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|  Office of Mental Health <hr/> Official Policy Manual | Date issued 10/14/2022 | Supersedes | Page 1 of 9 | Section # PC-701 |
| | Section: Patient Care | | | |
| | Directive: Seclusion and Restraint | | | |
| | Policy Owner: Division of State Operated Services | | | |

I. POLICY STATEMENT

NOTE: This policy shall not preclude security measures during transportation of patients who are committed to a facility pursuant to a criminal court order¹ or who are admitted to a facility in accordance with Mental Hygiene Law Article 10.

The Office of Mental Health (OMH) always seeks to provide a safe and therapeutic environment. Seclusions and restraints (i.e., restrictive interventions) are clinically determined emergency safety measures for behavioral management and medical/post-surgical care purposes and are only to be used as a last resort to minimize harm to the patient and/or others.

- 1) The only justifications for the use of any seclusion or restraint are imminent danger, the administration of court-ordered medication over a patient's objection, or the administration of medications approved per 14 NYCRR 527.8 for minors.
- 2) Seclusions or restraints can only be employed when less restrictive techniques have been tried and failed, or in the rare instance where the patient's danger is of such immediacy that less restrictive techniques cannot be safely applied.
- 3) Restrictive interventions for medical/post-surgical care purposes (e.g., to limit mobility or temporarily immobilize post-surgery or dental procedure) are used to ensure good medical outcomes when mechanical supports are not effective. The following types of restraints are permissible for this purpose: four-point restraint, five-point restraint, wrist-to-belt restraint, mitts, and helmets.
- 4) When determining the need for any restrictive intervention, the following must also be considered in the patient's history: physical or sexual abuse; intellectual/developmental disability; deafness or hard of hearing that may require communication by hands; visual impairment that may compromise awareness of environment; and medical conditions.
- 5) Prior to participating in the seclusion or restraint of a patient, staff must receive OMH-approved training and must demonstrate competence in the appropriate application of, and alternatives to, seclusion and restraint. Training for staff that participate in seclusion and restraint must also include the use of first aid techniques (as required by profession) and certification in the use of cardiopulmonary resuscitation, including required periodic recertification. Refer to Section VI.6) of the OMH Manual to Supplement Policy Section PC-701, Seclusion and Restraint (hereto referred to as "PC-701 Supplemental Manual").
- 6) When determining whether a physical intervention constitutes a restrictive intervention, reasonable consideration must be given to the nature of the patient's behavior precipitating the intervention, federal and state guidance, and clinical judgment.
- 7) The use of seclusion and restraint can be reduced through a diverse and culturally sensitive environment that promotes the empowerment of patients, identifies, and implements strategies to

¹ For purposes of this policy, patients who are committed to a facility pursuant to an order of a criminal court means and includes patients committed to the custody of the Commissioner pursuant to Section 330.20 or Article 730 of the Criminal Procedure Law, as well as those subject to subsequent retention orders following an initial commitment made under these statutes. This does *not* include: (1) persons who were initially admitted under Criminal Procedure Law Article 730 "Final Orders of Observation" whose original charges have been dismissed and who are, within 72 hours, converted to voluntary or involuntary status (*Ritter vs. Surles*); or (2) persons admitted under Criminal Procedure Law Article 730 who are converted to civil status as the result of a Court order issued pursuant to *Jackson v. Indiana*. Questions regarding applicability of this provision should be directed to Counsel's Office.

advance positive behavior management and incorporates strategies for the appropriate use of restrictive interventions.

- a. Each facility must have a plan to reduce and ultimately try to eliminate the use of seclusion and restraint, and the plan must be regularly monitored by the Clinical Director or designee.
- b. Facilities must convey to patients and to those families/significant others who, upon patient agreement, are involved in the patient's treatment planning process, the intentions of OMH to make the use of restrictive interventions a rare occurrence.
- c. Preferences expressed by the patient, such as the gender of and/or languages spoken by the observing staff person, must be honored as practicable and clinically appropriate in relation to prevention efforts and practices.

II. PURPOSE

The purpose of this policy is to supplement the provisions of 14 NYCRR Section 526.4², which sets forth conditions and general procedures for the use of seclusion and restraint in facilities under the jurisdiction of OMH, including State-operated psychiatric inpatient facilities. Each OMH facility must also have a facility-specific policy governing the use of restrictive interventions that incorporates all principles and applicable procedures outlined in this policy. NOTE: Refer to the PC-701 Supplemental Manual for additional details that expand on the general principles and procedures in this policy.

III. APPLICABILITY

This policy applies to all OMH psychiatric center inpatient services and Secure Treatment and Rehabilitation Center (STARC) programs, and all staff who work in these areas and participate in restrictive interventions.

IV. RELEVANT STATUTES, STANDARDS, AND REFERENCES

10 NYCRR §405.7

14 NYCRR Part 27.8, Part 524, §526.4, and §527.8

Mental Hygiene Law Article 10 and §33.04

OMH Policy Section QA-510, Clinical Risk Management and Incident Management Plans OMH Manual to Supplement Policy Section PC-701, Seclusion and Restraint

OMH Implementation Guidelines:

<https://www.omh.ny.gov/omhweb/guidance/implementation-guidelines.pdf> 42 C.F.R. §482.13 P.L. 106-310 (Children's Health Act of 2000)

The Joint Commission *Comprehensive Accreditation Manual for Hospitals (CAMH)*

CMS State Operations Manual: Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

V. DEFINITIONS

For purposes of this policy, the following terms are defined:

- 1) **Calming blanket:** a restraint consisting of a thick, stiff fabric comforter which encases a patient's torso and limbs and is held in place by two persons.
- 2) **Clinical director or designee:** the individual in charge of clinical services at the State-operated psychiatric facility, or a physician designated by that individual to carry out the responsibilities of the head of the clinical staff described in this policy.

² 14 NYCRR Section 526.4 can be accessed at

[https://govt.westlaw.com/nycrr/Document/I975a872e66c11e39ccd000845b8d3e?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/nycrr/Document/I975a872e66c11e39ccd000845b8d3e?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)).

- 3) **Comfort wrap:** a lightweight blanket or sheet that a patient may voluntarily use when they experience the need to feel safer and/or to provide an artificial boundary. When used in this manner, a comfort wrap is not considered a restraint.
- 4) **Drug used as a restraint:** medication used as a restriction to manage behavior or to restrict the patient's freedom of movement and the medication is not a standard treatment or dosage for the patient's condition. Refer to PC-701 Supplemental Manual, Sections III.4) and V.8) for further details.
- 5) **Episode of seclusion or restraint:** all *continuous* seclusion or restraint interventions, beginning with the first hands-on intervention and ending at the conclusion of all subsequent interventions. In this context, *continuous* refers to consecutive orders from the initiation until the safe release of the patient.
- 6) **Five-point restraint:** a four-point restraint with the addition of a strap, which is placed over the patient's upper torso and secured to the bed frame.
- 7) **Four-point restraint:** restraints that are applied to the wrists and ankles, and are secured to the bed frame, of a patient lying on a bed.
- 8) **Individual Crisis Prevention Plan (ICPP), Individual Calming, Wellness and Recovery/Resilience Plan (ICWRP), or equivalent:** a document that identifies a patient's early warning signs, triggers, coping skills, patient preferences, and behaviors related to behavioral management interventions.
- 9) **Manual restraint:** the use of a manual or physical hold to restrict a person's freedom of movement or normal access to their body. For example, a physical "takedown" to the floor is always considered a manual restraint. However, the physical holding of a patient for the purpose of conducting routine physical examinations or tests, may not necessarily meet the definition of "manual restraint." Refer to PC-701 Supplemental Manual, Sections III.9) and V.4) for further details.
- 10) **Mechanical restraint:** an apparatus which restricts a patient's movement of their head, limbs, or body, and which the patient is unable to remove. This term may also apply to an apparatus not normally used for this purpose, such as a bed rail or bed sheet if the patient is unable to release the mechanism. Refer to PC-701 Supplemental Manual Section III.10) for further details.
- 11) **Mechanical support:** a device intended to keep a patient in a safe or comfortable position or to provide the necessary stability for therapeutic measures such as immobilization of fractures, administration of intravenous solutions, or other medically necessary procedures, and which the patient *can* remove at will.³ Refer to PC-701 Supplemental Manual Section V.6) for further details.
- 12) **Mitts or helmet:** constitutes a restraint when used as an emergency intervention to avoid imminent injury to the patient or others and the patient cannot easily remove them at will in the same manner it was applied by staff. By extension, applying the mitts so tightly that the patient's hands or fingers are immobilized, or using mitts that are so bulky that a patient's ability to use their hands is significantly reduced, would also constitute a restraint. Pinning or otherwise attaching mitts to bedding or using a wrist restraint in conjunction with mitts is not permitted.
- 13) **One-to-one constant observation:** a situation in which a staff member is responsible for maintaining continuous monitoring of a single patient, keeping them in view at all times, and, if clinically appropriate, attempting to initiate dialogue with the patient. In this situation, the staff member must remain in close enough proximity to the patient to be able to respond immediately if needed and must not have supervisory responsibilities for other patients.

³ Each facility should have in place a separate policy that governs the use of mechanical supports.

- 14) Restraint:** any manual method or mechanical device which immobilizes or reduces the ability of a patient to freely move their arms, legs, body, or head which the patient *cannot* remove at will. This also includes pharmacologic measures that meet the definition of *drug used as a restraint* (see above).
- 15) Restrictive Intervention:** an intervention used to restrict the freedom of movement of a patient for the purposes of behavioral management or medical/post-surgical care. This may include the use of seclusion, manual restraint, mechanical restraint, and drug used as a restraint.
- 16) Seclusion:** the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. This also applies where the patient reasonably believes that they will be prevented from leaving, with no ability to meaningfully interact with others. It does not mean confinement on a locked unit or ward where a patient is with others.
- 17) Time out/Calming time:** a therapeutic intervention in which the patient, either upon the recommendation of staff or at the patient's initiative, consents to spend time alone in a designated area. For an intervention to be considered a time out, the patient must be permitted to enter the area/room voluntarily, and the patient's ability to exit the time out area or room must not be restricted by any means. When feasible, rooms used for time outs should not be the same room as that used for seclusion or restraint.
- 18) Wrist-to-belt restraint:** a belt, secured around a patient's waist, with attached restraints that encase their wrists. The tethers that secure the restraints to the belt may be of adjustable lengths, which allow variation in the degree of restricting the patient's arms.

