
 - D. Adequate allocation of resources to prevent the frequent use of restraint or seclusion; and
 - E. Appropriate decision-making guidelines for when the use of restraint or seclusion is necessary.
2. Restraint or Seclusion Orders
- A. Drug restraints must be preceded by a written order by a qualified physician. That physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.
 - B. Only a board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases, may order the use of restraint or seclusion.
 - 1. Such orders utilize the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
 - 2. Each order must include:
 - a. The name and signature of the staff issuing the order;
 - b. The date and time the order was issued; and
 - c. The type of emergency safety intervention order, including the length of time authorized.
 - 3. For Hospital-Based Facilities: A board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases who issued the order must conduct a ***face-to-face assessment*** of the youth's well being ***within one (1) hour of the initiation of the emergency safety intervention***.
 - 4. For Non-Hospital-Based Programs: If the authorized individual who issued the order is not available, Centers for Medicare and Medicaid Services (CMS) regulations require a clinically qualified registered nurse trained in the use of emergency safety interventions must conduct a ***face-to-face assessment*** of the youth's well being ***within one (1) hour of the initiation of the emergency safety intervention***.
 - 5. All assessments will include, but are not limited to:

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- a. The youth's physical and psychological status;
 - b. The youth's behavior;
 - c. The appropriateness of the intervention measures; and
 - d. Any complications resulting from the intervention.
6. The board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases issuing the order must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.
 7. If the emergency safety situation continues beyond the time limit of the order for the use of restraint or seclusion , a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the person who issued the order to receive further instructions.
 8. In the absence of a board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases, verbal orders must be received by a registered nurse at the time the emergency safety intervention is initiated by staff and the physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

Each order must include:

- a. The name of the staff issuing the order;
 - b. The date and time the order was obtained;
 - c. The type of emergency safety intervention ordered, including the length of time authorized; and
 - d. The signature of the staff issuing the order that verifies the verbal order within *twenty-four (24) hours of the order*.
- C. If the youth's treatment team psychiatrist is available, only he or she can order restraint or seclusion.
 - D. If the treatment team psychiatrist is not the person issuing the order, he or she must be consulted as soon as possible and informed of the situation that required the restraint or seclusion. The date and time of this action must be documented. The program must document attempts to establish contact within 24 hours.
 - E. Written orders are never issued as standing orders or *as-needed* basis.

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3. Monitoring of the Youth:
 - A. Clinical staff, trained in the use of emergency safety interventions, must be physically present, continually assessing and monitoring the physical and psychological well-being of the youth and the safe use of restraint throughout the duration of the emergency safety intervention.
 - B. Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside of the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the youth in seclusion. Video monitoring does not meet this requirement. The seclusion room must:
 1. Allow staff full view of the youth in all areas of the room; and
 2. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.
4. Parental Notification
 - A. At admission, parents or legal guardians and youths are informed of the program's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur. The policy is communicated in a language understood by the youth and his/her parents or legal guardians.
 - B. Each youth and/or his legal guardian shall be provided with a copy of the program's policy. The policy will inform them of the grievance procedure if they feel that this right has been violated.
 - C. The youth and/or parents/legal guardian (if the youth is a minor) will acknowledge in writing that they have been informed of and understand the facility's policy. This written acknowledgement will be filed in the youth's record.
 - D. The program must notify the parent(s) or legal guardian(s) that the youth has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention. Documentation of this notification, including the date and time of notification and the name of the staff person providing the notification, will be placed in the youth's file. The program must document attempts to establish contact within twenty-four (24) hours.
5. Post-Intervention Debriefings
 - A. Within twenty-four (24) hours after the use of restraint or seclusion, the youth and all staff (except when the presence of a particular staff person may jeopardize the well-being of the resident) involved in the emergency safety intervention must have a face-to-face discussion.

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- B. Other staff and the parents or legal guardians may participate when it is deemed appropriate by the facility. If this occurs the program must conduct such a discussion in a language that is understood by the parents or legal guardians. The discussion must provide both the youth and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the youth, or others that could prevent the future use of restraint or seclusion.

