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March 2, 2021

The Honorable Kate Lieber, Co-Chair
The Honorable Rob Nosse, Co-Chair
Joint Ways and Means Subcommittee on Human Services
900 Court St. NE
Salem, Oregon 97301

SUBJECT: February 25 Committee Questions

Dear Co-Chairs and Members of the Committee:

Thank you for the opportunity to present to the Joint Ways and Means Subcommittee on Human Services on February 25, 2021, about the Oregon State Hospital budget. Below are responses to questions we received during and after that committee meeting.

1. **Can we provide data related to physical intervention events and the impact of Collaborative Problem Solving? What does the data show about the use of restraints, seclusions, duration of seclusion and restraint, and injuries to staff and patients?**

   In 2015, OSH identified Collaborative Problem Solving (CPS) as another tool for staff to use when working with patients to build trust and rapport, develop problem-solving skills, prevent aggressive events, and avoid the use of more restrictive interventions. Since 2015, OSH has implemented CPS in phases. Staff on the first five units were trained in CPS in January 2015. Since then, CPS has been incorporated into New Employee Orientation, introducing the philosophy and basic concepts, while treatment teams may teach patients the same principles to facilitate communication and relationship-building. As of January 2021, 22 of the 28 units at OSH have staff trained in CPS.

   Because other variables (modification to treatment modalities, other improvements, etc.) occurred during this same time period, the change in the number of restrictive events and in the injuries sustained from aggressive events at OSH cannot be directly correlated to the implementation of CPS. However, the data do suggest that the implementation of CPS has had a positive effect on both patient and staff safety. (See graphs on page 3.)

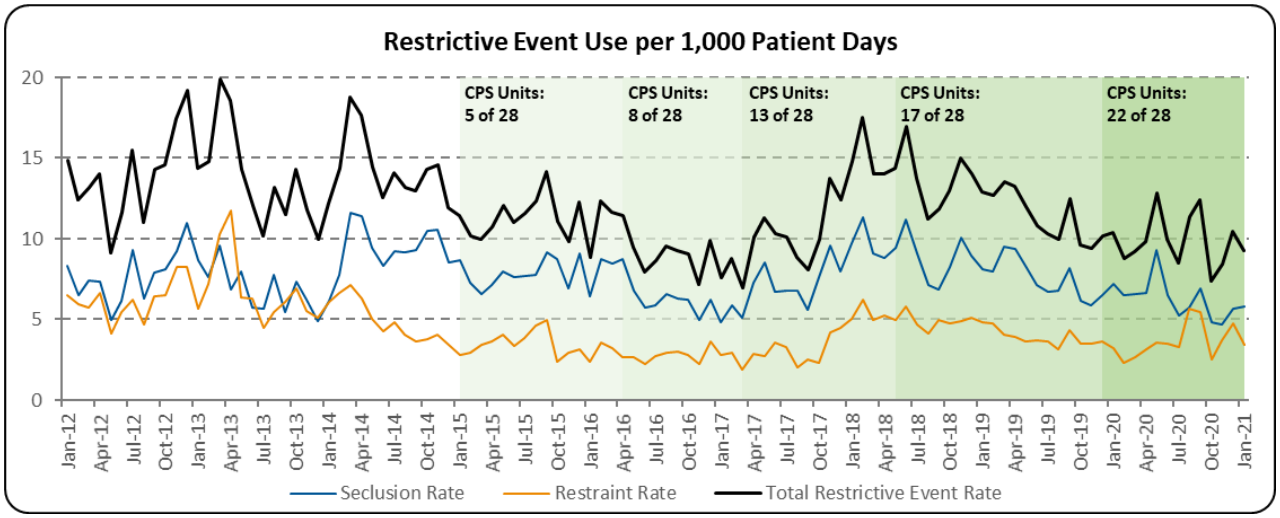
Definitions per Centers for Medicare and Medicaid (CMS) in 42 CFR § 482.13(e):

- "Seclusion" is defined by as the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior in a behavioral emergency.
- "Restraint" is defined as any manual method (including a physical escort), physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication 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.

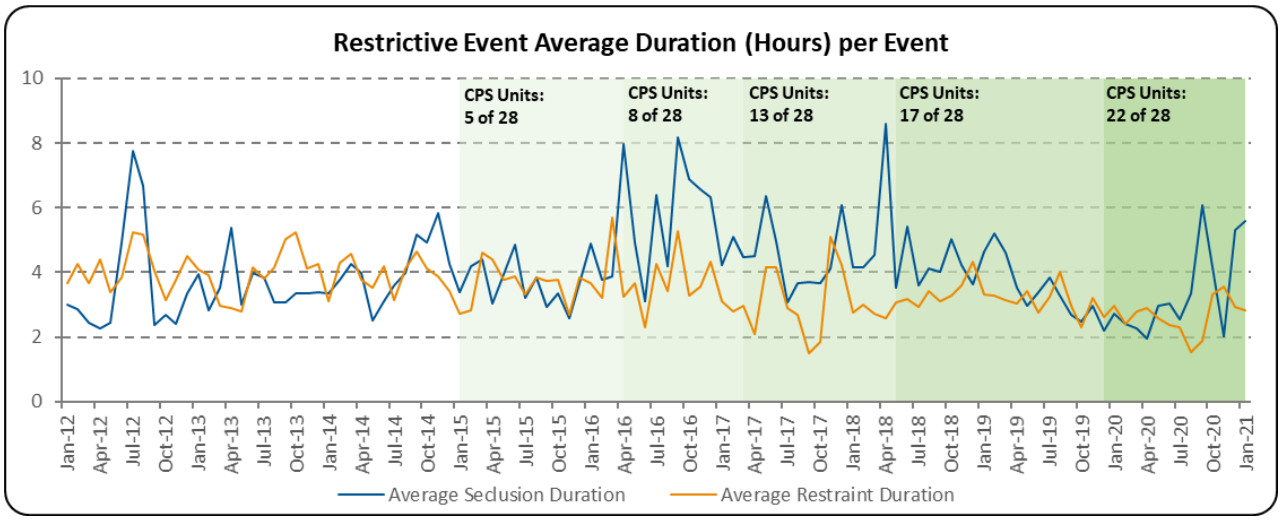
The use of restrictive events at OSH are limited to a small subset of patients with the most acute symptoms. In a study looking at restrictive event data from 2012-2019, OSH found:

