



Promoting Wellness and Recovery

John R. Kasich, Governor  
Tracy J. Plouck, Director

## **Seclusion and Restraint OAC Rules 5122-26-16 through 16.2 Effective April 1, 2016**

**Janel M. Pequignot, Chief  
Licensure and Certification**

### **Deemed Status**

- Outpatient or AoD MH Agencies:
  - If your provider has been granted deemed status by the department, you are deemed for seclusion and restraint.
    - Tip - pay attention to who is allowed to order seclusion & mechanical restraint, in accordance with Ohio Law.
- Type 1 Mental Health Residential
  - MHAS will review seclusion and restraint in Children's Residential Facilities and may review seclusion and restraint in Adult Residential

## Order of Rules Presented in Webinar

- Rules are grouped by and presented in an order to demonstrate their use toward your agency mission to eliminate the use of S/R
- Rules Covered Today:
  - 5122-26-16 Seclusion, restraint & time-out
  - 5122-26-16.1 Mechanical restraint & seclusion
  - 5122-26-16.2 Physical restraint
- Rule numbers throughout the presentation should correspond to 5122-26-16 unless otherwise noted.

## Restraint is Not...

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

## Definitions

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

(C)(6) "Physical restraint", also known as "manual restraint", means any method of physically restricting a person's freedom of movement, physical activity, or normal use of the person's body without the use of mechanical restraint devices.

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



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## Incident Reporting

## Incident Reporting

- (H)(2) Pursuant to rules 5122-26-13 and 5122-30-16 of the Administrative Code, the provider shall notify the department of each:
  - (a) Instance of physical injury to a client or resident that is restraint-related, e.g., injuries incurred when being placed in seclusion or restraint or while in seclusion or restraint, with the exception of injury that is self-inflicted, i.e. a client or resident banging their own head;
  - (b) Death that occurs while a person is restrained or in seclusion;
  - (c) Death occurring within twenty four hours after the person has been removed from restraints or seclusion, and
  - (d) Death where it is reasonable to assume that a person's death may be related to or is a result of such seclusion or restraint.



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## Core Philosophy

## Intro Paragraph

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

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

## Intro Paragraph

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

## Intro Paragraph

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

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



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**Implement standards in order to reduce the use of or prevent the need for seclusion and/or restraint.**

## Standards that Address Reducing Use or Prevention

- (D)(8) The inclusion of clients (including children), families, and external advocates in various roles and at all provider levels to assist in reducing the use of seclusion or restraint shall be considered.
- (E) Policies and procedures
  - (2) Policies and procedures governing the use of seclusion or restraint shall include attention to preservation of the person's health, safety, rights, dignity, and well-being during use. Additionally:
    - (b) Use of the environment, including the possible addition of comfort and sensory rooms, shall be designed to assist in the person's development of emotional self-management skills; and
- (C)(3) "Comfort rooms", (formerly known as quiet or time-out rooms), are adapted sensory rooms that provide sanctuary from stress or can be places for persons to experience feelings within acceptable boundaries.
- (C)(11) "Sensory rooms" means appealing physical spaces painted with soft colors with the availability of furnishings and objects that promote relaxation and/or stimulation.

## Staff Training to Minimize Use

- (F) Staff training
  - (1) The provider shall ensure that all direct care staff and any other staff involved in the use of seclusion or restraint receive initial and annual training designed to minimize their use.
    - (a) Staff shall be trained and demonstrate competency in the correct and appropriate use of non-physical techniques for intervention, such as mediation and conflict resolution, and de-escalation of disruptive or aggressive acts, persons or situations; and
    - (b) Staff shall be trained in understanding how their behavior can affect the behavior of clients

## Some Ideas Regarding Staff Training (Not Requirements)

- Trauma informed care
  - <http://www.samhsa.gov/nctic>
- Staff training in mediation, conflict resolution
  - More useful if leadership empowers staff (with guidance) to make immediate decisions about program rules/expectations to respond to events (e.g. power struggle about attending a group or meal time). On-going issues are treatment team matters.

