

The Joint Commission Standards on Restraint & Seclusion

Standard PC.03.05.01:	Joint Commission Elements of Performance	CCG Response
<p>The [organization] uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.</p>	<ol style="list-style-type: none"> 1. The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others. 2. The hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation. 3. The hospital uses restraint or seclusion only when less restrictive interventions are ineffective. 4. The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others. 5. The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order 	<p>CCG recommends physical restraint is used only as a last resort, when a patient has become an imminent danger to themselves or others. All verbal de-escalation skills and interventions should be implemented and exhausted in order to utilize the least restrictive intervention.</p> <p>CCG recommends that clients are continually evaluated and assessed in order to determine when a physical restraint can be released (i.e., client no longer a danger to self or others). CCG strongly advises organizations to follow the guidelines set forth by regulating and licensing entities.</p>
<p>Standard PC.03.05.03: The [organization] uses restraint or seclusion safely.</p>	<ol style="list-style-type: none"> 1. The hospital implements restraint or seclusion using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation. 2. The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care. 	<p>All of CCG's techniques are designed with staff and patient safety in mind. The goal is to attempt to build therapeutic rapport and relationship in order to assist the individual in regaining control without having to use a physical restraint until all other option have been exhausted and the individual is at imminent risk of harm to self or others.</p> <p>Staff trained in CCG learns how to identify precursors to crisis situations and intervene in order to prevent a situation from escalating. The goal of any crisis intervention is to stabilize the situation as quickly as possible while maintaining professionalism and safety of all involved in the interventions.</p> <p>CCG is sensitive to the fact that any form of physical restraint has the risk of emotional or physical harm. Once staff is aware of the risks, CCG believes they will be more open and willing to attempt other forms of verbal interventions in order to use the least restrictive intervention and minimize harm.</p> <p>CCG trains staff how to respond to crisis situations with special populations and educated staff about alternatives to consider when working with such identified individuals. Furthermore, CCG encourages organizations to evaluate each client for any medical, psychological, or cultural condition which could contraindicate the use of a restraint and that this information is documented directly in the client's chart/care plan in order to provide quality care.</p>
<p>Standard PC.03.05.05: The [organization] initiates restraint or seclusion based on an individual order.</p>	<ol style="list-style-type: none"> 1. A physician or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation. 2. The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion. 3. The attending physician is consulted as soon as possible, in accordance with hospital policy, if he or she did not order the 	<p>CCG's interventions are created to protect the safety and dignity of all involved in the crisis situation. CCG encourages organization to remain up to date regarding information related to local, state, and federal policies. CCG always directs staff to consult and collaborate with supervisors; direct care providers and regulatory boards to ensure all interventions and protocols are being followed in accordance with best practice standards.</p>

