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FAQ No.:	29
FAQ:	What is the JCAHO Restraint and Seclusion Standard for Behavioral Health. Effective January 1, 2001?

Restraint and Seclusion Standards for Behavioral Health
Effective January 1, 2001

Contents:

Applicability of Behavioral Health Care Restraint and Seclusion Standards

The behavioral health care standards for restraint and seclusion apply to any use of restraint and seclusion for behavioral health care reasons.

All of the standards in this section --standards TX.7.1 through TX.7.1.16-- apply to all *behavioral health care settings* in which restraint or seclusion is used, such as free-standing psychiatric hospitals, psychiatric units in general hospitals, and residential treatment centers.

Selected standards --Standards TX.7.1.4.1, TX.7.1.5, TX.7.1.6 through TX.7.1.8 and Standards TX.7.1.10 and TX.7.1.11-- apply to *non-behavioral health care settings* in which restraint or seclusion is used for behavioral health reasons. Restraint or seclusion associated with a behavioral health care disorder is different from restraint that is used to promote medical/surgical healing. For example, standards TX.7.1.4.1, TX.7.1.5, TX.7.1.6 through TX.7.1.8 and Standards TX.7.1.10 and TX.7.1.11 apply to individuals who are

- hospitalized in an acute care hospital that does not have a psychiatric unit,
- hospitalized in an acute care hospital in other than a psychiatric unit in order to receive medical or surgical services,
- in the emergency department for the purpose of assessment, stabilization, or treatment, even if awaiting transfer to a psychiatric hospital or psychiatric unit, or
- awaiting transfer from a non-psychiatric bed to a psychiatric bed or psychiatric unit after receiving medical or surgical care.

When the individual is awaiting transfer to a psychiatric unit, the transfer is accomplished as rapidly as possible. If the individual is in restraint or seclusion, emergency department staff or medical or surgical services staff collaborate with psychiatric staff to ensure appropriate evaluation of the individual, until the transfer occurs.

Exceptions to the Applicability of the Behavioral Health Care Restraint and Seclusion Standards

The standards for restraint and seclusion **do not** apply

- to the use of restraint associated with acute medical or surgical care which is covered under standards TX.7.5 through TX.7.5.5;
- when a staff member(s) physically redirects or holds a child, without the child's permission, for 30 minutes or less; however, standard TX.7.1.2, which addresses staff competence and training, is applicable under these circumstances;

- to a time-out when the individual is restricted for 30 minutes or less from leaving an unlocked room and when its use is consistent with the individual's treatment plan;
- to instances in which an individual is restricted to an unlocked room or area, consistent
  with a unit's rules or regulations, and organization policy(ies) and procedure(s);
- to the use of restraint with individuals who receive treatment through formal behavior management programs (to which the behavior management standards in this manual apply --TX.7.4 and TX.7.4.1). Such individuals exhibit intractable behavior which is severely self-injurious or injurious to others, have not responded to traditional interventions, and are unable to contract with staff for safety (e.g., understand the concept of, and act on, criteria for the discontinuation of restraint or seclusion);
- to forensic restrictions and restrictions imposed by correction authorities for security purposes. However, restraint or seclusion use related to the clinical care of an individual under forensic or correction restrictions is surveyed under these standards;
- to protective equipment such as helmets;
- to adaptive support in response to assessed physical needs of the individual (for example, postural support, orthopedic appliances); and
- to standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes (for example, surgical positioning, IV arm boards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients).

Introduction to the Behavioral Health Care Restraint and Seclusion Standards

Use of restraint and seclusion. The use of restraint and seclusion poses an inherent risk to the physical safety and psychological well-being of the individual and staff. Therefore, restraint and seclusion are used only in an emergency, when there is an imminent risk of an individual physically harming himself or herself or others, including staff. Non-physical interventions are the first choice as an intervention, unless safety issues demand an immediate physical response.