VI. PROCEDURES (for ALL restrictive interventions unless otherwise specified)

1) General Considerations and Principles:

- a. All applicable steps related to initiating, maintaining, and discontinuing the seclusion or restraint must be documented in the clinical record using OMH-approved Restrictive Intervention Forms. These forms may also provide additional instructions on how to appropriately record each step in the process.
- b. All procedures must be performed in accordance with the requirements of all relevant statutes, standards, and references cited above.
- c. In cases where restraint or seclusion is needed, the least restrictive type which is appropriate and effective under the circumstances must be used.
- d. Staff must continuously assess and monitor the patient to ensure they are released from restraint or seclusion at the earliest possible time (i.e., when they no longer present a danger to self or others), regardless of the maximum time specified in the physician's order.
- e. Every effort must be made to protect the patient's privacy during the restrictive intervention.
- f. If the patient has requested notification to family and/or a patient advocate of the application of seclusion or restraint, a staff member must make such notification as soon as possible. Notifications are required for patients under the age of 18 (unless they are an emancipated minor). If a family has submitted a written request not to be notified of instances of seclusion and restraint, the facility must honor this request.
- g. Injuries and deaths related to the use of any restrictive intervention must be reported as mandated in regulations and OMH policy.
- h. The following are **prohibited**:
 - i. Restrictive interventions as punishment; as a substitute for treatment; for staff convenience; or solely based on an individual's history of seclusion, restraint, or dangerous behavior.

- ii. Restrictive interventions with patients whose sole diagnosis is an intellectual developmental disorder. However, seclusion can be permitted for persons with a dual diagnosis of mental illness and intellectual developmental disorder.
- iii. For children less than 9 years of age, any restraint other than manual restraint, unless prior approval is obtained (See Section 2)c. below).
- iv. PRN orders for the use of seclusion or restraint.
- v. Seclusion and mechanical restraint used simultaneously.
- vi. The use of two types of restraint simultaneously. *However, the following exceptions are permitted: mitts and helmets together; manual restraint while placing a patient in seclusion or mechanical restraint; and drug used as a restraint with seclusion or other types of restraint.*
- vii. Mechanical restraints which employ a locking mechanism released by a key. Refer to PC-701 Supplemental Manual Section V.7b.) for exceptions regarding wrist-to-belt at forensic facilities and facilities treating residents pursuant to Mental Hygiene Law Article 10.
- viii. Placing objects on or over a patient's face during restraint procedures.
- ix. Placing a patient in a face-down or chest-down position during restraint. If a patient is inadvertently in a face-down or chest-down position, staff must immediately reposition the patient.
- x. Using any technique that obstructs a patient's respiratory airway or impairs their breathing or respiratory capacity, including techniques in which a staff member places pressure on a patient's back, neck, or throat, or places their body weight against the patient's torso or back.
- xi. Using any technique on a patient who has a known medical or physical condition where there is reason to believe that use of such technique would endanger the person's life or significantly exacerbate the person's medical condition.
- i. Every effort must be made to ensure patients are not placed in seclusion or restraint in a nude or semi-nude state to preserve the patient's dignity.

2) Prior to initiating restrictive interventions:

- a. Each patient must have an ICPP, ICWRP, or equivalent.
 - i. The plan is developed and implemented as soon as possible after admission. However, on rare occasion, the immediacy of a dangerous situation may require the application of restrictive interventions prior to the development of the plan.
 - ii. Each facility must develop a mechanism to ensure that staff on all shifts, as well as floating staff, are aware of these plans. The plans are developed in collaboration with the patient and must be:
 - individualized to each patient's needs
 - linked to any personal history of trauma
 - tailored to environmental resources
 - incorporated into the patient's plan of care
 - readily accessible by staff
 - given to the patient
 - routinely reviewed and updated when changes are warranted
- b. Less restrictive interventions should always be considered first.
- c. **Prior Approvals** are required from the OMH Chief Medical Officer (CMO) or designee for the following:
 - i. Any exception to the approved types of mechanical restraint.
 - ii. Any type of restraint used for transportation
 - iii. The use of mechanical restraint for patients under the age of 18.

- iv. The use of seclusion or any type of restraint other than manual restraint with patients under the age of 9.
- v. The rare events when mechanical supports are used as restraints.
- vi. Exceptions to time limits and periodic renewals of restrictive interventions.

3) During restrictive interventions:

a. Safe application/initiation of restrictive interventions:

- i. Staff will immediately interact/intervene to prevent the patient from seriously injuring themselves or others.
- ii. When a physician is not immediately present, a restrictive intervention may be initiated in accordance with OMH-approved techniques.
- iii. The patient will be searched, and any potentially dangerous objects will be removed.
- iv. A registered nurse must assess the patient immediately after the seclusion or restraint is applied. This assessment is done to ensure that the intervention was safely and correctly applied and includes a review of the circumstances leading to the intervention, and the patient's mental status and behavior. This assessment is documented in the medical record.
- v. If not immediately present, a physician must be immediately called to conduct an in-person examination of the patient. If a physician cannot arrive within 5 minutes, a telephone order must be issued by a physician.
- vi. The patient must be informed of release criteria and released as soon as they meet the criteria and no longer present an imminent danger to self or others.

b. Physician's order:

- i. The physician must write an order(s) for the full duration of time in which the patient was in seclusion or restraint.
- ii. The physician must consider any prior medical diagnoses, conditions, and significant history (including but not limited to cardiometabolic history, physical or sexual abuse history, drug interactions, intellectual/developmental disabilities, range of motion concerns, and relevant hearing/visual concerns), and the need for additional care or monitoring must be ordered, as indicated.
- iii. The physician's written order must:
 - Include behaviors justifying the intervention(s).
 - Specify the maximum duration of the intervention.
 - Specify the type of intervention(s) to be used. Note: If additional restrictive intervention is required after the order is signed, an additional order form must be completed.
 - Identify the behavioral criteria for release.
 - Include any special care or monitoring instructions.
- iv. Duration of order/maximum allowable times: Refer to Section VI.3)m of the PC-701 Supplemental Manual for details.
 - one hour for adults
 - 30 minutes for ages 9 to 18, or over age 18 in a children's facility or unit
 - up to 15 minutes for manual restraint for any age
 - up to 15 minutes for the use of a calming blanket
 - up to 24 hours for medical/post-surgical care purposes
- v. Continuation orders must be written in accordance with Section VI.3)m.iii. of the PC-701 Supplemental Manual.
 - Prior approval is required from the Clinical Director or designee for seclusion or restraint beyond a continuous 4-hour period.

c. Notifications are required as follows:

- i. to the Clinical Director or designee for medical/post-surgical care interventions.

- ii. to and in consultation with the Clinical Director for mechanical restraint or seclusion exceeding 2 hours for behavioral management purposes.
 - iii. to the Clinical Director or designee for the issuance of 2 or more separate episodes within any 12-hour period.
 - iv. to the OMH CMO or designee for continuous use beyond 24 hours.
- d. **Physician Assessment/In-Person Evaluation:**
- i. Required for each episode of restrictive intervention. Refer to Section VI.3)q. of the PC-701 Supplemental Manual for additional information related to the frequency of evaluations.
 - ii. Should be completed within 30 minutes of notification of the event, and at a minimum every 24 hours thereafter for the duration of the episode.
 - iii. Must include an assessment of the:
 - immediate situation
 - patient's reaction to the intervention
 - patient's medical and behavioral condition
 - need to continue or terminate the intervention
 - iv. Must include a physical assessment that includes a review of the patient's medical history and current medication regimen.
 - v. Documentation of the evaluation should be completed as soon as possible after the assessment is completed and must include the time of the physician's examination. If a physician's arrival exceeds 30 minutes from the time called, the delay in arrival and a description of the patient's behavior must be documented in the clinical record.
- di. **Monitoring:**
- i. Monitoring must be done by a staff member who is appropriately trained and competent in OMH policies and procedures regarding seclusion and restraint.
 - ii. Patients must be monitored in person and not through camera surveillance.
 - iii. A patient in seclusion or restraint must receive one-to-one constant observation and monitoring for the duration of the event to ensure that physical needs, comfort, and safety are properly addressed.
 - iv. For *drug used as a restraint*, the minimum duration for observation must be 30 minutes after administration, and the minimum level of observation must be one-to-one constant observation. Refer to Section V.8)b.iii. of the PC-701 Supplemental Manual for details regarding post-medication administration assessment and reassessment, monitoring of vital signs, and administration of sequential medications.
 - v. Staff must carefully observe the patient's physical status and will immediately notify the RN if the patient presents with any signs of distress. An RN, NP, or Physician must then assess the patient for any physical and psychological signs of injury and take appropriate action.
 - vi. Observations must be documented as follows for the duration of the event, or more frequently as directed by the physician:
 - For behavioral management purposes:
 - At the time of the initial application and at least every 15 minutes for all restrictive interventions.
 - For medical/post-surgical purposes:
 - At the time of the initial application and every 15 minutes thereafter for four-point or five-point restraints.
 - At the time of the initial application and every hour thereafter, for all other types of mechanical restraints.