- 61% of all patients served during that eight-year period never had a single seclusion or restraint event while at OSH.
- Roughly one-fifth (21%) of patients accounted for nearly all (94%) of the restrictive events.
- Just 24 patients (0.4%) accounted for one-third (33%) of all events.

Analysis of Restrictive Events and Injuries from Aggressive Events at Oregon State Hospital Before and After the Implementation of Collaborative Problem Solving



Period	Dates	Seclusion Rate	Restraint Rate	Total Restrictive Event Rate
Pre-CPS	Jan 2012 – Dec 2014	8.038	5.953	13.991
Post-CPS	Jan 2015 – Jan 2021	7.391	3.642	11.033
	Percent Change	**-8.0%**	**-38.8%**	**-21.1%**



Period	Dates	Average Seclusion Duration	Average Restraint Duration
Pre-CPS	Jan 2012 – Dec 2014	3.80	3.94
Post-CPS	Jan 2015 – Jan 2021	4.19	3.24
	Percent Change	**+10.3%**	**-17.8%**

Below is the most recent data regarding both patient and staff injuries *that can be directly related* to a seclusion or restraint event.

- "First aid" means the individual did not need medical attention above what can be provided on the unit, such as a bandages, ice or ointment.

- "Medical attention" means any time the individual needed outside medical treatment at a clinic or hospital, such as x-rays, sutures, or prescription medications.

Year	Patient injuries requiring first aid only	Patient injuries requiring medical attention	Staff injuries requiring first aid only	Staff injuries requiring medical attention
2018	1	1	83	125
2019	0	4	102	94
2020	2	1	154	134

2. How was the current OSH training protocol for restraint and seclusion – known as Safe Together – developed?

The process that led to the Safe Together training program began in 2012 as part of an OSH initiative led by the Chief Medical Officer called "Culture of Safety." The initiative comprised several staff work groups tasked with addressing multiple issues that affected both patient and staff safety at OSH. The two workgroups most relevant to restraint and seclusion issues were Safe Communication and Safe Containment.

- Safe Communication focused on developing ways to communicate with people, especially during hard conversations or saying no, that would be less likely to cause agitation and help diffuse difficult interactions before they became aggressive events. When OSH adopted the Collaborative Problem-Solving model in 2015, this workgroup was no longer needed, as CPS addressed these communication issues.
- Safe Containment focused on decreasing the risk of injury to patients and staff if communication failed and there was no other option than using manual and/or mechanical restraint to keep everyone safe. Safe Containment rolled out as a supplement to ProACT, the former training program, in 2014.

As the hospital began rolling out CPS, it became clear that CPS and ProACT were incompatible with each other and often contradictory. For example, ProACT labels patients by their behavior and dictates interactions based on those labels. This did not align with a person-centered approach and caused confusion for staff. Thus, the hospital began looking for a different program that would work in alignment with CPS. However, the workgroup was unable to find a national training system that met the hospital's goals of both aligning with CPS and continuing the use of Safe Containment, which had shown to decrease patient and staff injuries. So instead, the hospital embarked on creating its own training program that:

- Would be understandable and simple to learn
- Adhered to adult learning principles
- Focused on decreasing instances of seclusion and restraint and creating a culture where these interventions were seen as a last resort, and
- Established practices to make unavoidable restraints safer for patients and staff.

The end product of these efforts was Safe Together. The new training was provided to the first group of staff in May 2017. Since then, Safe Together has been presented to the Joint Commission during two separate surveys. In both instances, the surveyors described Safe Together as the best training that had ever seen. Safe Containment and Safe Together have been presented at the Western Psychiatric State Hospital Association annual conference, and as a result, several other state psychiatric hospitals have approached OSH for assistance improving their own training around patient and staff safety. Safe Together is focused on real results and culture change as opposed to simply meeting regulatory requirements.

3. **Who developed Safe Together and who was consulted?**

   Safe Together was developed through a collaboration of the Chief Medical Officer and staff from CPS, Employee Education and Development, Medicine, Nursing, Peer Recovery, and Psychology, as well as two patient representatives. The Chief Medical Officer consulted with Disability Rights Oregon, and presented the program to the Governor-appointed OSH Advisory Board.

4. **Why does OSH use its own internal program rather than something used by other programs and that is nationally known and tested?**

   When OSH looked for a replacement for ProACT, the national products they found were not current and did not focus on reducing physical restraints and injuries to patients and staff. Those products were for-profit and did not align with the hospital's goals of CPS alignment and person-centered focus.

   The driving force behind creating an original training was to be able to offer better and more current training that specialized on avoiding seclusion and restraint through relationship building and de-escalation. Offering its own training allows OSH to constantly update the curriculum and incorporate multiple programs such Motivational Interviewing and Collaborative Problem Solving.

