DRAFT - NOT FOR FILING

5122-26-16.1 ~~Mechanical restraint~~Restraint and seclusion.

(A) The purpose of this rule is to state the specific requirements applicable to ~~mechanical~~ restraint and seclusion.

(B) The requirements for the use of mechanical restraint or seclusion do not apply:

(1) To mechanical restraint use that is only associated with medical, dental, diagnostic, or surgical procedures and is based on standard practice for the procedure. Such standard practice may or may not be described in procedure or practice descriptions (e.g., the requirements do not apply to medical immobilization in the form of surgical positioning, iv arm boards, radiotherapy procedures, electroconvulsive therapy, etc.);

(2) When a device is used to meet the assessed needs of an individual who requires adaptive support (e.g., postural support, orthopedic appliances) or protective devices (e.g., helmets, tabletop chairs, bed rails, car seats). Such use is always based on the assessed needs of the individual. Periodic reassessment should assure that the restraint continues to meet an identified individual need;

(3) To forensic and corrections restrictions used for security purposes, i.e., for custody, detention, and public safety reasons, and when not involved in the provision of health care.

(C) In addition to the definitions in rule 5122-24-01 of the Administrative Code, the following definitions apply to this rule:

(1) "Licensed independent practitioner" means an individual who is authorized by the provider to order seclusion and restraint. A licensed independent practitioner includes a "medical practitioner authorized to order seclusion and restraint" as defined in (2) of this paragraph, as well as a licensed psychologist, licensed independent social worker, licensed professional clinical counselor, licensed independent chemical dependency counselor, or a registered nurse.

(2) "Medical practitioner authorized to order seclusion and restraint" means an individual who is authorized by the provider to order seclusion and restraint and who is a psychiatrist or other physician, or a physician's assistant, certified nurse practitioner or clinical nurse specialist authorized to order restraint or seclusion in accordance with his or her scope of practice and as permitted by applicable law or regulation.

(3) "Order" means written authorization to implement seclusion or restraint.

(4) "Psychiatric residential treatment facility" means a provider that offers inpatient psychiatric services for individuals under age 21 in accordance with 42 C.F.R. 441.151 to 441.182.

~~(C)~~ (D) ~~Mechanical restraint~~Restraint or seclusion shall not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is possible. It shall be employed for the least amount of time necessary in order that the individual may resume his/her treatment as quickly as possible.

(E) Prohibitions

(1) PRN and standing orders for seclusion or restraint.

(2) Restraint and seclusion may not be used simultaneously.

(3) Mechanical restraint may not be used on an individual under age eighteen.

~~(D)~~ (D) ~~Implementation of mechanical restraint or seclusion.~~

~~(1)~~ (1) ~~Authorized staff may implement mechanical restraint or seclusion at the direction and in the presence of an individual with specific clinical privileges/authorization granted by the provider to authorize mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, clinical nurse specialist, or registered nurse.~~

~~(2)~~ (2) ~~Upon any implementation of mechanical restraint or seclusion, an individual with specific clinical privileges or authorization granted by the provider shall:~~

~~(a)~~ (a) ~~Perform an assessment and document it in the clinical record. This assessment shall include, at minimum:~~

~~(i)~~ (i) ~~The reason for the utilization of mechanical restraint or seclusion;~~

~~(ii)~~ (ii) ~~All prior attempts to use less restrictive interventions;~~

~~(iii)~~ (iii) ~~Notation that any previously identified contraindication to the use of mechanical restraint or seclusion were considered and the rationale for continued implementation of mechanical restraint or seclusion despite the existence of such contraindications; and~~

~~(iv)~~ (iv) ~~A review of all current medications.~~

~~(v)~~ (v) ~~Documentation of the individual's history of traumatic experiences as a means to gain insight into origins and patterns of the individual's actions.~~

~~(b)~~ (b) ~~Assess and document vital signs; and~~

~~(c)~~ (c) ~~Explain to the individual the reason for mechanical restraint or seclusion, and the required behaviors of the individual which would indicate sufficient behavioral control so that mechanical restraint or seclusion can be discontinued.~~

~~(3)~~ (3) ~~For adults in mechanical restraint, an assessment shall include health and related safety concerns including body positioning, comfort and circulation.~~

~~(E)~~ (F) Ordering mechanical restraint or seclusion.