- vii. An RN will assess and document the patient's condition at least once every 30 minutes, (or more frequently as directed by the physician) after the initiation of restraint or seclusion.
- viii. To assess the patient's physical status during the use of seclusion or restraint, vital signs consisting of blood pressure, temperature, pulse, and respiratory rate must be taken and recorded. Refer to the PC-701 Supplemental Manual and the OMH-approved Restrictive Intervention Physician's Order Form for specifics regarding vital signs during behavioral management and medical/post-surgical care interventions.
- ix. For medical/post-surgical care interventions, the patient must be monitored to ensure that their physical needs, nutrition, hydration, comfort, and safety are properly addressed, including administration of range of motion exercises to the limbs at least every 2 hours when the patient is awake.
- x. Staff will continuously assess and monitor the patient throughout the restrictive intervention. Note: the physician's order provides a maximum duration for the intervention, but the patient must be released at the earliest possible time.
- xi. It is the responsibility of the physician who has ordered the seclusion or restraint, or a covering physician, to be accessible to staff in the event of an emergency. Each facility must develop and implement written procedures to ensure physician coverage.
- f. **Release:** Refer to Section VI.4j. of the PC-701 Supplemental Manual for additional details.
 - i. Unless a RN, NP, or Physician determines the patient is obviously dangerous, an attempt to release the patient should be made and documented at least every 30 minutes.
 - ii. If at any time clinical assessment indicates that the patient has met the criteria for release, the patient must be immediately released.

4) Following the use of restrictive interventions:

- a. **Patient Evaluation:** Upon the patient's release, the registered nurse must conduct an in-person evaluation that includes an assessment of any immediate needs.
- b. **Debriefings:** Facilities must ensure that debriefing activities occur to determine what led to the event, what might have prevented or curtailed it, and how to prevent future occurrences. Refer to Section VI.5)b. of the PC-701 Supplemental Manual for additional details.
 - i. **Patient Debriefing:** Must take place as soon as the patient is released from seclusion or restraint. If the patient is initially unwilling or unable to participate, additional attempts should be made prior to the treatment team's Post Event Analysis meeting. It shall be conducted preferably by the primary clinician. This debriefing may include relevant others at the patient's request.
 - ii. **Staff Debriefing:** Must be conducted with the parties involved as soon as possible following the intervention and may occur before the conclusion of the event. It must be led by the nurse in charge, unit nurse, the on-site supervisor, or primary clinician. Participants include the key individuals involved in the episode and the staff who authorized and ordered the seclusion or restraint, whenever possible.
- c. **Post Event Analysis:** To evaluate the information obtained from staff and patient debriefing activities, an analysis is conducted by a senior manager or clinician. This must occur as soon as possible following the debriefings, but no later than the next business day following each episode. The analysis must include a review of and modification to the Plan of the Care. If modifications are not indicated, rationale must be provided and documented. Refer to Section VI.5)c. of the PC-701 Supplemental Manual for details, including conducting analyses for a single episode or multiple episodes.
- d. **Clinical Reviews:**
 - i. The attending psychiatrist or designee must review the clinical record of their patients who have been in seclusion or restraint since they were last on duty and shall ascertain the patient's current status. On an ongoing basis, the attending psychiatrist

and treatment team will review all restrictive interventions during the course of a patient's treatment and make modifications to the plan of care as needed.

- ii. The Clinical Director or designee must review the use of seclusion and restraint daily and must immediately investigate unusual or unwarranted patterns of utilization.
- iii. A documented review must be conducted when three or more episodes occur with a patient in a 30-day period. This review must take place within 3 business days of the third episode; must include the Clinical Director or designee, the patient's treatment team and if available, at least one peer specialist; and must include a review of the patient's treatment plan/plan of care and an assessment of current medications.

e. Administrative Actions:

- i. A Quality Assurance Review is completed within 3 business days of each Post Event Analysis. Information gathered is used to identify areas for improvement and is documented separately from the patient's record. Reviews must occur as detailed in Section VI.5)e.i. of the PC-701 Supplemental Manual.
- ii. As part of the facility's quality improvement program, the incidence of violent behavior and the associated use of restrictive interventions must be monitored.
- iii. Injuries and deaths related to the use of restrictive interventions must be reported as incidents.
- iv. OMH must report to the Centers for Medicare and Medicaid Services, by the next business day, any death that occurs while a patient is secluded or restrained, or in which it is reasonable to believe that the death was a result of seclusion or restraint.



OMH MANUAL TO SUPPLEMENT POLICY SECTION PC-701 Seclusion and Restraint

Issued 10/14/22

OMH MANUAL TO SUPPLEMENT POLICY SECTION PC-701, SECLUSION AND RESTRAINT

I. INTRODUCTION

This document applies to OMH psychiatric center inpatient services and Secure Treatment and Rehabilitation Center (STARC) programs, and all applicable staff working in these areas who participate in restrictive interventions. It serves as a supplement to the *Office of Mental Health (OMH) Policy Section PC-701, Seclusion and Restraint*. Additional information and instructions can also be found in the: 1) OMH approved Restraint and Seclusion forms, and 2) *FREQUENTLY ASKED QUESTIONS RELATED TO RESTRAINT AND SECLUSION: A Guide to Restraint and Seclusion Documentation*. While the *Implementation Guidelines: 14 NYCRR §526.4 Restraint and Seclusion* provides some general guidance, facilities must ultimately follow the direction and details found in this manual (including the relevant statutes, standards, and references; definitions; general principles; specific circumstances; and procedures, organized by section below).

As outlined in the OMH Policy Section PC-701, the use of restrictive interventions is limited to the prevention of imminent harm to self or others, or as defined for the use of court ordered medications and the administration of medications over objection for minors. Decisions regarding the use of restrictive interventions is based on clinical need as determined by the patient's presentation and clinical assessment. All efforts to reduce the use of restrictive interventions must be made and every effort to use the least restrictive intervention must be employed.

The use of restrictive interventions may be for either Behavioral Management or Medical/Post-Surgical Care purposes:

1) **Behavioral Management Purposes:**

OMH always seeks to provide a safe and therapeutic environment, to reduce risk to self and others and to prevent violent behavior. While violent behavior may lead to seclusion or restraint, in other instances violent behavior may begin or increase following the initiation of seclusion or restraint. Statistically, seclusion and restraint are associated with increased risk of injury to both patients and staff.

Seclusion or restraint are interventions to be used only as a measure of last resort to avoid imminent injury to the patient or others. The use of seclusion or restraint must serve as a prompt for treatment teams to review plans of care and their effectiveness. Seclusion and restraint may have deleterious effects on all patients but especially vulnerable patients, such as survivors of sexual trauma and/or physical abuse; patients who are deaf or hard of hearing and are unable to communicate without the use of their hands; patients with intellectual/developmental disabilities; and patients with visual impairments that significantly compromise awareness of their environment based on clinical judgment. In assessing the need to use these interventions, therefore, the OMH staff must consider the potential for any negative impact of the restrictive intervention on the patient and whether special considerations and additional monitoring to ensure safety are necessary.

The decision to use a restraint or seclusion is not driven by diagnosis, but by a comprehensive individual assessment. This comprehensive individual patient assessment will determine whether the use of less restrictive measures poses a greater risk than the risk of using a restraint or seclusion. The assessment should also include a physical assessment to identify medical problems that may be causing behavioral changes in a patient. For example, temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions, and drug side

effects may cause confusion, agitation, and combative behaviors. Addressing these medical issues may eliminate or minimize the need for the use of seclusion or restraint.

The use of seclusion and restraint for behavioral management can generally be reduced through the creation and maintenance of an environment which promotes the empowerment of patients, identifies and implements strategies to advance positive behavior management and restraint reduction efforts, incorporates strategies in hiring or workforce development practices to advance these efforts, and emphasizes the education and sensitization of staff regarding the appropriate use of restraint and seclusion. This manual seeks to encourage this result.

2) **Medical/Post-Surgical Care Purposes:**

In medical/post-surgical care, a restraint may be necessary to ensure good medical outcomes when mechanical supports are not effective. For example, restraints may be used to prevent an intravenous line or feeding tube from being removed, to prevent a patient who is temporarily or permanently incapacitated with a broken hip from attempting to walk before it is medically appropriate, or to prevent opening of an incision or surgical wound. In these circumstances, a medical restraint may be used to limit mobility or temporarily immobilize a patient in relation to a medical, post-surgical, or dental procedure. As with all restraints, risks associated with restraints for medical/post-surgical care must be considered in the ongoing loop of assessment, intervention, evaluation, and re-intervention. The greater the risks associated with an intervention, the more thorough the assessment must be. The following types of restraints are permissible for this purpose: four-point restraint, five-point restraint, wrist-to-belt restraint, mitts, and helmets.

II. RELEVANT STATUTES, STANDARDS, AND REFERENCES

10 NYCRR §405.7

14 NYCRR Part 27.8, Part 524, §526.4, and §527.8

Mental Hygiene Law Article 10 and §33.04

OMH Policy Section QA-510, Clinical Risk Management and Incident Management Plans OMH

Policy Section PC-701, Seclusion and Restraint

OMH Implementation Guidelines:

<https://www.omh.ny.gov/omhweb/guidance/implementation-guidelines.pdf> 42 C.F.R. §482.13 P.L.

106-310 (Children's Health Act of 2000)

The Joint Commission *Comprehensive Accreditation Manual for Hospitals (CAMH)*

CMS State Operations Manual: Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

III. DEFINITIONS

In addition to the terms defined in 14 NYCRR §526.4¹, for purposes of this manual, the following terms are defined:

- 1) **Calming blanket:** a restraint consisting of a thick, stiff fabric comforter which encases a patient's torso and limbs and is held in place by two persons.
- 2) **Clinical director or designee:** the individual in charge of clinical services at the State-operated psychiatric facility, or a physician designated by that individual to carry out the responsibilities of the head of the clinical staff described in this manual.

¹ 14 NYCRR Section 526.4 can be accessed at

[https://govt.westlaw.com/nycrr/Document/Id975a872e66c11e39ccd000845b8d3e?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/nycrr/Document/Id975a872e66c11e39ccd000845b8d3e?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)).