5. **Where does Safe Together land in the spectrum between more violent and invasive/aggressive interventions with those that are based on de-escalation and least use of force?**

   Safe Together's guiding philosophy is that the safest restraint is the one you avoid. This philosophy informs our training and is behind our constant efforts to improve our training. The majority of all Safe Together trainings focus on how to build therapeutic relationships and use verbal de-escalation as the primary forms of increasing patient and staff safety. Trainers teach only those manual restraint techniques that have undergone extensive internal testing and interdisciplinary evaluation to ensure that they adhere to the standard of decreasing risk of injury to both the patient and staff while being as trauma informed as possible in any given situation.

6. **How does OSH demonstrate that training has occurred?**

   OSH tracks all staff competencies based on CMS and The Joint Commission requirements. The Employee Education and Development Department ensures all direct care staff have the primary Safe Together training as well as an annual refresher. The Department also tracks ongoing skill maintenance through drill exercise attendance

7. **Is Safe Together based somewhat on ProAct?**

   No.

8. **Would staff ever put their weight on the person?**

   OSH staff never put weight on a patient's torso. Trainers have taken great care to create a program that eliminates the risk of positional asphyxia, and staff are never in a position to even accidently put their weight on a patient's core. Instead, Safe Together trains in containment (manual restraint) techniques that focus on controlling limbs using leverage and gravity. (OSH uses the term containment to differentiate between a manual restraint and mechanical restraint.)

   In the original assessment of patient and staff injuries during manual restraint, the workgroup found that lost control of a limb was the number one cause of injury. By teaching techniques that prevent loss of control while simultaneously mitigating the risk of positional asphyxia, OSH has decreased the chance of patients and staff being injured during a containment event. All positions are designed to ensure no pressure is placed on any joints, no twisting or torqueing of limbs, and no pain is caused to the person being restrained. The registered nurse monitors the patient throughout the restraint event to ensure their physical and emotional safety and instructs staff to adjust their positions as necessary. A team lead also monitors staffs' adherence to technique fidelity and maintains verbal de-escalation with the patient to end the restraint as soon as possible.

9. **Does OSH use prone/supine restraints?**

   Staff use prone positioning only temporarily if a patient is being contained on the floor, in circumstances when a wall containment is not safe to use. Staff learn how to transition the patient to supine as quickly as it is safe to do so. They also learn how to adjust their position to allow for more movement if a patient is having any difficulty breathing.

   The reason staff may move the patient to the floor in the prone position is to avoid going backwards, which has a higher risk of injury. Trainers have tested and tried multiple techniques to avoid the patient being in the prone position, but they have not yet discovered a technique that works safely.

OSH does not mechanically restrain patients in the prone position.

10. Please describe the types of restraints used at OSH, including crotch restraints, if applicable.

Eliminating the use of seclusion and restraint has been a primary goal of OSH since the inception of its Performance System in 2013. Through this system, data on incidents and duration of seclusion and restraint are tracked at the unit, program and hospital level. Hospital leaders review this data at every quarterly performance review to monitor progress, note trends and take appropriate action. OSH also shares this information with Disability Rights Oregon and reviews it at each quarterly meeting. OSH does the same with the OSH Advisory Board at its bimonthly meetings.

OSH staff use seclusion or restraint only as a safety measure of last resort when all other methods of intervention have failed, including CPS verbal de-escalation techniques and containment. After each incident of seclusion and restraint, there is a required debrief that includes the patient and the staff involved to determine what went wrong, what can be done to avoid future incidents of seclusion and restraint, and if unavoidable, how to conduct the restraint in a way that is less traumatizing and more comfortable for them.

We use Posey brand restraints pictured below. Again, these are only used as a last resort and only to keep patients and staff safe.

The chest restraint pictured below is rarely used, and it requires an additional doctor's order. The primary use of the chest restraint is to protect the patient from injuring themselves by tipping the bed over or hitting their head against the bed. Staff would only add the chest restraint in those instances when other alternatives have been tried and failed.

We do not use crotch restraints.

OSH takes the use of seclusion and restraint very seriously. Keeping seclusion and restraint to a minimum follows our efforts to be a person-centered, trauma-informed hospital that supports safety. It also reduces the risk of injury to patients and staff. The attached policy provides more information and a comprehensive representation of the hospital's overall strategy to use seclusion and restraint a little as possible, and when it is used, to do so safely.

Please let me know if I can address any other questions you may have. Thank you.

Sincerely,

Patrick M. Allen
Director

Enclosure:
Oregon State Hospital Policy 6.003 (Dated 12/21/20)

OREGON STATE HOSPITAL

POLICIES AND PROCEDURES

SECTION 6:	Patient Care	**POLICY: 6.003**
SUBJECT:	**Seclusion and Restraints**	
POINT PERSON:	**CHIEF MEDICAL OFFICER**	
APPROVED:	**DOLORES MATTEUCCI** **SUPERINTENDENT**	**DATE: DECEMBER 21, 2020**

I. DEFINITIONS

"Behavioral emergency" in this policy means a situation in which:

1. the patient presents an imminent danger of harm to self or others (as defined in this policy), *and*
2. nonphysical interventions are not viable, *and*
3. safety concerns require an immediate physical response.

“Chemical restraint” means a drug or medication 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.

“Code Green” means bringing together a group of staff responders sufficient to respond to an immediate behavioral emergency. “Code Green” is called by Access Control for an immediate response.

“De-escalation skill set” in this policy includes interpersonal communication and conflict resolution skills to de-escalate a potentially dangerous situation without using seclusion or restraint and to develop or maintain a positive relationship with the person(s) involved.

