NOTE: This policy directive shall not preclude the application of security measures during transportation of patients who are committed to a facility pursuant to an order of a criminal court¹ or who have been admitted to a facility in accordance with Article 10 of the Mental Hygiene Law.

### A. Policy Statement

The purpose of this policy directive is to supplement the provisions of 14 NYCRR Section 526.4, which set forth conditions and procedures for the use of seclusion and restraint in facilities under the jurisdiction of the Office of Mental Health, including State-operated psychiatric inpatient facilities. In this regard, the policy maintains the recent focus of requirements governing the use of restraints.

Historically, requirements focused on the type of device or restraint being used, and the setting in which it was being employed. Under current federal and NYS regulations and The Joint Commission (TJC) standards, a restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to freely move his or her arms, legs, body, or head. Further, a drug or medication is also considered a restraint when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

In medical or 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 (IV) line or feeding tube from being removed, or to prevent a patient who is temporarily or permanently incapacitated with a broken hip from attempting to walk before it is medically appropriate. 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.

¹ For purposes of this policy directive, 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 statues. 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.
For behavioral management purposes, seclusion and 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 should serve as a prompt for treatment teams to review the effectiveness of the treatment approaches currently being used for individual patients. It is the goal of the Office of Mental Health to make the use of seclusion and restraint a rare occurrence, and to continue efforts to reduce the rate of such rare occurrences.

The Office of Mental Health 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 and restraint, in other instances violent behavior may begin or increase following the initiation of seclusion and restraint. Statistically, seclusion and restraint are associated with increased risk of injury to both patients and staff.

Seclusion and restraint also may have deleterious effects on patients, including those who are survivors of sexual trauma and/or physical abuse, and patients with hearing impairments who are unable to communicate without the use of their hands. In assessing the need to use these interventions, therefore, OMH staff should consider the potential for any negative impact of the procedure on the particular patient.

For any given patient at a particular point in time, the use of a 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. Assessment should include a physical assessment to identify medical problems that may be causing behavior 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 and restraint.

The use of seclusion and restraint for behavioral management can 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 policy seeks to encourage this result.

Procedures for use of seclusion or restraint for behavioral management purposes are established in section E of this policy directive, while procedures for the use of restraints for medical or post-surgical care are set forth in section F.

Additional interpretive guidance regarding 14 NYCRR Section 526.4 and the principles outlined in this policy directive can be found in OMH Implementation Guidance available at: https://www.omh.ny.gov/omhweb/guidance/implementation-guidelines.pdf, (affixed hereto as Appendix B).

**B. Relevant Statutes and Standards**
Mental Hygiene Law §33.04
14 NYCRR §526.4 (Appendix A)
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) Provision of Care, Treatment, and Services Chapter

C. Definitions
In addition to the terms defined in 14 NYCRR §526.4\(^2\), for purposes of this policy directive, the following terms are defined:

1) **Calming blanket** means a restraint consisting of a thick, stiff fabric comforter which encases a person’s torso and limbs and is held in place by two persons.

2) **Clinical director or designee** means 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 directive.

3) **Comfort Wrap** means a lightweight blanket or sheet that a person 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 a form of restraint.

4) **Five-point restraint** means a four-point restraint with the addition of a strap, which is placed over the person’s upper torso and secured to the bed frame.

5) **Four-point restraint** means restraints that encase the wrists and ankles of a person lying on a bed, which are secured to the bed frame.

6) **Individual crisis prevention plan** means a document that identifies a patient’s individual preferences and behaviors related to behavioral management interventions.

7) **Mechanical support** means a device intended to keep a person 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\(^3\).

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\(^2\) 14 NYCRR Section 526.4, attached as Appendix A, can also be accessed at https://govt.westlaw.com/nycrr/Document/Id975a872e66c11e39ccd0000845b8d3e?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc. Default).

\(^3\) Where the restraint is effectively equivalent to preventing a patient temporarily or permanently incapacitated by, e.g., a broken bone, from attempting prematurely to walk, the standard applicable to medical and post-surgical care, as identified in Section F of this directive, applies.
8) **One-to-one constant observation** means a situation in which a staff member is responsible for maintaining continuous watch of a single patient, keeping the patient 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 shall have no supervisory responsibilities for other patients.

9) **Wrist-to-belt restraint** means a belt, secured around a person’s waist, with attached restraints that encase the person’s wrists. The tethers that secure the restraints to the belt may be of adjustable lengths, which allow variation in the degree of restriction of the person’s arms.