Reducing the use of restraint and seclusion. Because restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of an individual's rights, and even death, organizations continually explore ways to prevent, reduce, and strive to

eliminate the use of restraint and seclusion use through effective performance improvement initiatives.

The role of leaders. The leaders' role is to create an environment that minimizes circumstances that give rise to restraint and seclusion use and that maximizes safety when they are used. This requires allocating sufficient resources, providing initial and ongoing education, and integrating restraint and seclusion into performance improvement activities. The result is an organization approach to restraint and seclusion that seeks to prevent and reduce and strive to eliminate their use and, when they are used, protects the individual's health and safety, while preserving his or her dignity, rights, and well-being.

The role of the family. Throughout the standards there are references to the involvement of the individual's family in the decisions and activities that relate to the use of restraint or seclusion. While this is intended to promote communication with providers, and support and advocacy for the individual, it is recognized that there are instances in which such participation by the family may be inappropriate because it could have a deleterious affect on the individual and his or her rights. In these instances the standards related to family involvement would not be applicable.

Standards and Intents

Leadership

Standard
TX.7.1. The leaders establish and communicate the organization's philosophy on the use of restraint and seclusion to all staff who have direct care responsibility.

Intent of TX.7.1
At a minimum, the organization's philosophy addresses

- its commitment to prevent, reduce, and strive to eliminate the use of restraint and seclusion,
- preventing emergencies that have the potential to lead to the use of restraint or seclusion,
- the role of non-physical interventions as preferred interventions,
- limiting the use of restraint and seclusion to emergencies in which there is an imminent risk of an individual physically harming himself or herself or others, including staff,
- its responsibility to facilitate the discontinuation of restraint or seclusion as soon as possible,
- raising awareness among staff about how the use of restraint or seclusion may be experienced by the individual; and

- preserving the individual's safety and dignity when restraint or seclusion is used.

This philosophy is communicated to all members of the organization who have direct care responsibility.

Staffing

Standard
TX.7.1.1 Staffing levels and assignments are set to minimize circumstances that give rise to restraint or seclusion use and to maximize safety when restraint and seclusion are used.

Intent of TX.7.1.1
The organization bases its staffing levels and assignments on a variety factors, including:

- staff qualifications;
- the physical design of the environment; and
- diagnoses, co-occurring conditions, acuity levels, and age and developmental functioning of individuals served.

Staff Training and Competence

Standard
TX.7.1.2 Staff are trained and competent to minimize the use of restraint and seclusion, and in their safe use.

Intent of TX.7.1.2
The organization educates and assesses the competence of staff in minimizing the use of restraint and seclusion and, before they participate in any use of restraint or seclusion, in their safe use.

A. Training requirements for all direct care staff.
In order to minimize the use of restraint and seclusion, **all** direct care staff as well as any other staff involved in the use of restraint and seclusion receive **ongoing training** in and **demonstrate an understanding**

1. of the underlying causes of threatening behaviors exhibited by the individuals they serve;
2. that sometimes an individual may exhibit an aggressive behavior that is related to a medical condition and not related to his or her emotional condition, for example, threatening behavior that may result from delirium in fevers, hypoglycemia;

3. of how their own behaviors can affect the behaviors of the individuals they serve;

4. of the use of de-escalation, mediation, self-protection and other techniques, such as time-out; and

5. recognizing signs of physical distress in individuals who are being held, restrained, or secluded.

B. Training requirements for staff who are authorized to physically apply restraint or seclusion.

Staff who are authorized to physically apply restraint or seclusion receive the training and demonstrate the competence cited in **A1 through A5** above, and also **receive ongoing training** in and **demonstrate competence** in the *safe use of restraint,* including:

- physical holding techniques,
- take-down procedures, and
- the application and removal of mechanical restraints.