“Face-to-face assessment” in this policy means an in-person evaluation of the patient’s current condition.

“Imminent danger of harm” in this policy means a substantial likelihood of immediate physical harm to the patient or others, an immediate and substantial likelihood of significant property damage, or an immediate and serious disruption of the activities of other patients in the area.

NOTE: A situation in which a patient is shouting or arguing with staff does ***not*** on its own constitute imminent danger of harm.

"Manual assistance" means physically holding or guiding a patient's movement in order to provide routine medical care, or to provide care for activities of daily living (ADL), or when the patient agrees to be held or can easily gain release from the hold.

"Restraint" is defined by Centers for Medicare and Medicaid (CMS) in 42 CFR § 482.13(e) as any manual method (including a physical escort), physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication 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.

A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm. A physical escort which would otherwise meet the definition of restraint is not considered a restraint if the patient is at imminent risk of falling unless supported.

A restraint does not include a light physical grasp or hold where a patient can easily remove or escape the hold in the same manner as it was applied.

"Restrictive intervention" means any use or type of seclusion or restraint.

"Seclusion" is defined by CMS in 42 CFR § 482.13(e) as the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior in a behavioral emergency.

"Show of concern" means bringing together a group of staff to respond to a potential behavioral emergency.

"Voluntary movement restriction (VMR)" means a registered nurse (RN)-initiated request for a patient to go voluntarily into an unlocked seclusion room, which the patient may leave at will, for the purpose of giving them time to de-escalate.

II. POLICY

A. Oregon State Hospital (OSH) is committed to supporting a patient's right to be free from inappropriate seclusion or restraint while protecting the physical safety of patients, staff, and others. OSH strives to prevent and reduce seclusion and restraint. Seclusion or restraint may only be used when clinically justified by a behavioral emergency (as defined in this policy) when other interventions have been determined to be ineffective. When used, restrictive interventions must be discontinued as soon as possible.

B. Unless safety demands immediate physical response, staff must first consider non-restrictive interventions such as engagement, verbal redirection, asking the patient to remove self from milieu, offering VMR, calling a show of concern, or other de-escalation to prevent a situation from escalating to the point of using seclusion or restraint.

C. Staff must apply the least restrictive interventions incrementally and no more than what is necessary to safely manage the behavioral emergency.

D. Seclusion or restraint may not be used as a substitute for an activity or treatment, or as a means of coercion, discipline, convenience, or retaliation by staff.

E. Chemical restraint may not be used at any time.

F. OSH acknowledges patients can experience trauma during restrictive interventions and will educate staff about patient perspectives and trauma risk.

G. Only a physician, nurse practitioner (NP), or registered nurse (RN) may authorize a restrictive intervention.

   However, if de-escalation, disengagement, or evasion are not possible or fail, trained staff may temporarily restrain a patient from physical aggression in self-defense or immediate defense of another person until a RN is notified.

H. Staff will protect a patient's dignity and protect them from self-injury or injury by others while in seclusion or restraint.

I. To support patient and staff safety and consistent with patient rights, patients may only be restrained by staff who are trained and deemed competent by OSH's training program to provide restrictive interventions.

J. Seclusion, manual restraint, or mechanical restraint orders may ***not*** be written as a standing order, on an as-needed basis (*i.e.,* "PRN"), or be included in the treatment care plan (TCP).

K. Upon admission, staff will discuss patient rights regarding seclusion and restraint with each patient or their guardian, and will educate them about VMR, seclusion, and restraint processes outlined in this policy and procedures. Staff will also provide them with written materials about these processes and relevant policies (Oregon Administrative Rule [OAR] 309-112-0035).

L. This policy applies to all staff, including employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at OSH. Staff who fail to comply with this policy or related procedures may be subject to disciplinary action, up to and including dismissal.

M. OSH follows all applicable regulations, including federal and state statutes and rules; Oregon Department of Administrative Services, Shared Services, and Oregon Health Authority policies; and relevant accreditation standards. Such regulations supersede the provisions of this policy unless this policy is more restrictive.

Intervention Guidance

A. If a patient is escalating and other de-escalation measures have been unsuccessful, a RN who is familiar with the patient's behavior patterns or who has personally observed the escalating behavior may initiate a VMR. Although any staff may request a patient remove themselves from the milieu for a short period of time, only a RN may request a VMR. These procedures are described in Attachment A.

   1. VMR may not be used for the convenience of staff, as punishment, or for coercive purposes. A patient may not be placed in seclusion or restraint in response to refusing VMR.
   2. VMR must end when the patient chooses. If a patient cannot leave, or perceives he or she is prevented from leaving a room (whether or not an actual door exists), the patient is considered to be in seclusion and all seclusion processes apply.
   3. VMR may not last longer than 30 minutes. However, a patient may request to stay longer in the unlocked seclusion room. The seclusion room bathroom door must be locked at all times while the patient remains in VMR.

B. If staff are concerned a situation may approach imminent danger of harm, the physician, NP, or RN must assess the situation and guide the team in the safest, most appropriate, least restrictive intervention to mitigate the risk of physical harm. This may include calling a Code Green to assure that sufficient staff are present to safely respond, if physical intervention is necessary.

C. Before using an intervention, staff must evaluate:

   1. the degree of the patient's trauma history;
   2. the potential for psychological harm to the patient;
   3. the risk of potential physical harm;
   4. the physical capacity of the patient to engage in violent or destructive behavior; and
   5. whether they are seeing the patient's known precursor behaviors that have recently indicated a situation may escalate to imminent danger of harm.