D. General Principles

1) The health and safety of the patient are the primary concerns of the Office of Mental Health at all times. Therefore, whenever a patient demonstrates a need for serious medical attention in the course of an episode of seclusion or restraint, medical priorities shall supersede psychiatric 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 shall be employed only 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) Seclusion or restraint for behavior management is not a substitute for treatment. When it occurs, it indicates the need for a post-event analysis by the staff involved in the procedure, a debriefing by the treatment team and appropriate supervisory staff, and a treatment plan review. (See subdivision E(5))

4) Seclusion or restraint shall not be used as punishment, for the convenience of staff, or as a substitute for treatment programs.

5) The criterion for release of a patient from seclusion or restraint for behavior management is that the patient no longer presents an imminent risk of danger to self or others. To assist staff in making this determination, the physician must note in the order for seclusion or restraint a description of the specific behavior of the patient that resulted in the determination that seclusion or restraint was necessary. Examples that would satisfy this criterion include, but are not limited to: the patient is no longer hitting staff; the patient is no longer attempting to hit staff; the patient is no longer assaulting or attempting to assault other patients; or the patient is no longer attempting to hurt self.

6) Simultaneous use:
   a) Seclusion and mechanical restraint shall never be used simultaneously.
   b) Two forms of restraint should not be used simultaneously, with the following exceptions:
      (i) the use of mitts and helmets together;
      (ii) the use of manual restraint while placing a patient in mechanical restraint or seclusion; and
      (iii) The use of a drug as a restraint with other forms of restraint.
7) The decision to use seclusion or restraint shall not be based on the individual’s seclusion or restraint history or solely on a history of dangerous behavior.

8) Drug used as a restraint.
   a) When medication is used as a restriction to manage behavior or to restrict the patient’s freedom of movement, the use of the medication shall be deemed a restraint (i.e., drug used as a restraint).
   b) 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 medication as a restraint must specify that the medication is to be used as a restraint. In addition, the physician must further identify the duration of time for which the patient must be monitored once the medication has been given, as there is no defined time limit for medication effects. This duration of time shall be determined by the physician, based upon the anticipated effect of the medication on the patient.
   c) One defining factor in determining when the use of medication meets the criteria for restraint is the intended purpose of the physician’s order for the medication. If the purpose is to use the medication as an emergency safety intervention to prevent imminent harm or injury, then the use meets the criteria for 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 or not the use of that drug or medication is considered a restraint. The determining factor in whether or not medication is used as a restraint is the 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 “disable” the patient, the medication is a restraint. If the primary purpose of a drug is to calm a patient to “enable” him or her to remain in the therapeutic milieu, the medication is not being used as a restraint. The use of PRN or standing order drugs or medications is prohibited if a drug or medication meets the definition of a drug or medication used as a restraint.
   d) Monitoring and observation must include post-medication administration assessment by a registered nurse and shall include the same monitoring requirements as mechanical or manual restraint, as set forth in this policy directive, provided, however, that monitoring of vital signs shall be done more frequently than with mechanical or manual restraint, in accordance with good clinical practice and facility policy.

9) It is against Office of Mental Health policy to place objects on or over a patient’s face during restraint procedures, provided, however, certain spit guard products may 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.
10) Mitts and helmets: The use of mitts and helmets as an emergency intervention to avoid imminent injury to the patient or others constitutes a restraint for behavioral management purposes and must follow the procedures set forth in section E of this policy directive.

11) When manual restraint is required to facilitate the safe administration of court ordered or emergency medications administered over a patient’s objection, a physician’s order for such manual restraint is required, and all provisions of this policy directive governing the use of manual restraint shall apply.

12) The use of manual restraint is the only form of restraint permitted with children less than 9 years of age in facilities operated by the Office of Mental Health. Other forms of restraint, as well as seclusion, shall be prohibited for this age group, except upon prior approval on a case-by-case basis by the Chief Medical Officer of the Office of Mental Health or his/her designee.

13) When manual restraint is used for the purpose of facilitating the placement of a patient in seclusion and/or the administration of emergency medications over objection, ALL interventions must be included in a physician’s order. A separate order is not needed for the manual restraint if the seclusion order includes the directive to use manual restraint. The entire event must be documented in the patient’s clinical record. For example, an order for seclusion could read, “Restrain to administer medication over objection and seclude for up to 30 minutes.” The duration of each intervention (manual restraint and seclusion) should be noted when reporting via NIMRS or any successor format.