## Some Ideas Regarding Staff Training (Not Requirements)

- Understanding imminent threat/danger
  - How is it defined, recognized?
- Involve consumers in training
- Provide alternatives to S/R
  - Giving staff tools and teaching skills needed has more success than telling staff “we are no longer going to...”
- How staff can document or share “success”
  - If something worked w/ a consumer to de-escalate, prevent S/R, communicate the information to other staff
- Use a vendor for staff training that has data showing reduction in other agencies/facilities which have used its programs

## Reducing Use or Prevention

- (D)(7) A thorough review and analysis of each incident of the use of seclusion or restraint shall be undertaken in order to use the knowledge gained from such analysis to inform policy, procedures, and practices to avoid repeated use in the future and to improve treatment outcomes. Secondly, such analysis should help to mitigate, to the extent possible, the adverse and potentially traumatizing effects of a seclusion or restraint event for involved staff, clients, and for all witnesses to the event.

## S/R Debriefing 5122-26-16 (G) Documentation

- (G)(4) Debriefings following the conclusion of each incident of seclusion or restraint shall be documented, and shall include, at a minimum:
  - (a) The incident and antecedent behaviors which lead to the use of seclusion or restraint;
  - (b) What actions might have prevented the use of seclusion or restraint; and what techniques and tools might help the individual manage his or her own behavior in the future;
  - (c) The person's reaction to the method, including whether there is any need for counseling or other services related to the incident; and
  - (d) Whether any modifications to the person's ISP, ITP or individual crisis plan are needed.

## S/R Debriefing

- Use this information to reduce use of or prevent future need for S/R
  - Treatment plan modifications
  - New/Revised Crisis plan
    - ❖ (C)(4) "Individual crisis plan" means a written plan that allows the person to identify coping techniques and share with staff what is helpful in assisting to regain control of the person's behavior in the early stages of a crisis situation. It may also be referred to as a "behavior support plan."
  - Modification to program rules or expectations
  - Staff training
  - Performance improvement
  - ???

## Crisis Plan 5122-26-16 (G) Documentation

- (G)(2) In conjunction with the person's active participation, an individual crisis plan shall be developed at the time of admission and incorporated in the person's ISP or ITP for each child or adolescent resident of a department licensed residential facility, for each client known to have experienced seclusion or restraint, and when otherwise clinically indicated.
- The plan shall be based on the initial alcohol and other drug (AoD) or mental health assessment, and shall include and be implemented, as feasible, in the following order:
  - (a) Identification of the methods or tools to be used by the client to de-escalate and manage his or her own aggressive behavior;
  - (b) Identification of techniques and strategies for staff in assisting the person to maintain control of his or her own behavior; and
  - (c) Identification, in order of least restrictive to most restrictive, of the methods or tools to be used by staff to de-escalate and manage the client's aggressive behavior.



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**Apply seclusion and restraint in a safe, effective method to reduce risk of harm to the consumer and staff, and try to prevent its re-occurrence.**

## **S/R Permitted Only in Response to Imminent Risk**

- (D)(1) Seclusion or restraint 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 identified.
  - (a) They shall not be used as behavior management interventions, to compensate for the lack of sufficient staff, as a substitute for treatment, or as an act of punishment or retaliation.
  - (b) Absent a co-existing crisis situation that includes the imminent risk of physical harm to the individual or others, the destruction of property by an individual, in and of itself is not adequate grounds for the utilization of these methods.

## **S/R Permitted Only in Response to Imminent Risk**

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

## **Prohibited Techniques/Activities**

- (D)(2) The following shall not be used under any circumstances:
  - (a) Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises.
  - (b) Any technique that restricts the individual's ability to communicate, including consideration given to the communication needs of individuals who are deaf or hard of hearing;
  - (c) Any technique that obstructs vision;
  - (d) Any technique [sic] that causes an individual to be retraumatized based on an individual's history of traumatic experiences.

## Prohibited Techniques/Activities

- (D)(2) The following shall not be used under any circumstances:
  - (e) Any technique that obstructs the airways or impairs breathing;
  - (f) Use of mechanical restraint on individuals under age 18;
  - (g) A drug or medication that is used as a restraint to control behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's medical or psychiatric condition or that reduces the individual's ability to effectively or appropriately interact with the world around the individual;

## Prohibited Techniques/Activities

- (D)(2) The following shall not be used under any circumstances:
  - (h) The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns & tasers.

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

## Prone Restraint

- (D)(3) Position in physical or mechanical restraint
  - (a) An individual shall be placed in a position that allows airway access and does not compromise respiration.
  - (i) The use of prone restraint is prohibited.
- 5122-26-16 (C)(8) "Prone Restraint" means all items or measures used to limit or control the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a face-down position for an extended period of time. Prone restraint may include either physical (also known as manual) or mechanical restraint.