D. Staff may physically escort a patient with a light grasp which a patient can easily remove or escape. Similarly, staff may lightly hold a patient to steady them for routine medical examinations or tests if the patient agrees to the hold and can easily remove or escape the grasp. Such light escorts or holds do not require an order or face-to-face assessment.

E. Brief manual restraint of a patient who is resistive but not violent (*e.g.,* with intramuscular medication administration, or escorting someone who is impaired so that they can't walk unassisted with a firm enough grip that it would otherwise be restraint) requires a physician or NP order but does not require a face-to-face assessment.

However, prolonged manual restraint or manual restraint of a violent patient requires a physician or NP order and a one-hour face-to-face assessment.

F. Designated, certified seclusion rooms must be used for secluding or restraining a patient. If, upon approval from the Chief Medical Officer (CMO) or their designee, a room other than an approved room is used, the RN must document the rationale for this alternative room as part of the Seclusion and Restraint Entry Note.

G. The seclusion room door to the hallway must be locked to prevent intrusions and protect the patient. Dependent on the patient's needs and RN direction, the ante-room door may be open or closed.

H. A patient may only be restrained by physical restraint techniques trained by OSH or with restraint devices specifically approved by OSH.

I. Ambulatory restraints (ARs) may be used for safe transport or in lieu of 4-point bed restraints.

1. When ARs are used, all the usual rules for restrictive interventions apply (*e.g.*, evidence of imminent danger of harm, orders, continuous monitoring, S/R flow sheet, other documentation).

2. A physician or NP may order ARs for safe transport. This does not require the approval of the CMO or designee.

3. If a psychiatrist/psychiatric mental health nurse practitioner (PMHNP) wishes to use ARs in lieu of 4-point bed restraints, they must obtain the approval of the CMO or designee. The psychiatrist/PMHNP must document this approval in a progress note.

   a. If the IDT deems that ARs are the best choice for the patient when mechanical restraint is necessary, the psychiatrist/PMHNP must request renewed authorization from the CMO or designee at least every 30 days. The psychiatrist/PMHNP must document renewed authorization in a progress note.

   b. If the psychiatrist/PMHNP anticipates that ARs may be used more than once, the TCP must be updated to define the circumstances or indications which would lead to choosing ARs in lieu of bed restraints.
   (*e.g.,* ACCEPTABLE: "if RN or physician/PMHNP assesses that X behavior cannot be safely managed by any less restrictive means than mechanical restraint, then use ARs in lieu of bed restraint."
   NOT ACCEPTABLE: "if X behavior, then apply ARs.")

4. Steel handcuffs or secure transport restraints (STRs) may not be used on clinical units or in patient-care areas for managing behavioral emergencies and may only be used within the parameters of OSH Policy and Procedure 8.039, "Secure Transport Restraints."

If, upon arrival at OSH, jail STRs are still on a patient and safety necessitates behavioral restraint, they may remain on the patient until the patient is safely contained on the unit. All restraint orders, documentation, monitoring, and evaluation processes apply.

Safety Measures

A. The RN must supervise staff actions in person during application of a restrictive intervention.

B. The patient may only be held in a manner consistent with OSH-provided training. During manual restraint, the decision for the physical position in which a patient is held must be based on all available clinical information at the time, in particular patient and staff safety, patient trauma history, and medical condition(s).

   1. During a restraint intervention, staff must continually monitor and protect the patient's breathing and circulation.
   2. No direct pressure may be placed on the patient's joints, spinal column, neck, or face.
   3. If the patient is in the prone position, every effort must be made to move the patient to a supine position as soon as safely possible to prevent positional asphyxia.

C. If a spit hood is considered to protect against infection from spit, the RN must approve before it is placed on the patient.

D. Before a patient is placed in seclusion or mechanical restraint, staff must inspect the room and remove any objects that could potentially cause harm to the patient or be used as a weapon. The bathroom door may remain open per RN direction or assessment.

E. Before a patient is placed in seclusion or mechanical restraint, the RN must evaluate the patient in person to determine what items they have in their possession. The RN may allow the patient to keep or to be given an object considered to be safe if the object assists the patient to deescalate, or if the removal of the object would further escalate the patient.

   1. Items may be removed only if there is an imminent safety concern as assessed by the RN, psychiatrist, or PMHNP.
   2. Only contraband items are required to be removed from a patient's possession during a restrictive event.

F. In partnership with the physician/NP, the RN must promptly establish the patient's release criteria and explain it to them at every assessment.

G. Patients in seclusion or restraint must be continuously monitored.

   1. The RN may delegate continuous monitoring and 15-minute checks to trained, qualified staff.

2. Staff must continuously, directly watch one patient at a time and monitor their physical status.

H. A patient's environment while in seclusion or restraint must be made as comfortable as reasonably possible (*e.g.*, elevating the patient's head, providing a blanket or pillow).

RN Assessment

A. The RN must conduct a face-to-face general assessment of the patient during the seclusion or restraint process and after a patient is placed in restraints.

B. The RN assessment and documentation must happen at the first possible opportunity and include assessment of airway exchange, proper positioning of the head and neck, skin integrity and signs of any injury associated with the event (*e.g.*, bruising, skin tears), circulation, physical and mental status, and comfort. Vital signs (*e.g.,* pulse and respiration) must also be assessed at the earliest practical opportunity.

C. The RN must assess the patient face-to-face no less than every 60 minutes while the patient is in seclusion or restraint and explain their release criteria to them. The assessment must include:

1. a brief mental status exam focusing on behaviors that led to the seclusion or restraint,
2. assessment of their physical health and comfort, and
3. determination of whether they are no longer an imminent danger of harm to self or others and meet their release criteria.