- 3) **Comfort wrap:** a lightweight blanket or sheet that a patient may voluntarily use when they experience the need to feel safer and/or to provide an artificial boundary. When used in this manner, a comfort wrap is not considered a restraint.
- 4) **Drug used as a restraint:** when medication is used as a restriction to manage behavior or to restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition, the use of the medication should be deemed a restraint.
 - a. The intent of federal regulations is not to interfere with the clinical treatment of patients who are suffering from serious mental illness and who need therapeutic doses of medication to improve their level of functioning so they can more actively participate in their treatment. Similarly, regulations are not intended to interfere with appropriate doses of sleeping medication prescribed for patients with insomnia, antianxiety medication prescribed to calm a patient who is anxious, or analgesics prescribed for pain management. See Section V.8) below for further details related to use of drug as a restraint.
- 5) **Episode of seclusion or restraint:** all *continuous* seclusion or restraint interventions, beginning with the first hands-on intervention and ending at the conclusion of all subsequent interventions. In this context, *continuous* refers to consecutive orders from the initiation until the safe release of the patient.
- 6) **Five-point restraint:** a four-point restraint with the addition of a strap, which is placed over the patient's upper torso and secured to the bed frame.
- 7) **Four-point restraint:** restraints that encase the wrists and ankles of a patient lying on a bed, which are secured to the bed frame.
- 8) **Individual Crisis Prevention Plan (ICPP), Individual Calming, Wellness and Recovery/Resilience Plan (ICWRP), or equivalent:** a document that identifies a patient's early warning signs, triggers, coping skills, patient preferences, and behaviors related to behavioral management interventions.
- 9) **Manual restraint:** the use of a manual or physical hold to restrict a person's freedom of movement or normal access to their body.
 - a. Manual restraints include, but are not limited to, physical restraints required to facilitate the safe administration of court ordered or emergency medications administered over the patient's objection and other physical interventions that are designed to involuntarily hold or pin the patient to restrict movement. Furthermore, a physical "takedown" to the floor is always considered a manual restraint.
 - b. Manual restraints are holds that are commonly referred to as "therapeutic holds." Nationally, many deaths have occurred while employing these practices. Physically holding a patient can be just as restrictive, and just as dangerous, as restraining methods that involve devices.
 - c. The physical holding of a patient for the purpose of conducting routine physical examinations or tests, may not necessarily meet the definition of "manual restraint." However, patients do have the right to refuse treatment (see 14 NYCRR Parts 27.8 and 527.8). Holding the patient in a manner that restricts a patient's movement against a procedure or test to which they have the right to object, in accordance with such Parts, is considered a manual restraint.
 - d. A staff member picking up, redirecting, or holding a child to comfort them is not considered restraint.
 - e. A physical escort, which is a light grasp to escort a patient to a desired location, is not considered a restraint if the patient can easily remove or escape the grasp. However, if the patient cannot easily remove or escape the grasp, this would be considered manual restraint and all of the procedural requirements for restraint would apply.

- 10) **Mechanical restraint:** an apparatus which restricts a patient's movement of their head, limbs, or body, and which the patient is unable to remove. This term may also apply to an apparatus not normally used for this purpose, such as a bed rail or bed sheet if the patient is not able to release the mechanism.
- a. Because the definition of mechanical restraint does not name each device and situation that can be used to immobilize or reduce the ability of a patient to move their arms, legs, body or head freely, it promotes looking at each patient situation on a case-by-case basis.
 - b. Generally, if a patient can easily remove a device, the device would not be considered a restraint. In this context, "easily remove" means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as was applied by the staff (e.g., side rails are put down, not climbed over), considering the patient's physical condition and ability to accomplish the objective. A determination as to whether something is "easily removed" is based on a patient's physical and cognitive abilities to remove a restriction within a brief time span.
 - c. A restraint does not include methods that protect a patient from falling out of bed. Examples include raising side rails when a patient is on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of the bed. The use of side rails in these situations prevents the patient from falling out of the bed and therefore would not be considered a restraint based on this definition.
 - d. However, the use of side rails to prevent the patient from exiting the bed would be considered a restraint and would be subject to all the procedural requirements applicable to restraints. For example, if all 4 side rails are raised in order to restrain a patient, then the requirements set forth apply. Raising fewer than 4 side rails when the bed has segmented side rails would not necessarily immobilize or reduce the ability of a patient to move freely, as defined above. For example, if the side rails are segmented and one segment is not raised to allow the patient to freely exit the bed, the side rails are not acting as a restraint. In addition, if a patient is not physically able to get out of bed, regardless of whether or not the side rails are raised, raising all 4 side rails would not be considered restraint because the side rails have no impact on the patient's freedom of movement.
- 11) **Mechanical support:** a device intended to keep a patient in a safe or comfortable position or to provide the stability necessary for therapeutic measures such as immobilization of fractures, administration of intravenous solutions or other medically necessary procedures, which the patient *can* remove at will.
- 12) **Mitts or helmets:** constitutes a restraint when used as an emergency intervention to avoid imminent injury to the patient or others and the patient cannot easily remove them at will in the same manner it was applied by staff. By extension, applying the mitts so tightly that the patient's hands or fingers are immobilized, or using mitts that are so bulky that a patient's ability to use their hands is significantly reduced, would also constitute a restraint. Pinning or otherwise attaching mitts to bedding or using a wrist restraint in conjunction with mitts is not permitted.
- 13) **One-to-one constant observation:** a situation in which a staff member is responsible for maintaining continuous monitoring of a single patient, keeping them in view at all times, and, if clinically appropriate, attempting to initiate dialogue with the patient. In this situation, the staff member must remain in close enough proximity to the patient to be able to respond immediately if needed and must not have supervisory responsibilities for other patients.

- 14) **Restraint:** any manual method or mechanical device which immobilizes or reduces the ability of a patient to freely move their arms, legs, body, or head which the patient *cannot* remove at will. This also includes pharmacologic measures that meet the definition of *drug used as a restraint* (see above).
- 15) **Restrictive Intervention:** an intervention used to restrict the freedom of movement of a patient for the purposes of behavioral management or medical/post-surgical care. This may include the use of seclusion, manual restraint, mechanical restraint, and drug used as a restraint.
- 16) **Seclusion:** the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. This also applies when the patient reasonably believes that they will be prevented from leaving, with no ability to meaningfully interact with others.
- a. Seclusion may only be used for the prevention of violent behavior or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.
 - b. Seclusion is not just confining a patient to an area, but involuntarily confining the patient alone in a room or area where the patient is physically, or cognitively prevented from leaving.
 - c. When the patient is restricted to a room alone, whether or not the door is actually closed or locked, the following situations are considered seclusion:
 - i. The patient attempts to leave the room and is not permitted to do so.
 - ii. Staff are physically intervening to prevent the patient from leaving the room.
 - iii. Staff actions can reasonably be interpreted by the patient as being threatened with physical interventions, or facing other implicit or explicit consequences, to prevent them from leaving the room/area.
 - d. The following situations are not considered seclusion:
 - i. A staff member is in a room with a patient and is engaging in positive therapeutic interventions in an attempt to help the patient maintain or regain control.
 - ii. Confinement on a locked ward or unit where the patient is with others.
 - iii. Time out.
- 17) **Time out/Calming time:** a therapeutic intervention in which the patient, either upon the recommendation of staff or at the patient's initiative, consents to spend time alone in a designated area. For an intervention to be considered a time out, the patient must be permitted to enter the area/room voluntarily, and the patient's ability to exit the time out area or room must not be restricted by any means. When feasible, rooms used for time outs should not be the same room as that used for seclusion or restraint.
- 18) **Wrist-to-belt restraint:** a belt, secured around a person's waist, with attached restraints that encase their wrists. The tethers that secure the restraints to the belt may be of adjustable lengths, which allow variation in the degree of restricting the person's arms.

IV. GENERAL PRINCIPLES

- 1) The health and safety of the patient are always the primary concern of the OMH. Therefore, whenever a patient demonstrates a need for serious medical attention during an episode of seclusion or restraint, medical priorities must supersede behavioral priorities, including the placement of the patient in seclusion or restraint.
- 2) Seclusion or restraint for behavioral management purposes are considered emergency safety interventions and can only be employed when necessary to prevent a patient from seriously injuring self or others and less restrictive techniques have been tried and failed, or in the rare

instance in which the patient's danger is of such immediacy that less restrictive techniques cannot be safely applied.

- 3) The facility must convey to patients and to those families/significant others who, upon patient agreement are involved in the patient's treatment planning process, the intentions of the OMH which is to make the use of restrictive interventions a rare occurrence. As such, every facility must have a plan to reduce and ultimately try to eliminate the use of restraint and seclusion.
- 4) Prior to participating in the restraint or seclusion of a patient, all clinical staff must demonstrate competence in alternatives to and the appropriate application of seclusion and restraint. Techniques sanctioned and taught by the OMH must be employed. The following is prohibited:
 - a. Using of excessive force in initiating the use of seclusion or restraint;
 - b. Placing a patient in a face-and/or-chest down position. Staff must be able to check the patient's airway and prevent the possibility of positional asphyxia. If a patient is inadvertently in a face-down or chest-down position, staff must immediately reposition the patient.
 - c. Using any technique that obstructs a patient's respiratory airway or impairs their breathing or respiratory capacity, including techniques in which a staff member places pressure on a patient's back, neck, or throat, or places their body weight against the patient's torso or back;
 - d. Using a technique that utilizes a pillow, blanket, or other item to cover the patient's face or to hold over or above the patient's face; or
 - e. Using any technique on a patient who has a known medical or physical condition where there is reason to believe that use of such technique would endanger the person's life or significantly exacerbate the person's medical condition.
- 5) Seclusion or restraint is not a substitute for treatment. When it occurs, it indicates the need for patient and staff debriefings and a Post Event Analysis, which includes a treatment plan review. (See Section VI.5)
- 6) A restrictive intervention must not serve as a substitute for adequate staffing to monitor patients.
- 7) Seclusion or restraint must not be used as punishment or for the convenience of staff.
- 8) Every effort must be made to protect the patient's privacy during the restrictive intervention.
- 9) The decision to use seclusion or restraint must not be based on the individual's seclusion or restraint history or solely on a history of dangerous behavior.
- 10) Seclusion must not be used with patients whose sole diagnosis is an intellectual developmental disorder. However, seclusion must be permitted for patients with a dual diagnosis of mental illness and intellectual developmental disorder, only if performed in accordance with the requirements of manual which govern seclusion interventions, in order to ensure compliance with 14 NYCRR Section 526.4.
- 11) In cases where restraint or seclusion is needed, the least restrictive type which is appropriate and effective under the circumstances must be used.
- 12) When determining whether a physical intervention constitutes a restrictive intervention, reasonable consideration must be given to the nature of the patient's behavior precipitating the intervention, federal and state guidance, and clinical judgment.
- 13) When a restrictive intervention is ordered for patients who, based on clinical judgment, have a significant history of physical or sexual abuse, intellectual/developmental disability, are deaf or hard of hearing and may require communication by hands, visual impairments that compromise awareness of environment, and/or medical conditions (e.g., cardiometabolic history, acute injuries, pregnancy, drug interactions), an explanation of why a restrictive intervention is the most appropriate course of action must be included in their clinical record. Special care or monitoring will be ordered, as indicated and relevant staff will be informed of any specialized plans, technique modifications, monitoring needs, or alternate strategies.