(1) Orders shall be in writing and issued by a licensed independent practitioner, and include the date and time the order was written or obtained. In a psychiatric residential treatment facility, the order must be issued by a medical practitioner authorized to order seclusion and restraint.

(a) The order for restraint or seclusion must be the least restrictive intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff and specify the type of intervention and the maximum length of time.

(b) Additional requirements for a psychiatric residential treatment facility.

If the resident's treatment team physician is available, only he or she may order restraint or seclusion. If the resident's treatment team physician is not available, the individual who orders restraint or seclusion must:

(i) Consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion; and

(ii) Document in the resident's record the date and time the treatment team physician was consulted.

(2) Verbal orders.

(a) When a licensed independent practitioner is not available in person to order restraint or seclusion, agency policy may permit staff to obtain a verbal order from a licensed independent practitioner while the restraint or seclusion is being initiated by staff, or immediately after the intervention ends, whichever is sooner.

In a psychiatric residential treatment facility, the verbal order must be obtained by a licensed or registered nurse from a medical practitioner authorized to order seclusion and restraint. The medical practitioner ordering seclusion or restraint must be available to staff for consultation, at least by telephone, throughout the period of the seclusion or restraint intervention.

(b) The verbal order must be signed within forty-eight hours by a licensed independent practitioner. In a psychiatric residential treatment facility, the verbal order must be signed by the ordering practitioner.

~~(1)~~ (1) ~~Orders shall be written only by an individual with specific clinical privileges or authorization granted by the provider to order mechanical restraint or seclusion, and who is a:~~

~~(a)~~ (a) ~~Psychiatrist or other physician; or~~

~~(b)~~ (b) ~~Physician's assistant, certified nurse practitioner or clinical nurse specialist authorized to order restraint or seclusion in accordance with his or her scope of practice and as permitted by applicable law or regulation.~~

~~(2)~~ (3) ~~Orders~~ Written and verbal orders may be written for a maximum of:

(a) ~~Two hours for mechanical~~ Four hours for restraint or seclusion of adults eighteen years of age or older;

(b) ~~One~~ Two ~~hour~~ hours for restraint or seclusion of children and adolescents age nine through seventeen; or

(c) ~~Thirty minutes~~ One hour for restraint or seclusion of children under age nine.

(4) If restraint is necessary as a means of safely transporting an individual to seclusion, a separate order is not required. However, the initial order for the seclusion must include the physical transport restraint and be consistent with the requirements for restraint/seclusion orders.

(5) If the restraint or seclusion continues past the original time in the order, staff shall contact the individual who issued the original order who shall issue a new written or verbal order if seclusion or restraint is to be continued. In a psychiatric residential treatment facility, a registered nurse shall be the person who contacts the medical practitioner.

(6) If the restraint or seclusion episode is concluded, and the client's behavior requires initiating another

restraint or seclusion, then a new order must be obtained, even if the ending time of the original order has not passed.

~~(3)~~ (3) ~~Prn orders are prohibited, whether individual or as a part of a protocol.~~

~~(4)~~ (4) ~~When indicated, a verbal order from an individual with specific clinical privileges or authorization granted by the provider to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist shall be obtained by a registered nurse upon implementation of mechanical restraint or seclusion, or within one hour. Such order shall be signed within twenty four hours by an individual with specific clinical privileges or authorization granted by the provider to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist.~~

~~(5)~~ (5) ~~After the original order for mechanical restraint or seclusion expires, the individual shall receive a face-to-face reassessment, as described in subsection five of this paragraph. The reassessment shall be by performed by an individual with specific clinical privileges or authorization granted by the provider to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist, who shall write a new order if mechanical restraint or seclusion is to be continued. However, provider policy and the original order may permit a registered nurse to perform such reassessment and make a decision to continue the original order for an additional:~~