## Transitional Hold

- (D)(3) Position in physical or mechanical restraint
  - (a) An individual shall be placed in a position that allows airway access and does not compromise respiration.
  - (ii) A transitional hold shall be limited to the minimum amount of time necessary to safely bring the person under control, at which time staff shall either terminate the transitional hold, and begin the post-restraint process required by this rule, or, if the individual cannot safely be released from the transitional hold, re-position the individual into an alternate restraint position.
    - “**Minimum necessary**” is a clinical determination

## Transitional Hold

- 5122-26-16 (C)(13) “Transitional hold” means a brief physical (also known as manual) restraint of an individual facedown for the purpose of effectively gaining physical control of an individual in order to prevent harm to self and others, or for the purpose of transport, i.e. carrying a individual to another location within the facility.

## Transitional Hold

- (D)(3)(b) The use of transitional hold shall be subject to the following requirements:
  - (i) Applied only by staff who have current training on the safe use of transitional hold techniques, including how to recognize and respond to signs of distress in the individual.
  - (ii) The weight of the staff shall be placed to the side, rather than on top of the individual. No transitional hold shall allow staff to straddle or bear weight on the individual's torso while applying the restraint, i.e. no downward pressure may be applied that may compromise the individual's ability to breathe.

## Transitional Hold

- (D)(3)(b) The use of transitional hold shall be subject to the following requirements:
  - (iii) No transitional hold shall allow the individual's hands or arms to be under or behind the individual's head or body. The arms must be at the individual's side.
  - (iv) No soft device, such as a pillow, blanket or other item, shall be used to cushion the client's head, since such a device may restrict the individual's ability to breathe.
  - (v) All staff involved in the procedure must constantly observe the individual's respiration, coloring, and other signs of distress, listen for the individual's complaints of breathing problems, and immediately respond to assure safety.

## Assessment & Responsibility to Inform Consumer (and others as appropriate)

- (D)(4) The choice of the least restrictive, safe and effective use of seclusion or restraint for an individual is determined by the person's assessed needs, including a consideration of any relevant history of trauma or abuse, risk factors as identified in paragraph (G)(3) of this rule, the effective or ineffective methods previously used with the person and, when possible, upon the person's preference.
  - (a) Upon admission or intake and when clinically warranted, the person and his/her parent, custodian or guardian, as appropriate, shall be informed of the agency's philosophy on the use of seclusion or restraint as well as of the presence of any provider policies and procedures addressing their use by the provider. Such policies and procedures shall be made available to the person or to their parent, custodian or guardian upon request.
  - Adult clients shall be offered the opportunity to give consent for the notification of their use to a family member or significant other.

## Notification of Use of S/R

- (D)(5) Within twenty-four hours of the initiation of seclusion or restraint, the provider shall notify the following individuals:
  - (a) For children or adolescents, the client's parent, custodian or guardian;
  - (b) For adults, the client's guardian, when applicable, or family or significant other when the client has given their consent for such notification.

## S/R De-Briefing

- (D)(6) Following the conclusion of each incident of seclusion or restraint, the client and staff shall participate in a debriefing.
- (a) The debriefing shall occur within twenty-four hours of the incident unless the client refuses, is unavailable, or there is a documented clinical contraindication.
- (b) The following shall be invited to participate unless such participation is clinically contraindicated and the rationale is documented in the clinical record:
- (i) For a child or adolescent client, the family, or custodian or guardian, or
  - (ii) For an adult client, the client's family or significant other when the client has given consent in accordance with paragraph (D)(4)(a) of this rule, or an adult client's guardian, if applicable.

## **5122-26-16 (E) Policies and Procedures**

- (E)(1) The provider shall establish policies & procedures that reflect how the utilization of seclusion or restraint is reviewed, evaluated, and approved for use. The provider shall document if & how the inclusion of clients & families in the development of such policies occurred.
- (E)(2) Policies and procedures governing the use of seclusion or restraint shall include attention to preservation of the person's health, safety, rights, dignity, and well-being during use. Additionally:
  - (a) Respect for the person shall be maintained when such methods are utilized;
  - (c) The number of appropriately trained staff available to apply or initiate seclusion or restraint shall be adequate to ensure safety. The use of non-agency employed law enforcement personnel, e.g., local police, to substitute for the lack of sufficient numbers of appropriately trained staff in such situations is prohibited.