- 14) The criteria for release of a patient from seclusion or restraint is directly related to the behaviors that necessitated the intervention. To help staff determine if the patient is no longer a risk to self or others and ready for release from the restraint or seclusion, the physician will note in the order both a description of the behavior(s) that resulted in the intervention(s) as well as the criteria for release. The patient must be informed of the criteria for release.
- 15) Staff must continuously assess and monitor the patient to ensure they are released from restraint or seclusion at the earliest possible time (i.e., when they no longer present a danger to self or others), regardless of the maximum time specified in the physician's order.
- 16) Office of Mental Health Prior Approval
 - a. The standard types of mechanical restraint are four-point restraint, five-point restraint, wrist-to-belt restraint, mitts, helmets, and calming blanket. No facility must use these devices unless the related manufacturer and model have been approved by the OMH Chief Medical Officer (CMO) or designee. Such approval must be interpreted to allow facility-wide use.
 - b. Prior approval from the OMH CMO or designee must be obtained before the use of any other type of mechanical restraints for specified patients for a specified period on a case-by-case basis. Any exception must include the maximum allowable time for each intervention, parameters for time limited use, and periodic renewal of the approval.
 - c. Prior approval from the OMH CMO or designee must be obtained before the use of any form of restraint used for transportation outside the facility.
 - d. The use of manual restraint is the only type of restraint permitted with children less than 9 years of age in facilities operated by the OMH. Other types of restraint, as well as seclusion, are prohibited for this age group, except upon prior approval on a case-by-case basis by the OMH CMO or designee.
 - e. Mechanical restraint must not be used for patients under the age of 18, except upon prior approval on a case-by-case basis by the OMH CMO or designee.
 - f. Facilities should include in their hospital policies a mechanism by which prior approvals are obtained and documented.

V. SPECIFIC CIRCUMSTANCES

- 1) **Simultaneous Use:**
 - a. Seclusion and mechanical restraint must never be used simultaneously. The patient may not be locked in a room alone while in mechanical restraints.
 - b. Two forms of restraint must not be used simultaneously, with the following exceptions:
 - i. the use of mitts and helmets together; or
 - ii. the use of manual restraint while placing a patient in mechanical restraint or seclusion; or
 - iii. the use of a drug as a restraint with other forms of restraint or seclusion.
- 2) **Spit Guard Products:** It is against the OMH policy to place objects on or over a patient's face during restraint procedures. Certain spit guard products may only be used if specifically approved by the Commissioner as safe, provided the technique used does not violate the provisions of 14 NYCRR §526.4. In situations in which infection control precautions need to be taken to protect staff against biting and spitting during restraint episodes, staff may wear bite gloves, masks, or clear face shields.
- 3) **Mitts and Helmets:** When the use of mitts **or** helmets meet the definition of a restraint, their application must follow the procedures for restrictive interventions set forth in Section VI of this manual.
- 4) **Manual Restraint:**
 - a. When manual restraint is required to facilitate the safe administration of emergency medications over a patient's objection, court-ordered medication over a patient's

objection, or medications approved per 14 NYCRR 527.8 process for minors, a physician's order for manual restraint is required and all provisions of this manual governing the use of manual restraint apply.

- b. When manual restraint is used for the purpose of facilitating the placement of a patient in seclusion or mechanical restraint:
 - i. ALL interventions must be included in a physician's order. For example, a separate order is not needed for a manual restraint if the seclusion or mechanical restraint order includes the directive to use manual restraint.
 - ii. The duration of each intervention (manual restraint and seclusion) should be noted when reporting via NIMRS or any successor format.

5) **Time Out** is a voluntary process carried out in collaboration with the patient. As a less restrictive alternative to the use of seclusion or restraint, it should be encouraged whenever possible to de-escalate the situation and to provide the patient the opportunity to reflect or regroup in an environment that is free from additional stimuli. This would allow the patient to practice coping skills and/or other calming techniques identified in the ICPP, ICWRP, or equivalent, or plan of care.

6) **Use of Mechanical Supports:**

- a. A mechanical support is used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such a mechanical support and is not considered a restraint. For devices intended to keep a person in a safe or comfortable position, however, the patient must be able to release the device at will; otherwise, the procedure needs to be defined and handled as a restraint.
- b. The use of mechanical supports must be ordered by a physician as part of the patient's treatment program in accordance with facility policy. Such order must be documented in the patient's clinical record. The order should include the following:
 - i. type of mechanical support device used;
 - ii. the reason for the use;
 - iii. the duration of use; and
 - iv. any special monitoring considerations.
- c. The use of mechanical support must include an assessment by the physician that documents the following:
 - i. why the device is needed to promote safety;
 - ii. parameters for use (e.g., as a support to prevent further injury and that the patient may remove it at will);
 - iii. other supportive actions that should be used to try to prevent the patient from further injury (e.g., one-to-one observation, counseling, medications, etc.);
 - iv. that the patient understands the reasons for use, how to remove it, and is agreeable to the intervention;
 - v. anticipated duration of use, if known; and
 - vi. the long-term plan to promote alternative measures for safety.
- d. As a matter of policy, mechanical supports must not be used as a substitute for restraint. In those rare events in which they are used as a form of restraint, such use must only be implemented following the prior approval of the OMH CMO or designee. Each facility should have a specific policy addressing the use of mechanical supports that includes at minimum the following:
 - i. circumstances for use;
 - ii. required contents of physician's order;
 - iii. order renewal frequency;
 - iv. treatment team's review frequency;
 - v. documentation requirements;

- vi. how use is incorporated in the treatment plan/plan of care.

7) Locking Mechanisms:

- a. Except as provided in Section b. below, mechanical restraints which employ a locking mechanism released by a key must never be used or considered approved for use.
- b. Wrist to Belt: Forensic facilities and facilities treating patients pursuant to Article 10 of the Mental Hygiene Law may use wrist-to-belt restraint devices with locking mechanisms released by a key if procedures are established to ensure:
 - i. when on duty, all employees with monitoring responsibility for a patient wearing a wrist-to-belt device with a locking mechanism are required to carry on their person the key to release the restraints;
 - ii. for each shift during the time that a patient is wearing a wrist-to-belt device with a locking mechanism, one or more keys to release the restraints are assigned to a safety officer on duty;
 - iii. training and practice sessions must be regularly conducted to ensure that all staff required to carry the key to the locked wrist-to-belt restraint are advised of the need to release a patient wearing such a device in a medical emergency and understand how to quickly release the restraint; and
 - iv. that when such devices are used, all employees required to carry the key, do in fact, have the key in their possession, and that the keys are accounted for at the beginning and end of each day.

8) Drug Used as a Restraint: When medication is used as a restriction to manage behavior or to restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition, the use of the medication must be deemed a restraint (i.e., drug used as a restraint). It may be used in conjunction with seclusion or other forms of restraint, but if done so, all interventions must be identified on the order form. The use of a drug or medication as a restraint should be considered a rare occurrence.

- a. An important consideration in determining when the use of medication meets the criteria for restraint is the intended purpose for which the medication is being ordered. If the patient's behavior has risen to a level where there is an imminent risk of serious injury to the patient or others, and the purpose of the medication is to limit their movement, the medication is a restraint. However, if the primary purpose of a drug is to calm a patient to enable them to remain in the therapeutic milieu, the medication is not considered a restraint. Whether or not an order for a drug or medication is STAT (immediate one-time order), PRN (as needed), or a standing order, does not determine whether the use of that drug or medication is considered a restraint. However, ordering PRN or standing medications solely for the purpose of a restraint is prohibited.
- b. While the use of drugs as a restraint is not considered a routine practice by the OMH, there may be emergency situations where the degree of harm posed by a patient's behavior is such that the primary intent of a physician in ordering a medication is to restrict the ability of the patient to engage in the dangerous behavior, thereby minimizing harm to the patient and others. When medication is used in this manner, there must be a STAT order for the medication, and the use of the medication must also be identified as a restraint.
 - i. As with any use of restraint or seclusion, an assessment of the patient must be done to determine if less restrictive alternative interventions are possible before using a drug or medication as a restraint.
 - ii. Consistent with other forms of restraint, all uses of drugs as a restraint can only be implemented following a written order of a physician. An order for the use of a drug as a restraint must specify that the medication is to be used as a restraint.