14) All clinical staff shall demonstrate competence in alternatives to and the appropriate application of seclusion and restraint prior to participating in the restraint or seclusion of a patient. Techniques sanctioned and taught by the Office of Mental Health must be employed. Excessive force shall not be used in initiating the use of seclusion or restraint. To enable staff to check the patient’s airway and to prevent the possibility of positional asphyxia, care shall be taken to assure that patients are not placed in a face-and/or-chest down position.

15) In the case of patients who are known or reasonably believed to have a history of physical or sexual abuse, or in the case of patients with hearing impairments who would be unable to communicate without the use of their hands, an explanation of why restraint is the most appropriate intervention under the circumstances shall be included in the patient’s case record when an order for the use of restraint is written pursuant to section E(3)).

16) The standard forms of mechanical restraint are the four-point restraint, five-point restraint, wrist-to-belt restraint, mitts, helmets, and calming blanket. No facility shall use these devices unless the related manufacturer and model have been approved by the Chief Medical Officer of the Office of Mental Health or his or her designee. Such approval shall be interpreted to allow facility-wide use.

17) Except as provided in paragraph 18 of this section, mechanical restraints which employ a locking mechanism released by a key shall never be used or considered approved for use.

18) 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:
a) all employees with monitoring responsibility for a patient wearing a wrist-to-belt device with a locking mechanism are required to carry the key to release the restraints on their person when on duty;
b) 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;
c) training and practice sessions are 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
d) 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.

19) Facilities may use other types of mechanical restraints for specified patients for a specified period when so authorized by the Chief Medical Officer of the Office of Mental Health or his/her designee.

20) In choosing among the possible forms of intervention for a particular patient, staff shall utilize the least restrictive type that is appropriate and effective under the circumstances and shall use restraint or seclusion only as a last resort. Similarly, in cases where restraint or seclusion is used as a last resort, the least restrictive type which is appropriate and effective under the circumstances must be used. In determining whether or not a physical intervention reached a level where it constitutes manual restraint, reasonable consideration must be given to the nature of the behavior of the patient that precipitated the intervention, the behavior of the patient subsequent to the intervention, federal guidance, clinical judgment, and common sense.

21) The facility shall convey the intentions of OMH to make the use of restraint a rare occurrence, and to continue efforts to reduce the rate of such rare occurrences, to patients and to those families who, upon patient agreement, are involved in the patient’s treatment planning process. Every state operated facility shall have a plan to reduce and ultimately try to eliminate the use of restraint and seclusion.

22) Time out is not considered a type of seclusion or restraint. In order for an intervention to be considered time out, (regardless of the name of the intervention, e.g., “calming time”), the patient must be permitted to enter the area/room completely voluntarily, and the patient’s ability to exit the time out area or room must not be restricted by any means. Whenever feasible, rooms used for time outs should not be the same room as that used for seclusion or restraint.

4 For example, if a staff member were to place his arm around a slightly agitated patient as he escorted him to a quiet room to regain control of his behavior, and the patient did regain control of his behavior and returned to the common area, such physical intervention would not constitute manual restraint. If an upset child was briefly held by staff to calm or soothe him, and the child soon quieted down, such physical intervention would not constitute manual restraint. If a patient erupted in violence and attempted to physically assault another patient or staff, and the patient had to be physically held prior to placing him in restraint or seclusion, such physical intervention would constitute manual restraint.
E. Procedures for Seclusion or Restraint for Behavioral Management Purposes

1) Individual Crisis Prevention Plans

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 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 may be found in Implementation Guidelines for 14 NYCRR § 526.4.

b) Individual crisis prevention plans are designed to:
   (i) help patients during the earliest stages of distress or escalation before a crisis erupts;
   (ii) help patients identify practicable coping strategies;
   (iii) help staff plan ahead and know what to do with each person if a problem arises; and
   (iv) help staff use interventions that reduce risk and trauma to individuals.

c) Individual crisis prevention plans should have at least three distinct sections: triggers, early warning signs and coping strategies. The plans should encourage creativity and should be individualized to each patient’s needs, linked to any personal history of trauma, and tailored to environmental resources.

d) Each facility shall develop a mechanism to be sure that all staff on all shifts, as well as floating staff, are aware of the patients’ individual crisis prevention plans. At a minimum, the crisis plans should be attached to the patient’s treatment plan and appear in condensed form which is readily accessible by staff. The information may also be included in other places where patient alerts are noted.

e) A copy of the individual crisis prevention plan should be given to the patient and routinely reviewed and updated throughout his/her inpatient admission when changes are warranted. Once the specific coping strategies are identified, they should be incorporated into the patient’s individual crisis prevention plan. To provide an opportunity for the patient to build proficiency and increase the probability that they will be effective during times of crisis, the patient should be given an opportunity to practice the identified coping strategies at times when he/she is not in crisis.