## **Staff Training in Application of S/R 5122-26-16 (F)(2)**

- (F)(2) The provider shall identify, educate and approve staff members to use seclusion or restraint. Competency of staff in the use and documentation of seclusion or restraint methods shall be routinely evaluated. The results of evaluations shall be maintained by the provider for a minimum of three years for each staff member identified.
  - (a) Staff shall have appropriate training prior to utilizing seclusion or restraint, and, at a minimum, annually thereafter. The exception to annual training is a first aid or CPR training or certification program of a nationally recognized certifying body, e.g. the american red cross or american heart association, when that certifying body establishes a longer time frame for certification and renewal.
  - (i) Staff shall be trained in and demonstrate competency in the identification and assessment of those possible risk factors identified in paragraph (G) of this rule and to understand how these may impact the way a client responds to seclusion or restraint, and place an individual at greater risk to experience physical or psychological trauma during an episode of seclusion or restraint;

## **Risk Factors Documentation (G)(3)**

- (G)(3) Initial and ongoing identification of individual-specific contraindications to the use of seclusion or restraint shall be documented. Consideration of the use of such methods shall take into account the following which may place the person at greater risk of physical or psychological injury as a result of the use of seclusion or restraint:
  - (a) Gender;
  - (b) Age;
  - (c) Developmental issues;
  - (d) Culture, race, ethnicity, and primary language;
  - (e) History of physical or sexual abuse, or psychological trauma;
  - (f) Medical and other conditions that might compromise physical well-being, e.g., asthma, epilepsy, obesity, lung and heart conditions, an existing broken bone, pregnancy, and drug or alcohol use; and
  - (g) Physical disabilities.

## **Staff Training in Application of S/R 5122-26-16 (F)(2) continued**

- (F)(2)(a) ... identify, educate, and approve. Annual training unless nationally recognized certifying body has established other time frame.
  - (ii) Staff shall be trained in and demonstrate competency in choosing the least restrictive intervention based on an individualized assessment of the client's behavioral or medical status or condition;
  - (iii) Staff shall be trained in and demonstrate competency in the safe application of all seclusion or restraint interventions he or she is authorized to perform, including specific training in utilization of transitional hold, if applicable;

## Staff Training in Application of S/R 5122-26-16 (F)(2) continued

- (F)(2)(a) ... identify, educate, and approve. Annual training unless nationally recognized certifying body has established other time frame.
  - (iv) Staff shall be trained and certified in first aid and CPR;
  - (v) Staff shall be trained in and demonstrate competency in recognizing and responding to signs of physical distress in clients who are being secluded or restrained;
  - (vi) Staff authorized to take vital signs and blood pressure shall be trained in and demonstrate competency in taking them and understanding their relevance to physical safety and distress;
    - ❖ (C)(14)"Vital signs" means the rates or values indicating an individual's blood pressure, pulse, temperature, and respiration.

## Staff Training in Application of S/R 5122-26-16 (F)(2) continued

- (F)(2)(a) ... identify, educate, and approve. Annual training unless nationally recognized certifying body has established other time frame.
  - (vii) Staff shall be trained in and demonstrate competency in assessing circulation, range of motion, nutrition, hydration, hygiene, and toileting needs; and
  - (viii) Staff shall be trained in and demonstrate competency in helping a client regain control to meet behavioral criteria to discontinue seclusion or restraint.
  - (ix) Staff shall be trained in and demonstrate competency in understanding the impact of trauma, and signs and symptoms of trauma.

## Staff Training in Application of S/R 5122-26-16 (F)(2) continued

- (F)(2)(b) Leadership shall maintain a current list of staff authorized to utilize seclusion or restraint interventions which is readily available to all provider staff who may be asked to participate in these interventions; and
- (F)(2)(c) The curriculum used to train staff shall be documented and shall be made available to the Department upon request.

## 5122-26-16 (G) Documentation

- (G)(1) The presence of advance directives or client preferences addressing the use of seclusion or restraint shall be determined and considered, and documented in the medical record. If the provider will be unable to utilize seclusion or restraint in a manner in accordance with the patient's directives or preferences, the provider shall notify the patient, including the rationale, and document such in the ICR.
  - (C)(1) "Advance directives" means a legal document used by an adult to direct in advance the mental or physical health treatment in the event the adult lacks the capacity to make such decisions. Two types of advance directives related to mental health treatment are: a "Declaration for Mental Health Treatment" subject to the requirements of Chapter 2135. of the Revised Code, and a "Durable Power of Attorney for Health Care" subject to the requirements of sections [1337.11](#) to [1337.17](#) of the Revised Code.