C. Training requirements for staff who are authorized to perform the 15 minute assessments.

Staff who are authorized to perform 15 minute assessments of individuals who are in restraint or seclusion receive the training and demonstrate the competence cited in **A1 through A5** above, and also **receive ongoing training** and **demonstrate competence** in:

1. taking vital signs and interpreting their relevance to the physical safety of the individual in restraint or seclusion;

2. recognizing nutritional/hydration needs;

3. checking circulation and range of motion in the extremities;

4. addressing hygiene and elimination;

5. addressing physical and psychological status and comfort;

6. assisting individuals in meeting behavior criteria for the discontinuation of restraint or seclusion;

7. recognizing readiness for the discontinuation of restraint or seclusion; and

8. recognizing when to contact a medically trained licensed independent practitioner or emergency medical services in order to evaluate and/or treat the individual's physical status.

D. Training requirements for staff who are authorized to initiate restraint or seclusion and/or perform evaluations/reevaluations.
Staff who, in the absence of a licensed independent practitioner, are authorized to initiate restraint or seclusion, and/or perform evaluations/reevaluations of individuals who are in restraint or seclusion in order to assess their readiness for discontinuation or establish the need to secure a new order, receive the training and demonstrate the competence cited in **A and C** above, and are also **educated** and **demonstrate competence** in:

1. recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual reacts to physical contact, and

2. the use of behavior criteria for the discontinuation of restraint or seclusion and how to assist individuals in meeting these criteria.

Training in first aid, cardiopulmonary resuscitation, and emergency medical services.

- An appropriate number of staff are available at all times who are competent to initiate first aid and cardiopulmonary resuscitation.

- The organization has a plan for the provision of emergency medical services.

The involvement of individuals who have experienced restraint or seclusion.

- The viewpoints of individuals who have experienced restraint or seclusion are incorporated into staff training and education in order to help staff better understand all aspects of restraint and seclusion use.

- Whenever possible, such individuals who have experienced restraint or seclusion contribute to the training and education curricula and/or participate in staff training and education.

Note: Requirements related to ongoing education and the continuous assessment of staff competence are
addressed in the Management of Human Resources chapter.

Initial Assessment of the Individual at Admission

Standard
TX.7.1.3 The initial assessment of each individual at the time of admission or intake assists in obtaining information about the individual that could help minimize the use of restraint or seclusion.

Intent of TX.7.1.3
Components of the assessment that address the use of restraint and seclusion.

The initial assessment of an individual who is at risk of harming himself or herself, or others, including staff, identifies:

- **techniques, methods, or tools** that would help the individual control his or her behavior. When appropriate, the individual and/or family assist in the identification of such techniques;
- pre-existing **medical conditions** or any **physical disabilities** and limitations that would place the individual at greater risk during restraint or seclusion; and
- any **history of sexual or physical abuse** that would place the individual at greater psychological risk during restraint or seclusion.

Also at the time of assessment:

- The individual and/or family is informed of the **organization's philosophy** on the use of restraint and seclusion to the extent that such information is not clinically contraindicated.
- The **role of the family,** including their notification of a restraint or seclusion episode, is discussed with the individual and, as appropriate, the individual's family. This is done in conjunction with the individual's right to confidentiality (refer to standard RI.1.2.2).
- The organization determines whether the individual has an **advance directive with respect to behavioral health care** and ensures that direct care staff are made aware of the advance directive.

Limiting the Use of Restraint or Seclusion to Emergencies

Standards
TX.7.1.4 Non-physical techniques are the preferred intervention in the management of behavior.

TX.7.1.4.1 Restraint or seclusion use is limited to emergencies in which there is an imminent risk of an individual physically harming himself or herself, staff, or others, and non-physical interventions would not be effective.

Intent of TX.7.1.4 through TX.7.1.4.1

- **Non-physical techniques** are always considered as the preferred intervention. Such interventions may include redirecting the individual's focus or employing verbal de-escalation.
- Restraint or seclusion is employed only when non-physical interventions are ineffective or not viable, and when there is an **imminent risk** of an individual physically harming himself or herself, staff, or others.