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5 An individual crisis prevention plan may also be known as an “individualized calming plan,” a “safety plan,” an “individualized calming, wellness, and recovery plan,” or similar reference. Although the name of the document may vary, its purpose and function of the document must be the same, i.e., to identify a patient’s individual preferences and behaviors related to behavioral management interventions.
f) Any preferences expressed by the patient regarding the gender of and/or languages spoken by the observing staff person shall be honored when practicable and clinically appropriate.

2) Strategies to Reduce the Use of Seclusion and Restraint
   a) Appropriate staff shall be made aware of patients’ individual crisis prevention plans and shall be instructed to implement these plans in the early stages of patient crisis to help him or her regain control.
   b) In addition, consistent with OMH’s emphasis on recovery, facilities shall demonstrate commitment to reduction of the use of seclusion and restraint through hiring practices, training and hands-on involvement of executive, administrative and supervisory staff. Such commitment can be demonstrated by assuring that all staff are encouraged and trained to utilize 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 State operated facility is required to develop and have in operation a plan to become violence and coercion-free, the progress of which must be monitored regularly by the Facility Director or his or her designee.

3) Initiating Seclusion or Restraint
   a) Except as provided in section E)3)k), the implementation of seclusion or restraint shall only be pursuant to a physician’s written order, based on the results of a documented personal examination of the patient by the physician.
   b) The examination of the patient conducted by the physician shall include an assessment of the patient’s psychiatric status and physical condition, as well as a review of the clinical record for any pre-existing medical diagnosis and/or physical condition that could contraindicate the use of seclusion and/or restraint.
      (i) The psychiatric status assessment shall include an evaluation of the person’s immediate situation, the patient’s reaction to the intervention, assessment of the patient’s behavior, thought content, actual dangerousness to self or others, level of consciousness, and any other assessments which are clinically necessary, including whether or not 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.
      NOTE: The only reason that can justify the use of seclusion or restraint is imminent danger.
      (ii) The physical assessment shall include an assessment of the patient’s general condition and vital signs, and any other examinations which are clinically necessary.
      (iii) The results of the examination shall 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.

(iv) 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 shall be recorded.

(v) Any prior medical diagnoses, conditions, or behaviors that could serve as relative contraindications to the use of seclusion or restraint, including but not limited to a history of physical or sexual abuse or hearing impairment, should be documented, as well as the physician’s rationale for ordering such an intervention at this time.

c) The physician shall review the patient’s existing medication orders and shall assess the need for modifying orders during the period of seclusion or restraint. Documentation of this medication review shall be included in the patient’s clinical record.

d) The physician must document the time at which he or she examined the patient in the patient’s clinical record.

e) The physician’s written order shall:
   (i) be written on the Order Sheet or electronic equivalent and included in the patient’s clinical record;
   (ii) specify the facts and behaviors justifying the intervention and set forth 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 he or she has 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;
   (iii) specify the type of intervention to be used. If a physician orders the use of restraint, the written order shall specify the type of restraint to be used;
   (iv) identify the behavioral criteria for release; and
   (v) Include any special care or monitoring instructions.

f) Notwithstanding the provisions of 14 NYCRR §526.4, the maximum time period of orders of seclusion or restraint shall be in accordance with the following; provided, however, that when a drug is used as a restraint, the provisions of D)(8) of this policy directive shall apply:
   (i) one hour for adults;
   (ii) 30 minutes for patients ages 9 to 18, or for patients over age 18 in a children’s facility or unit;
   (iii) up to 15 minutes for manual restraint of patients of any age;
   (iv) up to 15 minutes for the use of calming blanket which is not intended for use as an ongoing restraint; and
   (v) seclusion or mechanical restraint shall not be used for patients under the age of 9, except upon prior approval on a case-by-case basis by the Chief Medical Officer of Mental Health or his/her designee.
g) Seclusion shall not be used with persons with a sole diagnosis of a developmental disability. However, seclusion shall be permitted for persons with a dual diagnosis of mental illness and intellectual development disorder, only if performed in accordance with the requirements of this policy directive which govern seclusion interventions, in order to ensure compliance with 14 NYCRR Section 526.4.

h) PRN orders shall not be used to authorize the use of seclusion or restraint.