- iii. The physician must identify the duration of time for which the patient must be monitored, as there is no defined time limit for medication effects. This must be based on the anticipated effect of the medication on the patient, their clinical status, and the judgement of the physician. However, at minimum, the duration for observation must be 30 minutes; and the minimum level of observation must be one-to-one constant observation. Monitoring and observation must include:
 - Post-medication administration assessment and reassessment by a registered nurse at a minimum of every 15 minutes.
 - Monitoring of vital signs must be done more frequently than with mechanical or manual restraint, in accordance with good clinical practice and facility policy, and at the discretion of the physician. At a minimum, vital signs will be monitored every 15 minutes for one hour after administration of the drug used as a restraint.
 - If sequential medications are administered, vital signs must be monitored at a minimum of every 15 minutes for two hours after the initiation of the last medication given.

VI. PROCEDURES

All procedures herein apply to the use of restrictive interventions for behavioral management and medical/post-surgical care purposes unless otherwise stated.

1) Individual Crisis Prevention Plans (ICPPs), Individual Calming, Wellness and Recovery/Resilience Plans (ICWRPs), or equivalent:

- a. Within its assessment procedure for all patients, facilities must incorporate a patient interview, as clinically indicated, in which a number of specific inquiries are made regarding the patient's early warning signs, triggers, coping skills, and individual preferences and behaviors related to behavioral management interventions. These preferences or recommendations must be documented in the clinical record and used to develop an individual crisis prevention plan. Additional guidance regarding the development of individual crisis prevention plans can be found in the Implementation Guidelines for 14 NYCRR §526.4.
- b. The plan is developed and implemented as soon as possible after admission. However, on rare occasion, the immediacy of a dangerous situation may require the application of restrictive interventions prior to the development of the plan.
- c. ICPPs, ICWRPs, or equivalent are designed to:
 - i. be a collaborative effort between patients and staff to identify agreed-upon strategies designed to assist the patient in maintaining or regaining control of their emotions and behaviors;
 - ii. help patients during the earliest stages of distress before a crisis escalates;
 - iii. help patients identify practicable coping strategies;
 - iv. help staff plan ahead and know what to do with each patient if a problem arises; and
 - v. help staff use interventions that reduce risk and trauma to patients.
- d. ICPPs, ICWRPs, or equivalent must have at least three distinct sections: triggers, early warning signs and coping strategies. The plans must encourage creativity and must be individualized to each patient's needs, linked to any personal history of trauma, and tailored to environmental resources.
- e. Each facility must develop a mechanism to be sure that staff on all shifts, including floating staff, are aware of the patients' ICPPs, ICWRPs, or equivalent. At a minimum, the plans must be available and readily accessible by staff. The information may also be included in other places where patient-alerts are noted.

- f. A copy of the ICPPs, ICWRPs, or equivalent must be given to the patient and routinely reviewed and updated when changes are warranted. To provide an opportunity for the patient to build proficiency and increase the probability that their plan will be effective during times of crisis, the patient must be given an opportunity to practice their identified coping strategies at times when not in crisis.
- g. Any preferences expressed by the patient regarding the gender of and/or languages spoken by the observing staff person must be honored when practicable and clinically appropriate.

2) Strategies to Reduce the Use of Seclusion and Restraint:

- a. Appropriate staff must be made aware of patients' ICPPs, ICWRPs, or equivalent and must be instructed to implement these plans in the early stages of crisis to help the patient regain control.
- b. Consistent with the OMH's emphasis on recovery, each facility must be able to demonstrate commitment to reduction of the use of seclusion and restraint through hiring practices, training, and active involvement of executive, administrative, and supervisory staff. This commitment can be demonstrated by ensuring that all staff are trained and are able to demonstrate the use of clinical intervention strategies that contribute to therapeutic communication, negotiation, problem solving, prevention of power struggles between patients and staff, and proactive prevention and management of crisis behavior through use of verbal de-escalation strategies, trauma informed interventions, and least restrictive measures.
- c. Each facility is required to develop a plan to become violence and coercion-free, the progress of which must be monitored regularly by the Facility Director or designee.

3) Initiating Seclusion or Restraint:

- a. Every effort must be made to implement any applicable provisions of the ICPP, ICWRP or equivalent, except in those rare instances in which the patient's dangerousness is of such immediacy that less restrictive interventions cannot be safely applied.
- b. The OMH expects that staff will immediately interact/intervene to prevent a patient from seriously injuring themselves or others. When patients display antecedents to aggressive behavior and a potential crisis appears to be evolving, the registered nurse, nurse practitioner, or physician must be immediately notified.
- c. The implementation of seclusion or restraint can only be pursuant to a physician's order. However, it may be initiated in the absence of a physician's order if a patient presents an imminent danger to self or others and a physician is not immediately available to examine the patient.
- d. Prior to ordering the use of seclusion or restraint, the physician will consider any prior medical diagnoses, conditions, or significant history, including but not limited to cardiometabolic history, a history of physical or sexual abuse, drug interactions, intellectual/developmental disabilities, range of motion concerns and relevant hearing/visual concerns. The need for special care or monitoring will be ordered, as indicated.
- e. Implementation of the seclusion or restraint order must be consistent with the techniques sanctioned and taught by the OMH.
- f. The use of restraint for the purpose of medical/post-surgical care requires notification to the clinical director or designee.
- g. Prior to placing a patient in seclusion or restraints, a search for potentially dangerous objects must be conducted, and such objects must be removed. If such a search cannot

safely be conducted, the reason for the delay must be documented in the patient's clinical record. The search must be conducted as soon as safely possible.

- h. To enable staff to check the patient's airway and prevent positional asphyxia, patients are prohibited from being placed in a face-and-chest-down position. In cases where the patient moves or is inadvertently moved to a chest-down position, the patient must be immediately repositioned.
- i. Every effort must be made to ensure patients are not placed in seclusion or restraint in a nude or semi-nude state to preserve the patient's dignity.
- j. Immediately after the application of the seclusion or restraint, a physician or registered nurse must assess the patient to ensure that the intervention was safely and correctly applied without undue harm or pain to the patient.
- k. The use of a restrictive intervention must be employed in accordance with the following directives:
 - i. A physician must be called immediately to conduct an in-person examination of the patient. If the physician cannot arrive within 5 minutes, a telephone order must be issued to initiate the restraint or seclusion. Telephone orders to initiate restraint or seclusion will be issued sparingly.
 - A nurse must note in the patient's clinical record the time of the call, the name/title of the person making the call, the name of the physician contacted who gave the order, and the name of the person or persons who initiated the seclusion or restraint, and must complete a telephone order in accordance with facility policy.
 - The physician who ordered initiation of the restraint or seclusion via telephone order, or a covering physician must authenticate the order in writing and perform an examination of the patient within 30 minutes of the time of notification.
 - ***Delay in physician arrival:*** If the physician's arrival exceeds 30 minutes from the time called:
 - the patient will remain under constant supervision.
 - the registered nurse must record the delay in the clinical record, in addition to a description of the patient's behavior which requires seclusion or restraint, the type of procedure used, any condition for maintaining the seclusion or restraint pending the arrival of the physician, the reasons why alternative interventions were not used, and a description of the steps taken to ensure the patient's comfort and safety.
 - the physician will record in the patient's clinical record the explanation for the delay in arrival.
 - ii. Based on a physician's in-person examination:
 - If the physician determines that the use of seclusion or restraint was and/or ***continues to be indicated***, they must authenticate the telephone order and write an order for the procedure consistent with the requirements. The order must commence from the time at which the patient was initially placed in seclusion or restraints. The combined duration of the period specified in the physician's written order and the period of seclusion or restraint initiated by the registered nurse must not exceed the maximum time allowed for the intervention (See Section VI.3)m. below).
 - If the physician determines that seclusion or restraint ***is no longer indicated***, the order will be discontinued. This should not be interpreted as

a judgement of the initial decision to initiate the restrictive intervention; the crisis may have passed. In addition, the physician must write an order to cover the time in which the patient was in seclusion or restraint prior to the physician's examination.

- I. The ***physician's written order*** must:
 - i. Be written on the standardized OMH approved Restraint and Seclusion order form and included in the patient's clinical record.
 - ii. Specify the circumstances and behaviors justifying the intervention(s).
 - iii. Specify the time of initiation and expiration of the authorization; when writing an order for seclusion or restraint, the time frame should be written using language indicating the patient should only remain in restraint or seclusion until they have met the behavioral release criteria. Phrases such as "for a maximum of" or "up to" should be used to indicate staff have the discretion to release the patient before the time of the order has elapsed, if the behavioral release criteria have been met. The physician has the discretion to write the order for a shorter length of time.
 - iv. Specify the type of intervention(s) to be used. If a physician orders the use of restraint, the written order must specify the type of restraint to be used; If an additional intervention(s) is required after the order is signed, an additional order form must be completed for this supplementary intervention.
 - v. Identify the behavioral criteria for release.
 - vi. Include any special care or monitoring instructions.
- ii. Notwithstanding the provisions of 14 NYCRR §526.4, the maximum time period for orders of seclusion or restraint must be in accordance with the following (provided, however, that when a drug is used as a restraint, the provisions of Section V.8) of this manual apply).
 - i. For behavioral management purposes:
 - one hour for adults
 - 30 minutes for patients ages 9 to 18, or for patients over age 18 in a children's facility or unit
 - up to 15 minutes for manual restraint for patients of any age
 - up to 15 minutes for the use of a calming blanket which is not intended for use as an ongoing restraint
 - ii. The maximum time period for each order of restraint for medical/post-surgical care is 24 hours.
 - iii. Continuation orders must be written in accordance with the maximum time periods noted above. Exceptions may only occur upon prior approval on a case-by-case basis by the OMH CMO or designee. Prior approval must include the maximum allowable time for each intervention, parameters for time limited use, and periodic renewal of the approval. Refer to Section IV.16) for additional information regarding prior approvals.
- iii. If an attending physician did not order the restraint or seclusion, an attending physician must be consulted as soon as possible.
- o. Continuous/multiple use of seclusion or restraint.
 - i. If an episode of mechanical restraint or seclusion has exceeded 2 hours for adults, 1 hour for children and adolescents ages 9 to 17, or 30 minutes for children under age 9, and it is expected that restraint or seclusion will be required beyond such time periods, the facility's Clinical Director or Director of Psychiatry, or designee must be notified and consulted.