- The **type of physical intervention** selected takes into consideration information learned from the individual's initial assessment (*see Standard TX.7.1.3*).
- The organization **does not permit** use of restraint or seclusion for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.
- The use of restraint or seclusion is **not** based on an individual's restraint or seclusion history or solely on a history of dangerous behavior.

Initiation of Restraint or Seclusion

Standard
TX.7.1.5 A licensed independent practitioner orders the use of restraint or seclusion.

Intent of TX.7.1.5
Initiation of restraint or seclusion.
Because restraint and seclusion use is limited to emergencies (in which a licensed independent practitioner may not be immediately available), **the organization may authorize qualified registered nurses or other qualified, trained staff members who are not licensed independent practitioners** to *initiate* the use of restraint or seclusion before an order is obtained from the licensed independent practitioner (see section D in the intent statement of standard TX.7.1.2).

All restraint and seclusion is used and continued pursuant to an **order by the licensed independent practitioner** who is primarily responsible for the individual's ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner.

As soon as possible, but no longer than **one hour** after the initiation of restraint or seclusion, a qualified registered nurse or other qualified staff (see section D in the intent statement of standard TX.7.1.2)

- notifies and obtains an order (verbal or written) from the licensed independent practitioner and
- consults with the licensed independent practitioner about the individual's physical and psychological condition.

The role of the licensed independent practitioner.
The licensed independent practitioner

- reviews with staff the physical and psychological status of the individual,
- determines whether restraint or seclusion should be continued,

- supplies staff with guidance in identifying ways to help the individual regain control in order for restraint or seclusion to be discontinued, and
- supplies an order. (Orders are limited to the timeframes cited in standard TX.7.1.7.)

Notification of the Individual's Family

Standard
TX.7.1.5.1 The individual's family is notified promptly of the initiation of restraint or seclusion.

Intent of TX.7.1.5.1
In cases in which the individual has consented to have the family kept informed regarding his or her care and the family has agreed to be notified (refer to standard TX.7.1.3), staff promptly attempts to contact the family to inform them of the restraint or seclusion episode.

Evaluation of the Individual in Restraint or Seclusion

Standard
TX.7.1.6 A licensed independent practitioner sees and evaluates the individual in-person.

Intent of TX.7.1.6
Timeframe for the in-person evaluation of the individual by the licensed independent practitioner.
The licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner conducts an in-person evaluation of the individual

- **within 4 hours** of the initiation of restraint or seclusion for individuals ages **18 or older** and
- **within 2 hours** of initiation for children and adolescents **age 17 and under.**

The purpose of the in-person evaluation by the licensed independent practitioner.
At the time of the in-person evaluation, the licensed independent practitioner

- works with the individual and staff to identify ways to help the individual regain control,
- makes any necessary revisions to the individual's treatment plan, and
- if necessary, provides a new written order. This order and any subsequent orders follow the time-limits cited in standard TX.7.1.7.

If the individual is no longer in restraint or seclusion when an original *verbal* order expires.
The licensed independent practitioner conducts an in-person evaluation of the individual within **24 hours** of the initiation of restraint or seclusion.

Orders for Restraint or Seclusion

Standard
TX.7.1.7 Written or verbal orders for initial and continuing use of restraint and seclusion are time-limited.

Intent of TX.7.1.7
Time-limits for orders.
Verbal and written orders for restraint and seclusion are limited to

- **4 hours** for individuals ages **18 and older,**
- **2 hours** for children and adolescents ages **9 to 17**; and
- **1 hour** for children **under age 9**.

Orders for the use of restraint or seclusion are not written as a standing order or on an as needed basis (that is, PRN).

Continuation of the order for restraint or seclusion.
If restraint or seclusion needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner.

Discontinuing restraint or seclusion before the time-limit of the order expires.