i) Continuous use of seclusion or restraint.
   (i) The use of seclusion or restraint beyond a continuous 4-hour period requires prior approval by the clinical director or his/her designee. Continuous use shall not exceed 24 hours without notification of the Chief Medical Officer of the Office of Mental Health, or his or her designee.
   (ii) The Clinical Director or his/her designee shall immediately be notified of the issuance of 2 or more separate orders for the use of seclusion or restraint on any patient within any 12 hour period.

j) The Office of Mental Health expects that staff will immediately interact/intervene to prevent a patient from seriously injuring him/herself or others. When patients display antecedents to aggressive behavior and a potential crisis appears to be evolving, the registered nurse or nurse practitioner and physician should be immediately notified. Seclusion or restraint may be initiated in the absence of a physician’s written order if a patient presents an imminent danger to self or others and a physician is not immediately available to examine the patient. Every effort should be made to implement any applicable provisions of the patient’s individual crisis intervention plan, except in those rare instances in which the patient’s dangerousness is of such immediacy that less restrictive interventions cannot be safely applied. The use of a restrictive intervention shall only be employed in accordance with the following directives:
   (i) A physician must be called immediately to conduct a personal examination of the patient. If the physician cannot arrive on the ward or unit within 5 minutes, he/she must issue a telephone order to initiate the restraint or seclusion. Telephone orders to initiate restraint or seclusion will be issued sparingly.
   (ii) A nurse, nurse practitioner, or physician’s assistant shall 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 shall complete a telephone order in accordance with facility policy. All actions taken must be recorded on the Restraint or Seclusion Monitoring Form.
   (iii) The physician who ordered initiation of the restraint or seclusion via telephone order must authenticate the order in writing and perform an examination of the patient within 30 minutes of the time that he or she was notified. If the physician’s arrival exceeds 30 minutes from the time called:
a) the registered nurse, nurse practitioner, or physician’s assistant shall record the delay in the patient’s 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 assure the patient’s comfort and safety; and

b) the physician shall record in the patient’s clinical record the explanation for his or her delay in arrival.

(iv) In no event shall seclusion or restraint be applied for longer than 30 minutes without the written authenticated order of a physician.

(v) If, based on the results of the physician’s personal examination, the physician determines that the use of seclusion or restraint was and/or continues to be indicated, he or she shall authenticate the telephone order and write an order for the procedure consistent with the requirements of section E)3). The order shall 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, nurse practitioner, or physician’s assistant shall not exceed the time period allowed pursuant to section E)3)f).

(vi) If, based on the physician’s personal examination, it is determined that seclusion or restraint is not needed, the physician shall document his or her rationale in a progress note. This should not be interpreted as a reflection of the judgment of the registered nurse, nurse practitioner, or physician’s assistant; the crisis may have passed. In addition, the physician must write an order to cover the period of time in which the patient was in seclusion or restraint prior to the physician’s examination.

k) Prior to placing a patient in seclusion or restraints pursuant to section E)3)a) or E)3)j), he or she shall be searched for potentially dangerous objects, and such objects shall be removed. If such search cannot safely be conducted, the reason for the delay shall be documented in the patient’s clinical record. However, such search shall be conducted at a later time, as soon as it can be completed safely. In no event shall a patient be placed in seclusion or restraint in a nude or semi-nude state.

l) Implementation of the seclusion or restraint order shall be consistent with the techniques sanctioned and taught by the Office of Mental Health.

m) To enable staff to check the patient’s airway and prevent positional asphyxia, care shall be taken to assure that patients are not placed in a face- and- chest- down position. In cases where the patient moves, or is inadvertently moved, to a chest- down position, he or she shall be immediately repositioned.

n) Immediately after the application of the seclusion or restraint, a physician or registered nurse shall conduct an assessment of the
patient to ensure that the intervention was safely and correctly applied without undue harm or pain to the patient.

o) If the patient has granted permission for notification of his/her family and/or a patient advocate of the initiation of seclusion or restraint, a professional staff member shall promptly make such notification. If the seclusion or restraint is applied during the night, such notification may occur the following morning.

If a family has submitted a written request not to be notified of instances of seclusion and restraint, the facility shall honor this request.

p) If, at any time after application of seclusion or restraint, clinical assessment indicates that the patient has met the behavioral criteria for release, release shall be immediate.

4) Monitoring Persons in Seclusion or Restraint

a) A patient in seclusion or restraint shall be monitored and assessed to ensure that his or her physical needs, comfort and safety are properly cared for.