~~(a)~~ (a) ~~Two hours for mechanical restraint or seclusion of adults eighteen years of age or older up to a maximum of twenty-four hours;~~

~~(b)~~ (b) ~~One hour for seclusion of children and adolescents age nine through seventeen up to a maximum of twenty-four hours; or~~

~~(c)~~ (c) ~~Thirty minutes for seclusion of children under age nine up to a maximum of twelve hours.~~

~~(6)~~ (6) ~~Continuation of orders cannot under any circumstances exceed the maximums stated in this paragraph without a face-to-face reassessment and a new written order. The reassessment shall be performed and new order written by an individual with specific clinical privileges or authorization granted by the agency to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist.~~

~~Such assessment shall be documented in the clinical record. It shall address the need for continued mechanical restraint or seclusion. It shall include a mental status examination, physical assessment, gross neurological assessment, and an assessment of the individual's verbal statements, level of behavioral control, and responses to stimuli and treatment interventions, unless contra-indicated for clear treatment reasons which shall be documented in the clinical record.~~

~~(7)~~ (G) Implementation of restraint or seclusion. ~~Mechanical restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.~~

(1) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(2) Within one hour of the initiation of the seclusion or restraint intervention, a licensed independent

practitioner must conduct an in person, face-to-face assessment of the physical and psychological well-being of the individual. In a psychiatric residential treatment facility, this assessment must be conducted by a medical practitioner authorized to order seclusion and restraint or a registered nurse. The assessment is to be conducted even if the seclusion or restraint intervention is ended before one hour. The assessment is to include, but is not limited to:

(a) The individual 's physical and psychological status;

(b) The individual 's behavior;

(c) The appropriateness of the intervention measures; and

(d) Any complications resulting from the intervention.

(3) Monitoring while in and immediately after seclusion or restraint.

(a) Restraint.

(i) A staff trained in the use of restraint, but not involved in the restraint must be physically present, continually assessing and monitoring the physical and psychological well-being of the individual and the safe use throughout the duration of the intervention. In a PRTF, the staff must be a licensed clinical staff.

(ii) Documentation of the condition of the person shall be made in the clinical record at routine intervals not to exceed fifteen minutes or more often if the person's condition so warrants. Such documentation shall address at a minimum, attention to respiration, the individual's physical status and behavior, the need for continued restraint, and other needs as necessary, and the appropriate actions taken. In a PRTF, documentation must be made at least every five minutes

(b) Seclusion.

(i) A staff trained in the use of seclusion must be physically present either in or immediately outside the seclusion room, continually assessing and monitoring the physical and psychological well-being of the individual and the safe use throughout the duration of the intervention. In a PRTF, the staff must be a licensed clinical staff. Use of video conferencing or similar technology does not meet this requirement.

(ii) Documentation of the condition of the person shall be made in the clinical record at routine intervals not to exceed fifteen minutes or more often if the person's condition so warrants. Such documentation shall address at a minimum, attention to respiration, the individual's physical status and behavior, the need for continued seclusion, and other needs as necessary, and the appropriate actions taken. In a PRTF, documentation must be made at least every five minutes

(c) At the conclusion of the restraint, a licensed clinical staff must immediately check the resident for any injuries, evaluate the individual's psychological well-being and document the results. In a PRTF, the staff must be a physician, physician's assistant, certified nurse practitioner, clinical nurse specialist or registered nurse.

(4) Staff must assure that a client injured during a restraint or seclusion intervention receives immediate medical treatment that is appropriate for the specific injury.

(H) Notification of the use of seclusion or restraint.

(1) If the client is a minor, the provider must notify the parent(s), custodian(s) or legal guardian(s) of the individual who has been restrained or placed in seclusion as soon as possible after the initiation of each episode.

(2) If the client is an adult, the provider must notify the client's guardian, when applicable, or family or significant other when the client has given their consent for such notification, within twenty-four hours of initiation of each episode.