D. If a patient is still in seclusion or restraint at 90 minutes from the start of the intervention, the program nurse manager or their designee must assess the patient in person and discuss options with the RN.

E. If unsafe, a face-to-face assessment may be conducted from the ante room. Staff may not conduct a face-to-face assessment of the patient via videoconference or telehealth.

F. A minimum of two staff must be present for all direct patient care. The patient's gender, trauma history, and preferences must be considered when assigning staff to provide the care.

G. At least every two hours and upon the patient's request, staff must offer or provide fluids and nourishment, personal hygiene and toileting/elimination opportunities, and exercise limb range of motion for at least 10 minutes when in restraint. All cares, including any cares offered and refused by the patient, must be documented in the flowsheet.

H. The RN must be present when restraints are unlocked for any reason.

RN Documentation

A. Staff must document every VMR and restrictive intervention. Documentation timeframes are described in Attachment B.

B. Progress notes describing the event are required for VMR, seclusion, and restraint. Nursing Services staff document per Nursing Service Department protocol.

C. Immediately after application of seclusion or mechanical restraint, the RN must document on the Emergency Seclusion and Restraint Entry Note and the Emergency Seclusion or Restraint Flowsheet. Each form must be completed, filed, and routed as directed on the form.

D. Initial documentation must include a description of the patient's behavior and interventions used, and other less-restrictive interventions considered or attempted.

E. Documentation about an event must be promptly completed and include:

1. the patient's response to the intervention;
2. assessments and care provided;
3. the rationale and plan for continuing the restrictive intervention, as applicable;
4. the plan to reduce the intervention; and
5. when or how the patient meets release criteria to discontinue the intervention.

Orders

A. Every incidence of seclusion or restraint requires an order from a physician/NP which must include a brief description of the behavioral emergency requiring the restrictive intervention. An order is not required for VMR.

1. If a physician/NP is not immediately available during a behavioral emergency, the RN may temporarily authorize restrictive intervention(s) until a physician/NP is contacted. As soon as possible, within a few minutes of the completed application of the intervention, the RN must contact the physician/NP to request a telephone order for the restrictive intervention(s).
2. If the physician/NP is present during a behavioral emergency, they must conduct a face-to-face assessment and write an order as appropriate.

B. Orders for manual restraint:

1. An order for manual restraint must be obtained at the time that the manual restraint occurs. If staff hold a patient because they are concerned that the patient may become combative, an order for manual restraint is required.
2. If a patient is released from mechanical restraint or seclusion and is then manually restrained, a new order for manual restraint is required.

C. Orders following initiation of seclusion or mechanical restraint:

1. The telephone order may not exceed one hour from the initiation of the first restrictive intervention, irrespective of the time that the order is obtained, except as described below for Junction City. The order must identify all restrictive interventions that have occurred.
2. Following a face-to-face assessment, the physician/NP may order continued seclusion or mechanical restraint, if indicated. This order may not exceed three hours and begins at the time that the telephone order expires, irrespective of the time that the face-to-face order is written.
3. If the physician/NP is present and conducts a face-to-face assessment during the process of seclusion or mechanical restraint, the initial order may not exceed four hours.
4. If the Psychiatrist On Duty (POD) for the Junction City campus is not present on the campus and is unable to arrive within one hour of the initiation of a seclusion or mechanical restraint:
    a. an RN trained and deemed competent must conduct the face-to-face assessment within one hour after seclusion or restraint is initiated; then
    b. the RN must immediately call the POD to discuss the assessment, the need for other interventions or treatment, and the need to continue or discontinue seclusion or restraint. The RN must document the assessment and discussion with the POD.
    c. If continued seclusion or restraint is indicated, a new telephone order for no more than one hour may be given; this order begins at the time that the first telephone order expires.
    d. The POD must conduct a face-to-face assessment no later than two hours after the initiation of seclusion or mechanical restraint. If continued seclusion or mechanical restraint is indicated, the order may not exceed two hours, and begins when the second telephone order expires, irrespective of the time that the face-to-face order is written.

D. Subsequent orders for seclusion or mechanical restraint may not exceed four hours and begin when written or when the previous order expires, whichever is earlier.

E. If the first assessment indicates continued seclusion or restraint is needed for safety, a physician/nurse practitioner NP must reassess the patient in person after the first assessment at least every eight hours from the start of the restrictive intervention.

F. When moving the patient to a more- or less-restrictive intervention:

1. A new order and face-to-face assessment by a physician/NP, as described above, is required to move a patient to a more restrictive intervention. No order is required to move a patient to a less restrictive intervention.

2. A patient may be released directly from restraint rather than moving to another less restrictive intervention.
3. A standard progression to less restrictive interventions is as follows:

5-point restraint (with chest strap)→ 4-point restraint→ seclusion→ release, *OR* 5-point restraint (net restraint)→ seclusion→ release

Physician/NP Assessment

A. A physician/NP must conduct a face-to-face assessment of the patient within one hour of the initiation of seclusion or restraint.

B. At the time of each face-to-face evaluation, the physician/NP must:
   1. assess the patient to determine possible injuries;
   2. determine whether the restrictive intervention should be continued;
   3. evaluate the patient's physical and mental status, including their current behavior and connection to psychiatric symptoms;
   4. supply guidance to staff on ways to help the patient regain self-control to meet release criteria.