(i) A patient in seclusion or restraint shall receive one-to-one constant observation and assessment by a staff member who is trained and competent in Office of Mental Health policies and procedures regarding seclusion and restraint with demonstrated skills in minimizing the use of seclusion and restraint, assisting patients in meeting behavior criteria for the discontinuation of seclusion or restraint, 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), assessing physical and psychological signs of distress or injury of patients who are in seclusion or restraint, and recognizing readiness for the discontinuation of these interventions.

(ii) A written assessment of the need for seclusion or restraint and of the general comfort and condition of the patient shall 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. The assessment shall be recorded on the Restraint and Seclusion Monitoring Form.

b) Although audiovisual monitoring may be useful for time-out, one-to-one constant observation shall be used to monitor persons in seclusion or restraint. Staff members assigned to provide one-to-one constant observation may not have other assigned responsibilities during the time period that they are assigned this supervision responsibility.

c) For patients held in manual restraint, a separate staff member not involved in the manual restraint shall carefully observe the patient’s physical status. If the patient is complaining of physical discomfort or difficulty breathing, or the staff person “witnessing” the event notices a physical change of color or similar concern, the RN or physician must assess the situation and alleviate the physical problem.
d) In order to reduce the possibility of choking, unless clinically indicated, patients shall not be fed while in restraints. If a patient has been restrained and not fed during mealtimes, immediately after release from restraints, he or she shall be offered food and fluids.

e) In order 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, shall be taken and recorded on the Restraint and Seclusion Monitoring Form according to the following guidelines:

(i) For patients in restraint, vital signs should be taken immediately after application of restraint, hourly thereafter, and upon release, or more frequently as ordered by the physician.

(ii) For patients in seclusion, vital signs should be taken immediately after placement in seclusion and upon release if the patient’s behavior is such that vital signs can be taken safely.

(iii) If a patient is in seclusion beyond a period of 1 hour, vital signs should be taken every two hours or more frequently as specified by the physician, if the patient’s behavior is such that vital signs can be taken safely.

(iv) If vital signs of a patient in seclusion or restraint cannot be taken safely at the frequency required, the reason for each omission shall be documented in the patient’s clinical record.

f) A patient shall be released from seclusion or restraint as soon as he or she no longer presents 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, doctor, or physician’s assistant determines that the patient is obviously dangerous, an attempt should be made to release the patient at least once every 30 minutes.

(i) If a patient, upon this attempt to release him/her from seclusion or restraint, is determined to be a continued danger to self or others, the intervention may be continued, unless the order pursuant to section E)3) has expired.

(ii) If the order has expired, a subsequent episode of seclusion or restraint can only be initiated in accordance with the procedures set forth in section E)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 shall not be re-imposed.

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6 The assessment of vital signs will include, in addition to assessing temperature, blood pressure, and pulse and respiration rate, observation and documentation of status of respiration, skin color, and appearance of nail beds.
g) It is the responsibility of the physician who has ordered seclusion or restraint to be accessible to staff in the event of an emergency. Accordingly, the physician shall advise appropriate staff how to contact him or her, or a relief physician, during the period of the order.

h) Each State-operated psychiatric facility shall 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 shall 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) Reviewing the Use of Seclusion or Restraint
   a) **Patient Evaluation.** Upon the patient’s release, the registered nurse, nurse practitioner, or physician’s assistant shall conduct an in-person re-evaluation of the patient and write a progress note that includes a description of the patient’s response to the use of seclusion or restraint.
   b) **Post Acute Event Analysis.** Immediately following the episode of seclusion or restraint, the key individuals involved in the procedure, including the staff who authorized and ordered the seclusion or restraint shall conduct and document a post acute event analysis.
      (i) When possible, the debriefing should be led by the on-site supervisor, and an individual who is not part of the treatment team should be invited to participate.
      (ii) The post-acute event analysis should include the patient, if clinically appropriate, and significant others at the patient’s request.
      (iii) This analysis must include an assessment of the patient’s immediate needs (e.g., physical well-being, psychological comfort, and right to privacy), which shall be documented in the patient’s clinical record, as well as a determination of the steps that need to be taken to return to the pre-crisis milieu.
      (iv) An assessment of the involved staff member’s physical and psychological well-being shall also be made.
   c) **Formal Debriefing:** The formal debriefing is a collaborative process that includes the patient, the treatment team, and other involved parties. It should occur no later than the next business day following the use of seclusion or restraint and shall be conducted by a senior manager.
      (i) The purpose of this debriefing is to review what happened, and how the participants feel about what occurred during the event.
      (ii) The scope and depth of the formal debriefing shall be commensurate with the nature and duration of the intervention utilized, provided minimum Joint Commission and CMS requirements are met.
      (iii) The formal debriefing shall include a review of the patient’s plan of care (treatment plan and individual crisis plan) and a
modification of such documents where indicated or documentation why revisions were not made.