- C. Within twenty-four (24) hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of:
 - 1. The emergency safety situation that required the intervention, including a discussion of the *precipitating factors* that led up to the intervention;
 - 2. Alternative techniques that might have prevented the use of the restraint or seclusion;
 - 3. The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
 - 4. The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

- D. The agency must document in the youth's record that *both* debriefing sessions took place and must include the names of staff who were present for the debriefing, names of staff who were excused, and any changes to the youth's treatment plan that resulted from the debriefings.

- 6. Medical Treatment
 - A. Staff must immediately obtain medical treatment from qualified medical personnel for a youth injured as a result of an emergency safety intervention.
 - B. The program must have affiliations or written transfer agreements with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that:
 - 1. A youth will be transferred to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;
 - 2. Medical and other information needed for care of the youth will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

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3. Services are available to each youth twenty-four (24) hours a day, seven (7) days a week.
 - C. Staff must document in the youth's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention. Staff must also document any indications or allegations of injury or misconduct made by the youth along with the program's determination of appropriate follow-up.
 - D. Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.
7. Facility/Program Reporting
- A. Each agency must record, maintain, and track, any use of seclusion and restraint following the use of the most recent and current Centers for Medicare and Medicaid Services accreditation requirements. At a minimum, reporting information shall include:
 1. The type of restraint or seclusion used;
 2. Staff involved;
 3. Documentation of the verbal and/or written order;
 4. Witnesses to the restraint/seclusion;
 5. The time frame and duration of use;
 6. The rationale for restraint or seclusion;
 7. The types of less restrictive alternatives that were tried or considered; and
 8. An assessment of the youth's adjustment during the episode and reintegration to the daily program.
 - B. A sentinel event telephone call is made to CAMHD within twenty-four (24) hours of the occurrence of the restraint or seclusion. A complete documentation of the episode will follow in the CAMHD seventy-two (72) hour Sentinel Event Report, including (1) a review of the less restrictive alternatives that were considered, and (2) a reference to the debriefing with all staff involved in the event.
 - C. Psychiatric residential treatment facilities must report each serious occurrence to both the state Medicaid agency and the state protection and advocacy system no later than close of business the next business day after a serious occurrence.
 1. Serious occurrences include: Youth's death; serious injury (refer to definition, page 2 of this policy), and youth's suicide attempt.

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2. Staff must document in the youth's record that the serious occurrence was reported and the name of the person to whom it was reported. ***A copy of this report must be maintained in the incident and accident report logs kept by the facility.***
 3. The report must include the name of the resident, description of the occurrence, and the name, street address, and telephone number of the facility.
 4. The facility must notify the youth's parent or legal guardian as soon as possible, but no later than twenty-four (24) hours after the serious occurrence.
8. Education and Training
- A. The facility must require staff to have ongoing education, training, and demonstrated knowledge of:
 1. Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;
 2. The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to present emergency safety situations; and
 3. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in youths that are restrained or in seclusion.
 - B. The facility must require or adhere to:
 1. Staff certification in the use of cardiopulmonary resuscitation, including annual re-certification;
 2. Individuals who are qualified by education, training, and experience must provide staff training;
 3. Staff training must include training exercises in which staff successfully demonstrates in practice the techniques they have learned for managing emergency safety situations;
 4. Trained staff who have demonstrated competency before participating in an emergency safety intervention;
 5. Documentation in individual personnel records certifying successful training and demonstration of competency. Documentation must include the date training was completed and the name of the persons certifying the completion of training;

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6. Initial training must be a minimum of eight (8) hours in duration. Staff must receive at least eight (8) hours of training in crisis intervention annually. At least two (2) times a year, a staff person must safely demonstrate the safe use of restraint or seclusion techniques; and
7. The availability of all training programs and materials for review by CMS, State Medicaid agency, and CAMHD.

ATTACHMENT: None