C. The physician/NP must document the following in a progress note no later than the end of their work shift:
   1. the time they conducted the face-to-face assessment;
   2. the patient's condition or symptom(s) and specific behavior(s) that justified using the intervention;
   3. the restrictive intervention used and the patient's response to the intervention;
   4. patient quotes from the interview during the in-person interaction or an explanation as to why the patient was unable to participate in a discussion;
   5. a summary of the patient's relevant history related to the current behavior and mental status, including documentation of any patient injury during the event;
   6. the circumstances around any expired orders, if applicable;
   7. the plan to reduce the intervention; and
   8. any consultation obtained during the restrictive event.

D. The physician/NP must consult with the CMO or their designee:
   1. every eight hours the patient is in continuous restraint, or
   2. every 16 hours the patient is in continuous seclusion or continuous restraint followed by seclusion.
   3. The physician/NP must document the consults.

Discontinuing Intervention

A. As soon as safely possible, the patient must be released or moved to a less restrictive intervention. Only the RN or physician/NP may authorize moving to a less restrictive intervention or releasing a patient from seclusion or restraint.

B. When a patient is assessed to be safe or meets their release criteria, a RN may authorize moving to a less restrictive intervention. If the RN does not authorize moving the patient to a less restrictive intervention, they must provide and document the rationale for declining to release.

C. A physician/NP or RN must be present when a patient is moved to a less restrictive intervention or when they are released to the milieu.

D. If the RN and physician/NP decide the patient should not be released or moved to a less restrictive intervention, they must collaborate to verify criteria for release and establish and document a plan for ending the restrictive intervention.

Debrief, Reports

A. Staff who were involved in the event must promptly debrief each event and use the information to prevent or reduce the need for such measures in the future.

B. Staff must attempt to debrief with the patient throughout the restrictive event. The debrief and debrief attempts must be documented on the “Emergency Seclusion or Restraint Review” form.

C. After each episode of seclusion or mechanical restraint, at least two IDT members must review and consider modifying the patient’s TCP interventions within five working days of the event (excluding weekends and holidays).

   If no changes are made, the IDT must document the justification for not modifying the TCP on the “IDT Review of Seclusion or Restraint Event” section of the “Emergency Seclusion or Restraint Review” form (OSH STK #75061).

D. The RN must notify the patient’s guardian of the restrictive intervention at a reasonable time.

E. If the patient and family requests and consents to notification, at a reasonable time the RN must notify the patient’s family of a restrictive intervention, unless such contact is deemed by the IDT to be clinically contraindicated. If the patient’s family is not contacted, the reason for not contacting the patient’s family must be documented in the medical record (see OSH Policy 6.021).

F. As required by OAR 309-112-0030, OSH will maintain a committee to review and evaluate the appropriateness of restrictive interventions and to identify improvement opportunities. The committee will report findings to the Superintendent.

G. OSH will submit restrictive events reports to other state and federal entities as delineated in applicable regulations. In addition, OSH will report deaths presumably associated with a restrictive intervention as delineated in 42 Code of Federal Regulations (CFR) § 482.13(g), OSH Policy 6.005, "Deceased Patient", and other applicable policies.

III. ATTACHMENTS

Attachment A Voluntary Movement Restriction

Attachment B Restrictive Intervention Tasks Timeline

Attachment C Seclusion and Restraint Orders Frequently Asked Questions

Attachment D Sample Seclusion and Restraint Orders Timeline

Attachment E Training Requirements

IV. REFERENCES

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Voluntary Movement Restriction

1. If a patient appears to be escalating, staff must attempt to engage the patient with de-escalation interventions before considering or requesting voluntary movement restriction (VMR). VMR is intended to be used to avoid seclusion or restraint.
2. To avoid further escalation, a registered nurse (RN) may request a VMR.
3. While a patient is in VMR, the bathroom door inside the seclusion room must be locked at all times. The seclusion room door may not be locked during VMR.
4. When a VMR extends to 30 minutes, staff must ask the patient whether they would like to remain in the seclusion room.
5. Every VMR incident must be documented in the medical record by the RN who initiated it.
6. All incidents of VMR must be reported to the attending or covering psychiatrist/psychiatric mental health nurse practitioner (PMHNP) at the next morning interdisciplinary treatment team (IDT) report.
7. When VMR for a particular behavior is requested more than twice daily, or if VMR is used in excess of four cumulative hours in any given month, the patient's IDT must implement treatment care plan (TCP) interventions designed to reduce or to eliminate the behavior that lead to VMR.
8. Examples of interventions which are not VMR and that staff are allowed to do when appropriate, include:
    - allowing a patient to use an unlocked limited-space area, including an unlocked seclusion room, for de-escalation when the patient initiates a request to use the area;
    - preventing a patient from entering another patient’s bedroom;
    - locking a patient out of their bedroom for therapeutic reasons (if included in the patient’s TCP);
    - preventing unmonitored access to bathrooms for a patient who has clinical or medical problems related to bathroom facilities (*e.g.,* polydipsia) (if included in the patient’s TCP); or
    - asking the patient to take time out of the milieu in an area other than the seclusion room.