## 5122-26-16 (G) Documentation

- (G)(5) Each incident of seclusion or restraint shall be clinically and/or administratively reviewed. Such review shall be documented.



## Seclusion and Mechanical Restraint Physical Restraint

5122-26-16.1 (Seclusion/Mechanical)

5122-26-16.2 (Physical)

### **5122-26-16.1 (C) and 5122-26-16.2 (B)**

- S/R 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.

### **Documentation**

#### **5122-26-16.1 (D) and 5122-26-16.2 (D)**

- The reason for implementation of the S/R
- All prior attempts to use less restrictive interventions
- Notation that any previously identified contraindication(s) to the use of S/R were considered and the rationale for continued implementation of S/R despite the existence of such contraindication(s)
- A review of all current medications
- Documentation of the individual's history of traumatic experiences as a means to gain insight into origins and patterns of the individual's actions.

**Documentation**  
**5122-26-16.1 (F) and 5122-26-16.2 (D)**

- Persons shall be continuously monitored, i.e., constant visual observation by staff in a manner most conducive to the situation or person's condition. [Mechanical restraint or Seclusion only]
- Explanation to the person for the reason for implementation of S/R and the required behaviors of the person which would indicate sufficient behavioral control so that the S/R restraint could be discontinued

**Documentation**  
**5122-26-16.1 (F) and 5122-26-16.2 (D)**

- The condition of the person 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, need for continued S/R, and other needs as necessary, and the appropriate actions taken
- Upon conclusion of the S/R, the results of a check of injuries shall be conducted. The appropriate actions taken for any injuries noted shall also be documented.

## Who Can Implement Mechanical Restraint and Seclusion

- (D)(1) Authorized staff at the direction of an individual permitted to order S/R (Slide 38) or a Registered Nurse
- (E)(4) RN must obtain telephone order within one hour from someone allowed to order S/R, which must signed within twenty-four hours by someone allowed to order S/R

## Who Can Order Mechanical Restraint and Seclusion

- (E)(1) Orders shall be written only by an individual with specific clinical privileges or authorization granted by the provider to order seclusion and restraint, and who is a:
  - (a) Psychiatrist or other physician; or
  - (b) Physician's assistant, certified nurse practitioner or clinical nurse specialist authorized in accordance with his or her scope of practice **and as permitted by applicable law or regulation.**

## Orders for Seclusion & Mechanical Restraint

- (E)(2) Orders may be written for a maximum of:
  - (a) Two hours for mechanical restraint or seclusion of adults eighteen years of age or older;
  - (b) One hour for seclusion of children and adolescents age nine through seventeen; or
  - (c) Thirty minutes for seclusion of children under age nine.
- (E)(3) Prn orders are prohibited, whether individual or as a part of a protocol.
  - (C) (7) "PRN (pro re nata)" means as the situation demands.
- (E)(7) Mechanical restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

## Continuing Orders for Seclusion and Mechanical Restraint

- (E)(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 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) Two hours for mechanical restraint or seclusion of adults eighteen years of age or older up to a maximum of twenty-four hours;
  - (b) One hour for seclusion of children and adolescents age nine through seventeen up to a maximum of twenty-four hours; or
  - (c) Thirty minutes for seclusion of children under age nine up to a maximum of twelve hours.

## **Continuing Orders for Seclusion and Mechanical Restraint**

- (E)(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.

## **If Unable to Implement Any Portion of the Rule 5122-26-16.1 (H) and 5122-26-16.2 (E)**

- 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.



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## Analyze data to develop plan to reduce the use of seclusion and restraint.

### Logs 5122-26-16 (H)

- (H)(1) A log shall be maintained for department review of each incident of mechanical restraint, seclusion, and physical restraint, and for time-outs exceeding sixty minutes per episode. The log shall include, at minimum, the following information:
  - (a) The person's name or other identifier;
  - (b) The date, time and type of method or methods utilized, i.e., seclusion, mechanical restraint, physical restraint and/or transitional hold, or time-out. The log of physical and mechanical restraint shall also describe the type of intervention as follows:
    - (i) For mechanical restraint, the type of mechanical restraint device used;
    - (ii) For physical restraint, as follows:
      - (a) Transitional hold, and
      - (b) Physical restraint.
- (C) (12) "Time-out" means an intervention in which a person is required to remove themselves from positive reinforcement to a specified place for a specified period of time. Time-out is not seclusion.