- ii. The use of seclusion or restraint beyond a continuous 4-hour period requires prior approval by the clinical director or designee. Continuous use must not exceed 24 hours without notification of the OMH CMO or designee.
 - iii. The Clinical Director or designee must immediately be notified of the issuance of 2 or more separate episodes for the use of seclusion or restraint on any patient within any 12-hour period.
 - iv. Facilities are required to include in their hospital policies a mechanism by which all required notifications are made and documented, and how prior approvals are obtained and documented.
- p. PRN orders cannot be used to authorize the use of seclusion or restraint.
- q. ***Physician assessment/in-person evaluation:***
 The examination of the patient conducted by the physician must include an assessment of the patient's psychiatric status and physical condition.
 - i. The psychiatric status assessment must include an evaluation of the patient's immediate situation, the patient's reaction to the intervention, assessment of the patient's behavior, thought content, actual dangerousness to self or others, and level of consciousness. It should also include any other assessments which are clinically necessary, if other factors (such as medication interactions, electrolyte imbalances, etc.) may be contributing to the patient's violent or self-destructive behavior, and the need to continue or terminate the restraint or seclusion.
 - Based on the results of a physician's in-person evaluation:
 - If the physician determines that the use of seclusion or restraint was and/or ***continues to be indicated***, documentation should support the need to continue the intervention.
 - If the physician determines that seclusion or restraint ***is no longer indicated***, the physician must document the rationale.
 - ii. The physical assessment must include:
 - an assessment of the patient's general condition and vital signs, and any other examinations which are clinically necessary;
 - a review of the clinical record for any pre-existing medical diagnosis and/or physical condition that could present the need for special considerations and additional monitoring when using seclusion and/or restraint, and that may require alternative interventions; and
 - a review of the patient's existing medication orders and must assess the need for modifying orders during the period of seclusion or restraint.
 - iii. Frequency:
 - The in-person evaluation is required for each episode of restrictive intervention and should be completed within 30 minutes of notification of the event.
 - If a patient remains in continuous restraint or seclusion 24 hours after the original order, the physician must see the patient again and conduct another face-to-face evaluation before writing a new order for the continued use of restraint or seclusion.
 - In-person evaluations may be conducted more frequently. Whether or not more frequent onsite evaluations are necessary prior to renewing a continuation order is left to the discretion of the physician in conjunction with a discussion with the registered nurse who is overseeing the care of the patient.
 - iv. Documentation:

- The results of the assessment must be documented in the patient's clinical record, along with the inadequacy of less restrictive interventions and the specific behaviors that necessitated seclusion or restraint. In addition, for medical/post-surgical care interventions, documentation must describe the circumstances justifying the intervention.
 - When any element of the examination cannot be performed due to the condition of the patient, an explanation for the omission and the physician's clinical observations of the patient must be recorded.
 - Documentation of the evaluation should be completed as soon as possible after the assessment is completed and must include the time of the physician's examination. If a physician's arrival exceeds 30 minutes from the time called, the delay in arrival and a description of the patient's behavior must be documented in the clinical record.
 - The physician must document in the clinical record the time they examined the patient.
- r. If the patient has requested notification to family and/or a patient advocate of the application of seclusion or restraint, a clinical staff member must make such notification as soon as possible. If a family has submitted a written request not to be notified of instances of seclusion and restraint, the facility must honor this request.

4) Monitoring and Release of Persons in Seclusion or Restraint:

- a. A patient in seclusion or restraint must be monitored to ensure that physical needs, comfort, and safety are properly addressed.
- i. A patient in seclusion or restraint must receive one-to-one constant observation while being monitored. Audiovisual monitoring may not be used for monitoring patients in restrictive interventions. The staff person should monitor a patient by being situated so that the staff person is able to hear and be heard by the patient and visually observe the patient at all times.
 - ii. For seclusion: The staff person monitoring the patient may be immediately outside a space in which a person is being secluded provided that the staff person is in full view of the patient; and the staff person is able at all times to observe the patient and to have immediate physical access to the patient in order to respond to any emergency situation.
 - iii. For mechanical restraints: The staff person monitoring the patient must remain in the room with the patient and be within close enough proximity to immediately respond to the patient's needs.
 - iv. For drug used as a restraint: The staff person monitoring a patient must maintain the patient in full view at all times and have immediate physical access to the patient in order to respond to any emergency situation.
 - v. The facility is responsible for providing the level of monitoring and frequency of reassessment that will protect the patient's safety.
 - vi. Staff members assigned to provide one-to-one constant observation will not have other assigned responsibilities during the time that they are assigned this supervision responsibility.
 - vii. A patient in seclusion or restraint must be monitored by a staff member who is trained and competent in OMH policies and procedures regarding seclusion and restraint. Monitoring staff must have demonstrated skills in minimizing the use of seclusion and restraint, assisting patients in meeting behavior criteria for the discontinuation of seclusion or restraint, and assisting patients in meeting their physical needs (e.g., nutrition and hydration, hygiene and elimination, circulation

and range of motion in the extremities, and vital signs). The RN/NP/Physician will assess physical and psychological signs of distress or injury of patients who are in seclusion or restraint, and determine readiness for the discontinuation of these interventions.

For ***behavioral management and medical/post-surgical care*** interventions:

- An assessment of the patient's condition must be made and documented at least once every 30 minutes, (or more frequently if so directed by the physician) after the initiation of restraint or seclusion. This assessment must be made by a registered nurse who is responsible for the care of the patient and who has been trained, and has demonstrated competency, in the use of restraint and seclusion. Note: caution should especially be exercised during episodes of manual restraint lasting more than 10 minutes, to ensure the health and safety of all involved.

For ***medical/post-surgical care*** interventions:

- Monitoring the patient's condition includes administration of range of motion exercises to the limbs at least every 2 hours, when the patient is awake.
- b. The time limits in the physician's order do not dictate how long a patient must remain in restraint or seclusion. Staff are expected to continuously assess and monitor the patient to ensure that the patient is released from restraint or seclusion at the earliest possible time. Staff should be continually attempting positive therapeutic interventions to help the patient meet the release criteria.
- c. A temporary directly supervised release that occurs for the purpose of caring for a patient's needs (e.g., toileting, feeding, or range of motion exercises) is not considered a discontinuation of the restrictive intervention. As long as the patient remains under direct staff supervision the intervention is not considered discontinued because the staff member is present and is serving the same purpose as the restraint or seclusion.
- d. Vital signs (consisting of blood pressure, temperature, pulse and respiratory rate) must be taken and recorded.
- i. For ***behavioral management*** interventions, at minimum (or more frequently as ordered by a physician):
 - For restraint: On initiation/immediately following application, hourly thereafter, and upon release.
 - For seclusion: On initiation/immediately following placement, every two hours thereafter, and upon release.
 - For drug used as a restraint: On initiation/immediately following administration, every 15 minutes for one hour. If sequential medications administered, every 15 minutes for two hours from initiation of the last medication given.
 - ii. For ***medical/post-surgical care*** interventions, at minimum (or more frequently as ordered by a physician):
 - For 4 point or 5 point mechanical restraint: On initiation and hourly.
 - For all other methods of mechanical restraint: On initiation and daily.
 - iii. If vital signs of a patient in seclusion or restraint cannot be taken safely at the frequency required, the reason for each omission must be documented in the patient's clinical record.
- e. Documentation must be completed as follows:
- i. For ***behavioral management*** interventions:
 - Documentation of the need for seclusion or restraint and of the general comfort and condition of the patient must be done at the time of the initial

application of the seclusion or restraint and every 15 minutes thereafter, or at more frequent intervals as directed by the physician. This must be documented in the clinical record.

- ii. For **medical/post-surgical care** interventions:
 - When utilizing four-point or five-point methods of mechanical restraint for medical/post-surgical care, documentation of the need for the restraint of the general comfort and condition of the patient must be done at the time of the initial application of the restraint and every 15 minutes thereafter, or at more frequent intervals as directed by the physician. This documentation must be recorded in the clinical record.
 - For all other forms of mechanical restraint used for this purpose, documentation of the need for the restraint of the general comfort and condition of the patient must be done at the time of the initial application of the restraint and every hour thereafter, or at more frequent intervals as directed by the physician. This documentation must be recorded in the clinical record.
- f. Facility policies should address the assessment expectations (e.g., vital signs, circulation, hydration needs, elimination needs, level of distress and agitation, mental status, cognitive function, skin integrity) and how to meet patient needs during the restrictive intervention.
- g. When the patient is complaining of physical discomfort or difficulty breathing, or the staff person observing the event notices a physical change of color or similar concern, the RN or physician must assess the situation and alleviate the physical problem.
- h. In order to reduce the possibility of choking, unless clinically indicated (e.g., patient in medical/post-surgical restraints), patients must not be fed while in restraints. If a patient has been restrained and not fed during mealtime, they must be offered food and fluids immediately after release from restraints.
- i. The patient must be informed of release criteria and they must be released from seclusion or restraint as soon as they no longer present an imminent risk of danger to self or others, consistent with the behavioral description provided by the physician in determining that seclusion or restraint was warranted. Unless the nurse, nurse practitioner, or physician determines that the patient is obviously dangerous, an attempt should be made to release them at least once every 30 minutes. This attempt must be documented.
 - i. If a patient, upon this **attempt to release** them from seclusion or restraint, is assessed to be a continued danger to self or others, the intervention may be continued, unless the order has expired. The patient will continue to be monitored as ordered until release criteria is met.
 - ii. If the order has expired, a subsequent order of seclusion or restraint can only be initiated in accordance with the procedures set forth in Section VI.3).
 - iii. If a patient, **upon being released** from seclusion or restraint, makes no overt gestures or verbalizations that would indicate a threat of serious harm or injury to self or others, the procedure must not be re-imposed.
 - iv. If **after being released**, restraint or seclusion needs to be reapplied, a new order is required; staff cannot discontinue a restraint or seclusion order, and then re-start it under the same order.
 - v. Restraint or seclusion must be reevaluated and ended at the earliest possible time the behavioral criteria is met or the intervention is no longer needed. A staff member who is trained and competent in OMH seclusion and restraint policies and procedures may discontinue the intervention. If a Registered Nurse is not immediately present to observe, evaluate, and document the patient's physical

and psychological condition upon release, the RN should be notified immediately. Upon release from restraint or seclusion, a registered nurse must document their assessment of the patient's condition.