(3) The provider must document in the client's record that the notification was made, including the date and time of notification, the name of the person(s) notified and the name of the staff person providing the notification.

(I) Debriefing.

(1) The agency shall conduct two debriefings to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the client, or others that could prevent the future use of restraint or seclusion. Both debriefing shall include discussion of:

(a) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;

(b) Alternative techniques that might have prevented the use of the restraint or seclusion;

(c) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

(d) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

(2) Client debriefing. Within 24 hours after the use of restraint or seclusion, all staff directly involved in a seclusion or restraint intervention and the client must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the client. Other staff may participate in the discussion when it is deemed appropriate by the agency.

(a) The agency shall invite the client’s parent(s), custodian(s) or legal guardian(s) to participate in the discussion.

(b) The debriefing shall be conducted in a language understood by the client, and his or her parent(s), custodian(s) or guardian(s).

(3) Staff debriefing. Within 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.

(4) Staff must document in the client’s record that both debriefing sessions took place and must include in that documentation the elements in paragraph (I)(1) of this rule, the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.

(J) Staff involved in a restraint or seclusion intervention that results in an injury to a client or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries. This documentation may be included with the client debriefing or contained elsewhere. The plan to prevent future injuries is to include at a minimum attention to revised procedures, and new or additional staff training.

(K) Documentation.

Staff must document the intervention in the client's ICR. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

(1) Each order for restraint or seclusion as required in paragraph (F) of this rule, and for a PRTF, documentation of consultation described in paragraph (F)(1)(b) of this rule, including the date and time of the consultation, when applicable.

(2) The time the restraint or seclusion began and ended.

(3) The client's behavior that required the client to be restrained or put in seclusion.

(4) Attempts to offer alternatives to the client based upon his/her crisis plan and/or de-escalation techniques, as applicable

(5) Each attempt to use less restrictive interventions, and the results.

(6) The time and results of the 1-hour assessment required in paragraph (G)(2) of this rule.

~~(8)~~ (7) The time and results of the on-going monitoring required in paragraph (G)(3) of this rule.

~~(9)~~ (8) The name of all staff involved in the restraint or seclusion, including the staff that conducts the one-hour assessment and the staff who ordered the restraint or seclusion.

~~(10)~~ (9) All injuries that occur as a result of the restraint or seclusion, including injuries to staff resulting from the intervention. Detailed information about any staff injury may be maintained outside the client's ICR. The appropriate actions taken for any injuries noted shall also be documented.

~~(F)~~ (F) ~~Continuous monitoring of persons in mechanical restraint or seclusion.~~

~~(1)~~ (1) ~~While in mechanical restraint or seclusion, persons shall be continuously monitored, i.e., constant visual observation by staff in a manner most conducive to the situation or person's condition.~~

~~(2)~~ (2) ~~Documentation of the condition of the person shall be made in the clinical record at routine intervals not to exceed fifteen minutes or more often if the person's condition so warrants. Such documentation shall address attention to vital signs, circulation, range of motion, nutrition, hydration, hygiene, toileting, the need for continued mechanical restraint or seclusion, and other needs as necessary, and the appropriate actions taken.~~

~~(3)~~ (3) ~~Upon conclusion of the mechanical restraint or seclusion, the results of a check of injuries shall be conducted and documented.~~

~~The appropriate actions taken for any injuries noted shall also be documented.~~

~~(G)~~ (L) Seclusion room requirements.

(1) The type of room in which seclusion is employed shall ensure:

(a) Appropriate temperature control, ventilation and lighting;

(b) Safe wall and ceiling fixtures, with no sharp edges;

(c) The presence of an observation window and, if necessary, wall mirror(s) so that all areas of the room are observable by staff from outside of the room; and

(d) That any furniture present is removable or is securely fixed for safety reasons.

~~(H)~~ (M) Clinically appropriate reason for the inability to implement any portion of this rule shall be documented in the clinical record, and shall be addressed in any staff de-briefing of the episode and in the provider's performance improvement process.