## Logs 5122-26-16 (H)

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

If both transitional hold and physical restraint are utilized during a single episode of restraint, the duration in each shall be included on the log. For example, a physical restraint that begins with a one minute transitional hold, followed by a three minute physical restraint shall be logged as one restraint, indicating the length of time in each restraint type.

## Analysis & Performance Improvement

- (D)(7) A thorough review and analysis of each incident of the use of seclusion or restraint shall be undertaken in order to use the knowledge gained from such analysis to inform policy, procedures, and practices to avoid repeated use in the future and to improve treatment outcomes.
- (I) Performance Improvement
  - (1) The provider shall collect data on all instances of the use of seclusion or restraint and integrate the data into performance improvement activities.

## Performance Improvement

- (I)(2) Data shall be aggregated and reviewed at least semi-annually by providers and at least quarterly by department licensed residential facilities and certified AoD residential providers. The minimum data to be collected for each episode shall include:
  - (a) Staff involved, including staff member who initiated the seclusion or restraint;
  - (b) Duration of the method;
  - (c) Date, time and shift each method was initiated;
  - (d) Day of week;
  - (e) Type of method, including type of physical hold or mechanical restraints utilized;
  - (f) Client age, race, gender and ethnicity;
  - (g) Client and staff injuries;
  - (h) Number of episodes per client; and
  - (i) Use of psychotropic medications during an intervention of seclusion or restraint.

## Performance Improvement

- (I)(3) Data shall be reviewed:
  - (a) For analysis of trends and patterns of use; and
  - (b) To identify opportunities to reduce the use of seclusion or restraint.
- (I)(4) The provider shall routinely compare how its practices compare with current information and research on effective practice.
- (I)(5) The results of data reviews and performance improvement activities shall be shared with staff at least semi-annually with the goal of reducing the use of seclusion or restraint.

## Plan to Reduce S/R

- (J) Plan to reduce seclusion and/or restraint.
  - (1) An provider which utilizes seclusion or restraint shall develop a plan designed to reduce its use. The plan shall include attention to the following strategies:
    - (a) Identification of the role of leadership;
    - (b) Use of data to inform practice;
    - (c) Workforce development;

## Plan to Reduce S/R

- (J) Plan to reduce seclusion and/or restraint.
  - (1) A provider which utilizes seclusion or restraint shall develop a plan designed to reduce its use. The plan shall include attention to the following strategies:
    - (d) Identification and implementation of prevention strategies;
    - (e) Identification of the role of clients (including children), families, and external advocates; and
    - (f) Utilization of the post seclusion or restraint debriefing process.

## Plan

- 6 Strategies in MHAS rule align with NASMHPD's 6 Core Strategies for the Reduction of S/R
  - <http://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf>
- Presentation, Six Core Strategies, Dr. Kevin Ann Huckshorn
  - <https://www.youtube.com/watch?v=by4gnMmr6CA>

## Use of Data & Other Resources

- Use of data
  - Log, de-briefing, PI, assessment data, etc.
- Draft examples on S/R de-briefing
  - [http://www.nasmhpd.org/sites/default/files/VI\\_B\\_MAPt\\_Debriefing.pdf](http://www.nasmhpd.org/sites/default/files/VI_B_MAPt_Debriefing.pdf)
  - [http://www.nasddd.org/uploads/documents/GA\\_Secl\\_Restraint\\_Debriefing\\_Form.pdf](http://www.nasddd.org/uploads/documents/GA_Secl_Restraint_Debriefing_Form.pdf)
- NASMHPD Publications – variety of topics
  - <http://www.nasmhpd.org/content/publications>

## Plan to Reduce S/R

- (J)(2) Plan to reduce seclusion and/or restraint.
  - (b) A written status report shall be prepared annually, and reviewed by leadership.

## Trauma-Informed Care Resources

OhioMHAS Trauma-Informed Care Website

<http://mha.ohio.gov/Default.aspx?tabid=104>

➤ Includes links to local, state, national resources

SAMHSA Tip 57 *“Trauma-Informed Care in Behavioral Health Services”*

<http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>

## MHAS Webpages

Incident Report Information

<http://mha.ohio.gov/Default.aspx?tabid=125>

Webinar Registration Information & Archived Recordings

<http://mha.ohio.gov/Default.aspx?tabid=743>

Rules in Effect Webpage

<http://mha.ohio.gov/Default.aspx?tabid=250>

Certification and Methadone Licensure Applications

<http://mha.ohio.gov/Default.aspx?tabid=259>

## Contact Information

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