- Time-limited orders do not mean that restraint or seclusion must be applied for the entire length of time for which the order is written. The standard for periodic assessment (TX.7.1.10), the standard for monitoring and assisting (TX.7.1.11), and the standard for reevaluation (TX.7.1.8) are intended to encourage the discontinuation of restraint or seclusion as soon as the individual meets the behavior criteria for its discontinuation.
- When restraint or seclusion is terminated before the time-limited order expires, that original order can be used to reapply the restraint or seclusion if the individual is at imminent risk of physically harming himself or herself or others, and non-physical interventions are not effective. However, a new order for restraint or seclusion is obtained from the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his or her licensed independent practitioner

designee, or other licensed independent practitioner when the original order expires.

Reevaluation of the Individual in Restraint or Seclusion

Standard
TX.7.1.8 Individuals who are in restraint or seclusion are regularly reevaluated.

Intent of TX.7.1.8
The in-person reevaluation.
By the time the order for restraint or seclusion expires, the individual receives an in-person reevaluation This in-person reevaluation is conducted by

- the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or
- his or her licensed independent practitioner designee, or
- other licensed independent practitioner, or
- a qualified registered nurse (see section D in the intent statement of standard TX.7.1.2), or
- other qualified, trained individual who has been authorized by the organization to perform this function (see section D in the intent statement of standard TX.7.1.2).

When restraint or seclusion is continued.
In conjunction with the reevaluation of the individual if the restraint or seclusion is to be continued

- **a written or verbal order** is given by the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner if the restraint or seclusion is to be continued. These orders for continuation of restraint or seclusion are limited to the timeframes outlined in Standard TX.3.7.
- the licensed independent practitioner or a qualified registered nurse or other qualified, authorized staff member **reevaluates the efficacy of the individual's treatment plan and works with the individual to identify ways to help him or her regain control.**

If the individual's licensed independent practitioner, or his or her licensed independent practitioner designee, is not the licensed independent practitioner who gives the order, **the individual's licensed independent practitioner is notified of the individual's status if the restraint or seclusion is continued.**

Time-frames for the in-person reevaluation.
Reevaluation of the individual takes place every

- **4 hours** for adults ages **18 and older**,
- **2 hours** for children and adolescents ages **9 to 17**, and
- **1 hour** for children **under age 9**.

Minimum Time-frames for an in-person reevaluation by a licensed independent practitioner.
The licensed independent practitioner conducts an in-person reevaluation at least every

- **8 hours** for individuals ages **18 years and older**, and
- **4 hours** for individuals ages **17 and younger**.

Notification of Clinical Leadership

Standard
TX.7.1.9 Clinical leadership is informed of instances in which individuals experience extended, or multiple episodes of, restraint or seclusion.

Intent of TX.7.1.9
Time-frames and circumstances for notification of clinical leadership.
The clinical leadership is immediately notified of any instance in which an individual

- remains in restraint or seclusion for more than **12 hours**, or
- experiences **2 or more separate episodes** of restraint and/or seclusion of any duration within **12 hours**.

Thereafter, the leadership is notified **every 24 hours** if either of the above conditions continue.

Purpose of the notification of clinical leadership.
This information is communicated to the leadership in order for it to

- discharge its clinical accountability, and
- assess whether additional resources are required to facilitate discontinuation of restraint or seclusion, or
- minimize recurrent instances of restraint and seclusion.

Periodically Assessing and Assisting Individuals in Restraint or Seclusion

Standard
TX.7.1.10 Individuals in restraint or seclusion are assessed and assisted.

Intent of TX.7.1.10
Time-frame for conducting assessments.
A staff member who is trained and competent in accordance with section C in the intent statement of standard TX.7.1.2 assess the individual **at the initiation** of restraint or seclusion and **every 15 minutes** thereafter.

Purpose of assessment.
This assessment includes, as appropriate to the type of restraint or seclusion employed,

- signs of any injury associated with the application of restraint or seclusion;
- nutrition/hydration;
- circulation and range of motion in the extremities;
- vital signs;
- hygiene and elimination;
- physical and psychological status and comfort; and
- readiness for discontinuation of restraint or seclusion.