<p>Standard PC.03.05.07: The [organization] monitors patients who are restrained or secluded.</p> <p>Standard PC.03.05.09: The [organization] has written policies and procedures that guide the use of restraint or seclusion.</p>	<p>restraint or seclusion.</p> <p>4. Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following limits:</p> <ul style="list-style-type: none"> – 4 hours for adults 18 years of age or older – 2 hours for children and adolescents 9 to 17 years of age – 1 hour for children under 9 years of age <p>Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.</p> <p>5. Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation.</p> <p>6. Orders for restraint used to protect the physical safety of the nonviolent or non-self-destructive patient are renewed in accordance with hospital policy.</p> <p>1. Physicians or other licensed independent practitioners or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. (See also PC.03.05.17, EP 3.)</p> <p>1. The hospital’s policies and procedures regarding restraint or seclusion include the following:</p> <ul style="list-style-type: none"> – Physician and other authorized licensed independent practitioner training requirements – Staff training requirements – The determination of who has authority to order restraint and seclusion – The determination of who has authority to discontinue the use of restraint or seclusion – The determination of who can initiate the use of restraint or seclusion – The circumstances under which restraint or seclusion is discontinued – The requirement that restraint or seclusion is discontinued as soon as is safely possible – A definition of restraint in accordance with 42 CFR 	<p>CCG’s training programs instructs participants in how to monitor the physical and psychological needs of the individual being restrained. CCG encourages staff to utilize documentation procedures practiced by the organization. Staff is instructed to monitor for changes in the individuals physical, psychological, or environmental status.</p> <p>CCG’s training programs are based in a recovery oriented, strength-based, culturally competent model which outlines and instructs when physical interventions are to be used. Only staff trained in CCG’s interventions should be allowed to implement the restraint. CCG strongly recommends that an organization have written policies and procedures regarding who has authority to physically intervene, how that decision is determined, when the physical intervention will be discontinued, as well as which techniques staff are permitted to utilize. CCG recommends that an organization review its policies regularly to ensure policies are in accordance with best practice standards as well as legislative regulations.</p>
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<p>Standard PC.03.05.11: The [organization] evaluates and reevaluates the patient who is restrained or secluded.</p> <p>Standard PC.03.05.13: The [organization] continually monitors patients who are simultaneously restrained and secluded.</p>	<p>482.13(e)(1)(i)(A–C) – A definition of seclusion in accordance with 42 CFR 482.13(e)(1)(ii) – A definition or description of what constitutes the use of medications as a restraint in accordance with 42 CFR 482.13(e)(1)(i)(B) – A determination of who can assess and monitor patients in restraint or seclusion – Time frames for assessing and monitoring patients in restraint or seclusion 2. Physicians and other licensed independent practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint and seclusion.</p> <p>1. A physician or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. 2. When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse or trained physician assistant, he or she consults with the attending physician or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy. 3. The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self destructive behavior that jeopardizes the physical safety of the patient, staff, or others, includes the following: – An evaluation of the patient’s immediate situation – The patient’s reaction to the intervention – The patient’s medical and behavioral condition – The need to continue or terminate the restraint or seclusion</p> <p>1. The patient who is simultaneously restrained and secluded is continually monitored by trained staff either in-person or through the use of both video and audio equipment that is in close proximity to the patient.</p>	<p>CCG endorses and supports agencies and organizations in complying with standards outlined by The Joint Commission related to the evaluation of the individual who experienced the restraint. CCG recommends every participant in the crisis intervention participate in a debriefing session. Debriefing can occur on multi-levels and should include separate sessions just for staff as well as the individual as determined by the treatment team. Debriefing with all members allows for assessment and evaluation of what led to the situation and for strategies to be developed for future incidents.</p> <p>CCG’s philosophy supports this principle as we believe and teach that individuals in crisis, especially those in restraint and seclusion need to be monitored continuously in order to monitor for opportunities to discontinue the physical intervention and attempt to work toward engaging in a less restrictive intervention.</p>
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<p>Standard PC.03.05.15: The [organization] documents the use of restraint or seclusion.</p>	<p>1. Documentation of restraint and seclusion in the medical record includes the following:</p> <ul style="list-style-type: none"> – Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior – A description of the patient’s behavior and the intervention used – Any alternatives or other less restrictive interventions attempted – The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion – The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention – Individual patient assessments and reassessments – The intervals for monitoring – Revisions to the plan of care – The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion – Injuries to the patient – Death associated with the use of restraint or seclusion – The identity of the physician or other licensed independent practitioner who ordered the restraint or seclusion – Orders for restraint or seclusion – Notification of the use of restraint or seclusion to the attending physician – Consultations 	<p>CCG’s training programs provides a structure for staff to debrief with an individual following all types of interventions. The goal is to re-establish therapeutic rapport and collaborate with the individual in order to discuss alternatives to the behaviors which precipitated the intervention. Staff trained in CCG’s programs is encouraged to examine attitudes and behaviors they may bring to a crisis situation in order to promote professional development. They are also taught how to identify client behaviors which may indicate a crisis situation is building, how to attempt to intervene at the least restrictive point and when to utilize a physical restraint.</p> <p>CCG impresses the importance of documenting all behaviors, observations, and individual responses to the interventions. CCG defers to organization policy and procedures related to reportable/sentinel events as outlined by licensing bodies and regulatory boards.</p>
<p>Standard PC.03.05.17: The [organization] trains staff to safely implement the use of restraint or seclusion.</p>	<p>1. The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals:</p> <ul style="list-style-type: none"> – At orientation – Before participating in the use of restraint and seclusion – On a periodic basis thereafter <p>2. Based on the population served, staff education, training, and demonstrated knowledge focus on the following:</p> <ul style="list-style-type: none"> – Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion – Use of nonphysical intervention skills – Methods for choosing the least restrictive intervention based on an assessment of the patient’s medical or behavioral status or condition – Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia) 	<p>CCG believes training in crisis intervention requires on-going practice. In order to be certified in CCG’s program, staff must attend, demonstrate, and pass a practice and written exam. CCG requires annual recertification in the program.</p> <p>CCG also encourages leaders in the organization organize practice drills for the physical techniques and role play situations during staff meetings or as supplemental training in order to keep the information and skills fresh. CCG encourages practicing the verbal de-escalation components of the training in order to increase the likelihood of keeping crisis situations at a level which do NOT require a physical restraint.</p>

<p>Standard PC.03.05.19: The [organization] reports deaths associated with the use of restraint and seclusion.</p>	<ul style="list-style-type: none"> – Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary – Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion – Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification (See also PC.03.05.07, EP 1) <p>3. Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.</p> <p>4. The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.</p> <p>1. The hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS):</p> <ul style="list-style-type: none"> – Each death that occurs while a patient is in restraint or seclusion – Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion – Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient’s death <p>2. The deaths addressed in PC.03.05.19, EP 1 are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone no later than the close of the next business day following knowledge of the patient’s death. The date and time that the patient’s death was reported is documented in the patient’s medical record.</p>	<p>CCG teaches training participants about the risk of physical injury/death during a restraint if not utilized properly. Staff are trained to use positions which decrease the likelihood of an injury or death however, in the case of such an event, CCG defers to the organizations policy and procedures on reporting a sentinel event. This includes notifying proper authorities immediately as well as the completion of a thorough review and investigation in accordance with any federal, state, and local legislations and regulations.</p>
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