(iv) As part of this debriefing, the patient should be assisted in identifying what led to the incident and what could have been done differently. A determination should also be made whether or not all alternatives to seclusion and restraint were considered, with a goal of avoiding the need to have to use such interventions in the future.

d) Quality Assurance Review of restrictive intervention.

(i) Application of information gained. The information gathered from the post-acute event analysis and formal debriefing should be used to identify, evaluate and modify facility policies and procedures, unit environments, rules, practices, staff interactions, individual crisis prevention plans, individual treatment plans, training needs and other areas, as appropriate.

(ii) Such information shall be documented in a record that is not part of the patient’s clinical record, (such as NIMRS). However any recommended solutions or intervention preferences offered by the patient during the Post Acute Event Analysis or Formal Debriefing must be noted in the patient’s clinical record, to ensure such information is considered in future situations, and implemented whenever clinically appropriate.

e) It shall be part of the treating psychiatrist’s responsibilities upon coming on duty to review the clinical record of any patients for whom he or she is responsible who have been in seclusion or restraint since he/she was last on duty, and to ascertain their current status.

f) A report which indicates the utilization of seclusion or restraint shall be sent to the clinical director or designee on a daily basis. The report shall, at a minimum, include:

(i) the patient’s name and ward;
(ii) the type of seclusion or restraint used;
(iii) the length of time that the patient was in seclusion or restraint for each written order;
(iv) the behavior(s) necessitating the intervention; and
(v) any less restrictive techniques attempted and a statement of why they were found inadequate.

g) The clinical director or designee shall review the use of seclusion and/or restraint daily, and shall immediately investigate unusual or unwarranted patterns of utilization. Each episode of seclusion or restraint involving patients under the age of 18 shall be reviewed by the clinical director or designee no later than the next working day.

h) Multiple episodes of seclusion or restraint with an individual patient shall be reviewed by the patient’s treatment team and the clinical director or his or her designee. At a minimum, such reviews, which shall include a review of the patient’s treatment plan, including an assessment of current medications, shall be conducted whenever three or more orders are written for a given patient within a 30 day
period. The review team shall include a senior psychiatrist and, if available, at least one peer specialist.

i) As part of the facility’s quality management program, the incidence of violent behavior and the associated use of seclusion and/or restraint shall be monitored. Data regarding each order of seclusion and/or restraint shall be collected, analyzed, and reported to Central Office. These data shall be integrated into facility and Office of Mental Health performance improvement activities.

j) Injuries and deaths related to the use of seclusion and/or restraint shall be reported as incidents pursuant to the mandates of 14 NYCRR Part 524 and the Office of Mental Health clinical risk management and incident management plans policy (QA-510). Staff injuries shall also be reported, pursuant to employee accident reporting policies.

k) The Office of Mental Health shall 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 Office of Mental Health Director for Quality Management after consultation with Associate Commissioner for State Psychiatric Center Management and the Chief Medical Officer or his/her designee and will occur by the next business day following the patient’s death.

6) Training
a) The facility shall assure that clinical staff, including professional staff, as well as any staff that may be involved in the seclusion and restraint, receive orientation and instruction in alternatives to both seclusion and restraint, the appropriate techniques of applying both seclusion and restraint, the potentially traumatic impact of seclusion and restraint, and the laws, regulations, policies and procedures governing the use of seclusion and restraint. The training shall also address the sensitization of staff regarding the use of seclusion and restraint and shall 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 shall be included as providers of training. If such persons are not available as trainers, the viewpoints of persons who have experienced seclusion or restraint shall be presented using written or audiovisual material, as available. A written record of training shall be maintained.

b) Such training must be provided to all staff working in an inpatient setting who interact with patients as follows: a 3-day minimum training program should be provided initially, with a 2-day review program provided on an annual basis.

c) Staff must initially demonstrate competency in all of the training areas identified in paragraph a) of this subdivision prior to their participation in the seclusion or restraint of a patient, and shall further be required to demonstrate such competence on an annual basis.
7) **Use of Mechanical Supports**
   a) The requirements of this directive do not preclude the use of mechanical supports\(^7\). 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 shall be ordered by a physician as part of the patient’s treatment program in accordance with facility policy. Such order shall be documented in the patient’s clinical record.
   c) As a matter of policy, mechanical supports shall not be used as a substitute for restraint. In those rare events in which they are used as a form of restraint, such use shall only be implemented following the prior approval of the Chief Medical Officer of the Office of Mental Health or his/her designee and in accordance with the provisions of Section F, below.