Staff provide assistance to individuals in meeting behavior criteria for the discontinuation of
restraint or seclusion.

Monitoring Individuals in Restraint or Seclusion

Standard
TX.7.1.11 Individuals in restraint or seclusion are monitored.

Intent of TX.7.11

- The purpose of monitoring an individual in restraint or seclusion is to ensure the individual's physical safety.
- Monitoring is accomplished through continuous in-person observation by an assigned staff member who is competent and trained in accordance with section A in the intent statement of standard TX.7.1.2.
- After the first hour, an individual in seclusion only, may be continuously monitored using simultaneous video and audio equipment, if this is consistent with the individual's condition or wishes. For example, it may be more helpful and less disruptive to the individual if staff is not

monitoring him or her by physically sitting in the seclusion room or watching through the window into the seclusion room.

- If the individual is in a physical hold, a second staff person is assigned to observe the individual.

Discontinuation of Restraint or Seclusion

Standard
TX.7.1.12 Restraint and seclusion use are discontinued when the individual meets the behavior criteria for their discontinuation.

Intent of TX.7.1.12

- As early as feasible in the restraint or seclusion process, the individual is made aware of the rationale for restraint or seclusion and the behavior criteria for its discontinuation.
- Restraint or seclusion is discontinued as soon as the individual meets his or her behavior criteria.

Examples of **behavior criteria** include

- an individual's ability to contract for safety,
- whether an individual is oriented to the environment, and/or
- cessation of verbal threats.

Post-Restraint and Seclusion Practices

Standard
TX.7.1.13 The individual and staff participate in a debriefing about the restraint or seclusion episode.

Intent of TX.7.1.13
Debriefing is important in reducing the recurrent use of restraint and seclusion. The individual and, if appropriate, the individual's family, participate with staff who were involved in the episode, and who are available, in a debriefing about each episode of restraint or seclusion. The debriefing occurs as soon as is possible and appropriate, but no longer than 24 hours after the episode.

The debriefing is used to

- identify what led to the incident and what could have been handled differently;
- ascertain that the individual's physical well-being, psychological comfort, and right to privacy were addressed;

- counsel the individual involved for any trauma that may have resulted from the incident; and
- when indicated, modify the individual's treatment plan.

Information obtained from debriefings is used in performance improvement activities.

Documentation

Standard
TX.7.1.14 Medical records document that the use of restraint or seclusion is consistent with organization policy.

Intent of TX.7.1.14
The use of restraint or seclusion is recorded in the individual's medical record. The focus of the entry(ies) is on the individual.

Documentation related to restraint and seclusion.
The clinical record documents

- that the individual and/or family was **informed of the organization's policy** on the use of restraint;
- any **pre-existing medical conditions** or any physical disabilities that would place the individual at greater risk during restraint and seclusion; and
- any **history of sexual or physical abuse** that would place the individual at greater psychological risk during restraint or seclusion.

Documentation of each episode of restraint and seclusion.
Each episode of use is recorded. Documentation includes information about

- the **circumstances** that led to their use;
- consideration or failure of **non-physical interventions**;
- the **rationale** for the type of physical intervention selected;
- **notification** of the individual's family, when appropriate;
- **written orders** for use;
- **behavior criteria** for discontinuation of restraint or seclusion;
- **informing the individual** of behavior criteria for discontinuation of restraint or seclusion;
- **each verbal order** received from a licensed independent practitioner;

- **each in-person evaluation** and reevaluation of the individual;
- **15 minute assessments** of the individual's status;
- **assistance provided** to the individual to help him or her meet the behavior criteria for discontinuation of restraint or seclusion;
- **continuous monitoring**;
- **debriefing** of the individual with staff; ; and
- any **injuries** that are sustained and treatment received for these injuries or **death**.

Documentation is accomplished in a manner (such as a restraint and seclusion log) that allows for the collection and analysis of data for performance improvement activities.

