DEPARTMENT OF MENTAL HEALTH MENTAL ILLNESS COMMUNITY PROGRAMS ADMINISTRATIVE CODE

CHAPTER 580-2-9
PROGRAM OPERATION

580-2-9-.24 Adult Seclusion And Restraint.

(1) Consumers treated in community programs certified by the Alabama Department of Mental Health have the right to be free of psychiatric restraint and seclusion. Restraint and seclusion are safety procedures to be used as a last resort.

(2) Consumers may be placed in seclusion or may be physically restrained only when psychiatrically necessary to prevent the consumer from physically harming self or others and after less restrictive alternative interventions have been unsuccessful or are determined not to be feasible and when authorized by a qualified physician.

(3) Psychiatric seclusion is the involuntary confinement of a consumer alone in a room, from which the consumer is prevented from leaving for a prescribed period of time in order to control or limit his/her dangerous behavior.

(4) Psychiatric restraint is defined as follows:

(a) Use of a commercial physical or mechanical device to involuntarily restrain the movement of the whole or a portion of a consumer's body as a means of controlling his/her physical activities in order to protect him/her or others from injury.

(b) Use of medication that is not a standard treatment for the consumer's medical or psychiatric condition and is used to control behavior or restrict the consumer's freedom of movement. Medications used for the consumer's positive benefit as an integrated part of a consumer's therapeutic plan of care and specific situation and representing standard treatment for the consumer's medical or psychiatric condition do not meet this restraint definition.

(5) Qualified physician is defined as follows:

(a) Psychiatrist.

(b) A licensed physician who has been granted privileges to order seclusion or restraint.

(6) Qualified registered nurse is defined as a registered nurse who has been granted privileges to implement seclusion or restraint.

(7) Adult residential programs, except for adult crisis residential programs and intermediate care programs, cannot seclude or restrain consumers.

(8) The following written policies must be Board approved and implemented if an adult crisis residential program includes psychiatric seclusion/restraint as part of its interventions.

(a) Psychiatric seclusion or restraint must be ordered by a qualified physician on the premises, except as noted in 580-2-9-.24(9)(b), only for the purpose of protecting the consumer from harming him/herself or others, and only for the period of time necessary for the consumer to no longer threaten his/her safety or that of other consumers and staff.

(b) Use of seclusion or restraint:

1. Shall not be for the purposes of punishment, discipline, staff convenience, coercion, or retaliation.

2. Shall not be used in place of appropriate mental health treatment.

3. Should not cause undue physical discomfort, harm, or pain to the consumer.

4. May not be used in lieu of effective communication with consumers who are deaf, hard of hearing, or have limited English proficiency. In the case of consumers who are deaf and who use sign language to communicate, restraints must be applied in a way that leaves at least one hand free to sign.

(c) PRN orders for seclusion or restraint are prohibited.

(d) Seclusion or restraint shall only be used after other, less restrictive interventions have been found ineffective.

(e) Consumers shall be respected as individuals. Their modesty and privacy shall be safeguarded. They shall be provided access to effective communication in the language of their choice (spoken or signed).

(f) The use of psychiatric restraint or seclusion must be in accordance with a written modification to the patient’s plan of care. If the consumer is deaf and uses sign language, provision shall be made to assure access to effective communication and that techniques used will not deprive the consumer of a method to communicate in sign language.

(g) The provider must report to the Department of Mental Health (DMH) immediately, any death or injury that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a consumer's death or injury is a result of restraint or seclusion.

(9) Seclusion or restraint must be initiated in accordance with the following procedures:

(a) Psychiatric seclusion or restraint, must be ordered by a qualified physician on the premises (except as noted in 580-2-9-.24(9)(b)).

(b) In situations when a qualified physician is not available, the use of psychiatric seclusion or restraint may be implemented for up to 1 hour to prevent a consumer from physically injuring himself/herself or others by a trained, experienced registered nurse who is physically present and who evaluates the consumer's physical condition to the extent feasible. This procedure may be followed only after determining that alternative interventions have been unsuccessful or would not be feasible.

(c) For an individual who is deaf or limited English proficient, communication in the language (spoken or signed) of the consumer's choice must be established within 1 hour by:

1. Staff fluent in the language the consumer prefers or, as appropriate, with an Intermediate Plus rating on the Sign Language Proficiency Interview.