**F. Procedures for use of Restraints for Medical or Post Surgical Care**

As with all restraints, risks associated with restraints for medical or 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 guidelines apply to restraint of a patient in a facility operated by the Office of Mental Health for purposes of medical or post-surgical care:

1) A restraint for medical or post-surgical care shall not serve as a substitute for adequate staffing to monitor patients.
2) The use of restraints for medical or post-surgical care shall be implemented in accordance with a written modification of the patient’s treatment plan.
3) Implementation of medical or post-surgical restraint shall be pursuant to a physician’s written order, based on the results of a documented personal examination of the patient by the physician.
4) The examination of the patient conducted by the physician shall include an assessment of the patient’s mental status and physical condition, as well as a review of the clinical record for any pre-existing medical diagnosis and/or physical condition which may contraindicate the use of restraint.
   a) The assessment shall include an evaluation of the patient’s general condition and vital signs, and any other examinations which are clinically necessary.
   b) The results of the examination shall be documented in the patient’s clinical record, along with the inadequacy of less invasive interventions, the specific circumstances that necessitated the restraint, and the purpose that the intervention is to serve.

\(^7\) Each facility should have in place a separate policy that governs the use of mechanical supports. The statements in this section are intended to clarify the relationship between mechanical supports and restraints.
5) The physician’s written order shall:
   a) be written on the Order Sheet or electronic equivalent and included in the patient’s clinical record;
   b) specify the facts and circumstances justifying the intervention and set forth the time of initiation and expiration of the authorization;
   c) specify the specific type of restraint to be used; and
   d) include any special care or monitoring instructions.

6) The maximum time period for each order of restraint for medical or post-surgical care shall be 24 hours.

7) Implementation of the restraint order for medical or post-surgical care shall be consistent with standard techniques to ensure safety and efficacy. The facility shall assure that clinical staff, including professional staff, receive orientation and annual instruction in all techniques commonly used in the facility for restraining patients in medical and post-surgical care.

8) A patient in restraint shall be monitored to ensure that his or her physical needs, comfort and safety are properly addressed, including administration to the patient’s limbs of range of motion exercises at least every 2 hours, when the patient is awake.

9) When utilizing four point or five point methods of mechanical restraint for medical or post-surgical care, written assessment of the need for the restraint of the general comfort and condition of the patient shall 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. The assessment shall be recorded on the Restraint and Seclusion Monitoring Form. Such patients shall be continually monitored on a one-to-one basis. For all other forms of mechanical restraint used for this purpose, written assessment of the need for the restraint of the general comfort and condition of the patient shall 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. The assessment shall be recorded on the Restraint and Seclusion Monitoring Form.

10) When utilizing four point or five point methods of mechanical restraint for medical or post-surgical care, in order to assess the patient's physical status during the use of restraint, vital signs, consisting of blood pressure, temperature, pulse and respiratory rate, shall be taken and recorded immediately after application of restraint, hourly thereafter, and upon release, or more frequently as ordered by the physician. For all other forms of mechanical restraint used for this purpose, such vital signs shall be taken and recorded immediately upon application of the restraint and thereafter on a daily basis, or at more frequent intervals as directed by the physician.

11) It is the responsibility of the physician who has ordered the medical post-surgical restraint to be accessible to staff in the event of an emergency. Accordingly, the physician shall advise appropriate staff how to contact him or her, or a covering physician, during the period of the order.

12) The clinical director or designee shall review the use of medical or post-surgical restraint daily, and shall immediately investigate unusual or unwarranted patterns of utilization.

13) Injuries and deaths related to the use of medical or post-surgical restraint shall be reported as incidents pursuant to the mandates of 14 NYCRR Part 524 and the Office of Mental Health incident management policy (QA-510).
14) The Office of Mental Health shall report to the Centers for Medicare and Medicaid Services any death that occurs while a patient is restrained, or in which it is reasonable to assume that the death is a result of restraint. This notification will be made by the Office of Mental Health Director for Quality Management after consultation with the Associate Commissioner for State Psychiatric Center Management and the Chief Medical Officer or his/her designee and will occur by the next business day following the patient’s death.