Performance Improvement

Standard
TX.7.1.15 The organization collects data on the use of restraint and seclusion in order to monitor and improve its performance of processes that involve risks or may result in sentinel events

Intent of TX.7.1.15
Purpose for collecting restraint and seclusion data.
The organization collects restraint and seclusion data

- in order to ascertain that restraint and seclusion are used only as emergency interventions,
- to identify opportunities for incrementally improving the rate and safety of restraint and seclusion use, and
- to identify any need to redesign care processes.

Data to be collected and frequency for aggregation.
The leaders determine the frequency with which data are aggregated. Using a patient identifier, data on *all* restraint and seclusion episodes are collected from and classified for all settings/units/locations by:

- shift,
- staff who initiated the process,
- the length of each episode,
- date and time each episode was initiated,
- day of the week each episode was initiated,

- the type of restraint used,
- whether injuries were sustained by the individual or staff,
- age of the individual, and
- gender of the individual.

Analysis of Data related to restraint and seclusion.
Particular attention is extended to

- multiple instances of restraint or seclusion experienced by an individual within a 12 hour timeframe;
- the number of episodes per individual;
- instances of restraint or seclusion that extend beyond 12 consecutive hours; and
- use of psychoactive medications as an alternative for, or to enable discontinuation of, restraint or seclusion.

Licensed independent practitioners participate in measuring and assessing use of restraint and seclusion for all individuals within the organization.

Policy(ies) and Procedure(s)

Standard
TX.7.1.16 Organization policy(ies) and procedure(s) address the prevention of the use of restraint and seclusion and, when employed, guide their use.

Intent of TX.7.1.16
Organization policy(ies) and procedure(s) include appropriate detail that addresses

- staffing levels;
- competence and training of staff;
- the initial assessment of the individual;
- the role of non-physical techniques in the management of behavior;
- time-out;
- limiting the use of restraint or seclusion to emergencies;
- notification of the individual's family when restraint or seclusion is initiated;
- ordering of restraint and seclusion by a licensed independent practitioner;

- in-person evaluations of the individual in restraint or seclusion;
- initiation of restraint and seclusion by an individual other than a licensed independent practitioner;
- time-limited orders;
- reassessment of an individual in restraint or seclusion;
- monitoring the individual in restraint or seclusion;
- discontinuation of restraint or seclusion;
- post-restraint and seclusion practices;
- reporting injuries and deaths to the organization's leadership and to the appropriate external agencies consistent with applicable law and regulation;
- documentation; and
- data collection and the integration of restraint and seclusion into performance improvement activities.

Footnotes

Restraint is the direct application of physical force to an individual, without the individual's permission, to restrict his or her freedom of movement. The physical force may be human, mechanical devices, or a combination thereof. *Note: This definition does not apply to (1) interactions with individuals that are brief and focus on redirection or assistance in activities of daily living, such as hygiene and (2) the use of any psychoactive medication that is not a usual or customary part of a medical diagnostic or treatment procedure, and that is used to restrict an individual's freedom of movement. Psychoactive medication used in this manner --which is sometimes referred to as chemical restraint-- is an inappropriate use of medication and would be addressed under the requirements of standard PI.3.1.1 and standard TX.3.*

Seclusion refers to the involuntary confinement of a person in a locked room.

Behavioral health care reasons for the use of restraint or seclusion are primarily to protect the individual against injury to self or others because of an emotional or behavioral disorder. The restraint standards for medical or surgical purposes apply when the primary reason for use directly supports medical healing.

Time-out. A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

Emergency. An emergency is an instance in which there is an imminent risk of an individual harming himself or herself or others, including staff; when nonphysical interventions are not viable; and safety issues require an immediate physical response.

Family. The person(s) who plays a significant role in the individual's life, which may include a person(s) not legally related to the individual receiving care. This person(s) is often referred to as a surrogate decision-maker, if authorized to make care decisions for the individual if he or she loses decision-making capacity.