2. A qualified interpreter.

(d) Orders for restraints must specify a type of restraint approved by the Medical Director and that the use must conform to the manufacturer's guidelines. For an individual who is deaf, at least one hand must be left free to communicate.

(e) A qualified physician should be notified immediately after the episode of psychiatric restraint or seclusion and a verbal order obtained by the RN. A physician must see the patient and evaluate the need for psychiatric restraint or seclusion within 1 hour after the initiation of this intervention. The episode of psychiatric restraint or seclusion may be extended up to 4 hours upon verbal order of a qualified physician (after the initial assessment within 1 hour of initiation) if necessary to prevent the patient from physically injuring himself/herself or others.

(f) All written orders for psychiatric restraint and seclusion shall be time-1imited and include specific behavioral criteria for release at the earliest possible time. A clinical assessment of the patient and the alternative treatment

interventions attempted shall be documented in the medical record.

(g) No order for seclusion or restraint shall exceed 4 hours.

(10) Continuation of seclusion and restraint shall be done in accordance with the following policies and procedures:

(a) When seclusion/restraint is initiated under a verbal order, a physician must see the patient and evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention and sign the verbal order.

(b) If the initial episode has extended for as long as 4 hours, the patient shall be released unless a qualified physician has examined the patient and has written a new order for psychiatric restraint or seclusion.

(c) When the behavioral criteria for release have been met or the time limit for the order reached, the patient must be released unless the patient is examined by a qualified physician who writes a new order.

(11) When seclusion/restraint procedures are implemented, the following procedures must be observed:

(a) The alternative treatment interventions attempted shall be documented in the clinical record.

(b) When the criteria for release are met, the consumer must be released.

(c) Continual observation shall be made of consumers in seclusion or restraint with documentation made at least every 15 minutes, including an assessment of the need to continue seclusion. Persons in restraint shall be on 1:1 supervision and observations will be documented at least every 15 minutes.

(d) Any special medical or behavioral concerns regarding the consumer shall be communicated in writing by the RN or physician to the person(s) observing the consumer.

(e) Documentation shall reflect that the consumer in seclusion or restraint was provided the opportunity for the following or reasons why it was clinically inappropriate to make the offer:

1. Hourly bathroom privileges.

2. Daily (every 24 hours) bath, or more frequently as needed.

3. Meals at regular mealtimes.

4. Hourly fluids.

5. Range of motion exercises for up to 10 minutes every 2 hours (restraint).

6. Circulation checks every 15 minutes (restraint).

7. Vital signs checked as clinically indicated.

(12) Staff who are involved in initiating and implementing seclusion and restraint procedures must meet the following training requirements:

(a) RN's must be specifically trained in the use of seclusion/ restraint policies and procedures and must provide supervision to program staff involved in the administration of seclusion/ restraint.

(b) All staff who have direct consumer contact must have annual education and training in the proper and safe use of restraint and seclusion application and techniques and alternative methods for handling behavior, symptoms, and situations.

(c) Each facility shall establish procedures to provide debriefing of consumers and staff involved in restraint or seclusion.

(13) If provider policy and procedure permit seclusion and/or restraint, the use must be reviewed as part of the agency PI Program.

(a) The organization must appropriately document all episodes of restraint and seclusion.

(b) The organization must collect data on all episodes of restraint and seclusion in order to monitor use of restraint and seclusion including the following:

1. Multiple instances of restraint or seclusion experienced by an individual within a 12-hour timeframe.

2. The number of episodes per individual.

3. Instances of restraint or seclusion that extend beyond 2 consecutive hours.

4. Use of psychoactive medications as an alternative for, or to enable discontinuation of, restraint and seclusion.

(c) The organization must report the use of restraint and seclusion to DMH in accordance with published reporting guidelines. Additionally, the organization is required by

applicable law and regulations to report injuries to external agencies.

(d) The organization must demonstrate that procedures are in place to properly investigate and take corrective action where indicated where seclusion/restraint result in consumer injury or death.

(14) Rooms in which consumers are secluded must be clean, neat, free of hazardous conditions, adequately ventilated (with heat or cooling as appropriate), adequately and appropriately lighted, reasonably spacious, and appropriately painted. All areas of the seclusion room must be visible from the viewing window.

Author: Division of Mental Illness, DMH
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