- j. It is the responsibility of the physician who has ordered seclusion or restraint, or a covering physician, to be accessible to staff in the event of an emergency. Accordingly, the physician must advise appropriate staff how to contact them, or a covering physician, during the period of the order.
- k. Each facility must develop and implement written procedures to ensure that physicians are accessible to staff on all shifts when the physician who has ordered seclusion or restraint is off duty after writing the order. These procedures must include mechanisms for communication among shifts regarding the names of patients in seclusion or restraint, the condition of the patients, changes in medication and any complications or problems encountered during the period of seclusion or restraint.

5) Following the Use of Seclusion or Restraint:

- a. **Patient Evaluation:** Upon the patient's release, the registered nurse must conduct an in-person evaluation that includes an assessment of the immediate needs (e.g., physical well-being, psychological comfort, right to privacy). This assessment must be documented in the patient's clinical record with a description of the patient's response to the use of seclusion or restraint. Family/guardian/significant other notification may be made at this time, as indicated.
- b. **Debriefings:** Facilities must ensure that debriefing activities occur following the use of restrictive interventions to determine what led to the event, what might have prevented or curtailed it, and how to prevent future occurrences. These activities include the following (and further details may be found on the OMH approved Restraint and Seclusion forms):
 - i. **Patient Debriefing:**
 - Must include the patient's perspective to ascertain what led to the incident, what might have prevented or curtailed it, any physical or psychological effects, and how to prevent future episodes.
 - Must be conducted preferably by the primary clinician. It may be conducted by the nurse in charge, unit nurse, or the on-site supervisor if the primary clinician is not available (e.g., off shifts, weekends). If clinically appropriate, this debriefing may include the participation of relevant others at the patient's request (e.g., staff preferred by the patient, peer specialist, advocate, family members).
 - The debriefing must take place as soon as the patient is released from restraint or seclusion. If the patient is initially unwilling or unable to participate, additional attempts must be made to elicit their participation at any point prior to the Post Event Analysis.
 - ii. **Staff Debriefing:**
 - Must include staff's perspective to ascertain what led to the incident, what actions may have been taken to either prevent or de-escalate the behavior, and what steps can be taken to prevent future episodes.
 - Must make efforts to explore the use of the ICPPs, ICWRPs, or equivalent for this patient, and any potential modifications to it, along with initial steps taken to meet the needs of the patient and the community.
 - Must be led by the nurse in charge, unit nurse, the on-site supervisor, or primary clinician. Participants include the key individuals involved in the episode and the staff who authorized and ordered the seclusion or restraint, whenever possible.

- Is required following all restrictive intervention episodes.
 - Must be conducted as soon as possible following the intervention. However, to ensure that the key participants who were involved with the initiation of the episode are available to participate, it is permissible to conduct this debriefing prior to the conclusion of the episode.
 - Must include a review of its impact on staff. Consideration must be given regarding the immediate needs of the staff including counseling for any emotional or physical trauma that may have resulted from the event.
- iii. The scope and depth of the debriefing activities must be commensurate with the nature and duration of the intervention utilized, provided requirements established by the Centers for Medicare and Medicaid Services or The Joint Commission, when applicable, are met.
 - iv. Debriefing procedures must be identified in facility policies and must include debriefing activities for the staff and the patient.
 - v. Documentation of all debriefing activities must follow standard protocols, be consistent with national standards, and must be included in the clinical record for use in treatment planning, revision of the ICPPs, ICWRPs, or equivalent, and ongoing restraint and seclusion prevention efforts.
- c. **Post Event Analysis:**
- i. Is conducted to evaluate the information obtained from staff and patient debriefing activities regarding what led to the event, what might have prevented or curtailed the behavior, and how to prevent future episodes of restrictive interventions (further details may be found on the OMH approved Restraint and Seclusion form).
 - ii. Is conducted by a senior manager or clinician and includes the treatment team, staff who participated in the event, and if clinically indicated, the patient is invited to participate.
 - iii. Must occur as soon as possible following the debriefings, but no later than the next business day after each episode. However, the debriefing activities from multiple episodes may be reviewed in ***a single consolidated Post Event Analysis*** at the discretion of the attending physician or designee with consideration of benefit to the patient and ability to collect additional meaningful information. The single consolidated Post Event Analysis must include a review of all debriefings from all episodes covered and may be conducted for:
 - More than one episode in 24 hours and must occur no later than the next business day.
 - Multiple episodes over a weekend or holiday and must occur no later than the next business day.
 - One or more episodes each day for up to three consecutive days and must occur within three business days of the initial episode and may not extend over a weekend or holiday.
 - iv. May conceptually focus on whether or not:
 - A treatment environment was created where conflict was minimized.
 - Triggers for conflict (e.g., disease, personal, environmental) could have been prevented.
 - Staff noticed and responded to events.
 - The interaction/intervention occurred at the earliest opportunity.
 - All pertinent members of the treatment team were involved in the de-escalation process.

- Staff ordered seclusion or restraint only in response to imminent danger.
 - The patient was released as soon as behavioral release criteria were met.
 - v. Is based on information gained during the debriefings and must include a review of the plan of care. The treatment team may assess and determine that recommended action(s) can be implemented that may mitigate or eliminate the likelihood of future seclusion/restraint for the patient. If safe and possible, implementation of these recommendations should happen at the earliest possible time. Examples could include modifying rules or practices and/or providing comfort items.
 - vi. Recommendations and/or modifications to the plan of care must be considered and documented, as applicable. If no modifications to the plan of care are indicated, the rationale must be documented.
- d. **Clinical Reviews:**
- i. Attending psychiatrist or designee must review the clinical record of their patients who have been in seclusion or restraint since they were last on duty and must ascertain the patient's current status.
 - On an ongoing basis, the attending psychiatrist and treatment team will review all restrictive interventions during the course of a patient's treatment and make modifications to the plan of care as needed.
 - ii. The Clinical Director or designee must review the use of seclusion and restraint daily and must immediately investigate unusual or unwarranted patterns of utilization. The Clinical Director may review the daily shift report for the utilization of seclusion and restraint. The review must include the following:
 - the patient's name and ward
 - the type of seclusion or restraint used
 - the length of time that the patient was in seclusion or restraint for each written order
 - the behavior(s) necessitating the intervention
 - any less restrictive techniques attempted and a statement of why they were found inadequate
 - iii. A documented review must be conducted when three or more episodes occur with a patient in a 30-day period. This review should take place within 3 business days of the third episode; must include the Clinical Director or designee, the patient's treatment team and if available, at least one peer specialist; and must include a review of the patient's treatment plan/plan of care and an assessment of current medications.
- e. **Administrative Actions:**
- i. Quality Assurance Reviews should be completed within 3 business days of the Post Event Analysis by a member of the facility Cabinet or their administrative designee.
 - The information gathered from the debriefing activities and Post Event Analysis should be used to identify, evaluate, and, when indicated, modify policies and procedures, rules, practices, environments, staff interactions, training needs and other considerations, as appropriate.
 - A review is required for each Post Event Analysis. Further, it is recommended that evaluation of multiple Quality Assurance Reviews, spanning across patients and units, takes place to examine facility practices more broadly and to help determine the existence of patterns or trends.

- This information is not part of the patient's clinical record.
- ii. As part of the facility's quality improvement program, the incidence of violent behavior and the associated use of seclusion and/or restraint must be monitored. Data regarding each order of seclusion and/or restraint must be collected, analyzed, and reported to Central Office. This data must be integrated into facility and the OMH performance improvement activities.
- iii. Injuries and deaths related to the use of seclusion and/or restraint must be reported as incidents pursuant to the mandates of 14 NYCRR Part 524 and the OMH Clinical Risk Management and Incident Management Plans policy (QA-510). Staff injuries must also be reported, pursuant to employee accident reporting policies.
- iv. OMH must report to the Centers for Medicare and Medicaid Services any death that occurs while a patient is secluded and/or restrained, or in which it is reasonable to assume that the death is a result of seclusion and/or restraint. This notification will be made by the facility's Director for Quality Management after consultation with the OMH Central Office Director for External Review or designee; the Associate Commissioner (Division of State-Operated Children's and Adult Services) or the Associate Commissioner (Division of Forensic Services); and the OMH CMO or designee. It will occur by the next business day following the patient's death.

6) Training:

- a. The facility must ensure that any staff involved in restrictive interventions receives orientation and instruction in alternatives to seclusion and restraint, selecting the least restrictive intervention, and the appropriate techniques of safely applying interventions. Training must also include strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion; clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary; and monitoring the physical and psychological wellbeing of the patient, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the physician; the potentially traumatic impact of seclusion or restraint; and the laws, regulations, policies and procedures governing the use of seclusion and restraint.
- b. The training must also address the sensitization of staff regarding the use of seclusion and restraint and must allow each staff member the opportunity to experience at least one of these interventions. When appropriate, persons who have experienced seclusion and restraint as patients must be included as providers of training. If such persons are not available as trainers, the viewpoints of persons who have experienced seclusion or restraint must be presented using written or audiovisual material, as available.
- c. Training for staff that participate in seclusion and restraint must also include the use of first aid techniques (as required by profession) and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
- d. A written record of training must be maintained.
- e. Training must be provided as an initial 3-day minimum training program with a 2-day review program provided on an annual basis, or as approved by OMH.
- f. Staff must initially demonstrate competency in all the required training areas prior to their participation in the seclusion or restraint of a patient and must further be required to demonstrate competency on an annual basis.