Restrictive Intervention Tasks Timeline*

	During situation	< 15 minutes	Hour 1	Hour 2	Hour 3	Hour 4	Hour 5	Hour 6	Hour 7	Hour 8	Other Requirements
Registered Nurse	• Assess for imminent risk of serious harm • Consider less restrictive interventions • Temporarily authorize intervention, if needed • Monitor situation	• Assess patient • Immediately, within a few minutes, obtain order • Document • Lead debrief	• Complete S/R entry note • Assess patient • Contact 3rd party assessor PNM before 90 min from event start	• Assess (60 min) • ROM • Document	• Assess (60 min) • Contact MD for order before 4 hr due • Document	• Assess (60 min) • ROM • Document	• Assess (60 min) • Document	• Assess (60 min) • ROM • Document	• Assess (60 min) • Contact MD for order for face to face • Document	• Assess (60 min) • ROM NOTE: Continue assessing at minimum every 60 min throughout event	• Contact MD for order before 12 hr due • Contact MD for face to face before 16 hr continuous seclusion and/or restraint due • Complete patient debrief when possible
Staff	• Attempt de-escalation • If emergency imminent risk of serious harm, restrain • Follow RN instructions • Begin continuous observation	Through entire event: • Continuously monitor, contact RN as needed • Complete flowchart, other documentation Debrief		(As needed, and now) • Offer fluid, food, elimination • Exercise limbs • Document		(As needed, and now) • Offer fluid, food, elimination • Exercise limbs • Document		(As needed, and now) • Offer fluid, food, elimination • Exercise limbs • Document		(As needed, and now) • Offer fluid, food, elimination • Exercise limbs • Document	• Continue fluid, food, elimination, exercise cadence throughout event • Complete debriefing process per policy
Physician/NP	If present, • Assess situation • Provide direction • Write order • Document	• Provide telephone order	• Assess face to face • Provide additional order, if needed • Document			• If needed, provide telephone order (up to 4 hrs) • Document if seen face to face				• Assess face to face • Provide order (up to 4 hrs), if needed • Notify CMO or designee if restraints NOTE: Continue face to face, order cadence throughout event	At 16 hrs: • Assess face to face • Provide order (up to 4 hrs), if needed • Notify CMO or designee if continuous seclusion and/or restraint Document all consults
Program Nurse Manager			• At 90 min from event start, provide 3rd party assessment • Document								
IDT											• Review, update TCP • Within 5 days, complete IDT debrief

*Restart this process whenever move to a more restrictive intervention

Seclusion & Restraint Orders FAQ

Q: On the seclusion or restraint order form, there are boxes for "Telephone Order" and "Face-to-Face Assessment Order". Which one should I check?

A: Nurses will check "Telephone Order" when getting a T.O. for restraint and/or seclusion. Psychiatry staff will check "Face-to-Face Assessment Order" on a new order form when they see the patient, if they write new orders for seclusion or restraint.

Q: For the "Restrictive Intervention Used," what about things that aren't listed, like a chest strap or spit hood?

A: On the rare occasions that a chest strap or net restraint are used, check the "Other" box and write in the intervention that was used. If a chest strap is added after 4-point bed restraints have been applied, a new order is required; if the face-to-face assessment by Psychiatry staff has already occurred, then a new face-to-face assessment by the Psychiatry staff is also required. A spit hood does not require an order from Psychiatry.

Q: Can you clarify the rules for Ambulatory Restraint? Is that the box to check if we do Safe Containment?

A: Safe Containment, when the ambulatory restraints and backboard/Stryker are used, is considered to be a manual restraint followed by a mechanical restraint. An order for both manual restraint and mechanical restraint is required whenever the full Safe Containment process is used, even if it's only for a few minutes before the person is released from the restraint.

If ambulatory restraints are used to transport a civilly committed/voluntary by guardian patient, or a GEI patient with privileges outside the secure perimeter due to concerns for unsafe behaviors, the "Ambulatory Restraint" box is checked and otherwise the observation/assessment/paperwork requirements are no different than for mechanical restraint.

If ambulatory restraints are being considered for use *as an alternative to the standard 4-point bed restraints*, this requires prior approval from the Chief Medical Officer or designee (documented in the psychiatry seclusion/restraint note).

Q: What is the "Event Initiated At" time and date supposed to be?

A: This is when a seclusion/restraint event begins, even if there are moves to more and/or less restrictive interventions before the patient is finally released. *This time/date should not change until the patient is fully released from seclusion/restraint.*

For an example, see the attached sequence of restrictive interventions and orders for two separate events for the same patient.

Q: In the example, the 3-hour extension order given at 2115 expires at 0105. Why doesn’t it expire at 0015, since that’s 3 hours after 2115?

A: This is the sole exception to the usual rule about order duration. The 1-hour T.O. plus the 3-hour extension always equals 4 hours, beginning at the initiation of the seclusion or restraint intervention (which was 2115, due to the addition of a chest strap, in the example). For all other extension orders, writing the order (or getting a T.O.) before it’s due means that the order expires 4 hours from the time of the order (in the example: the T.O. obtained at 1950 expires at 2350).

Q: What happens if the extension order is late? If the nurse can’t get a hold of the Psychiatry staff, or they see the patient and then write the order after it’s due?

A: The order would then expire 4 hours from when it ought to have been due. For example, if the T.O. that was due at 1200 had been obtained at 1210 (10 minutes late), the order would expire at 1600 (which is when it would have expired if obtained exactly on time).

Q: Who fills in the times inside the box on the order form?

A: If the order is a Telephone Order, the RN fills these in with direction from the Psychiatry staff. If a Face-to-Face Order, the Psychiatry staff fills these in.

In general, the RN should call for a renewal T.O. as close to the time it is due as possible. For an upcoming face-to-face reassessment, a call to provide 30-60 minutes advance notice is appropriate.

Sample Seclusion/Restraint Orders Timeline

Date	Time	Event Initiated	Intervention	Telephone Order	Face-to-Face Order	Order Expiration	CMO Notification	Notes
RESTRICTIVE EVENT 1								
7/1	0800		Safe containment, then 4-point bed restraint					
	0810	7/1 @ 0800		1 hour (manual & mechanical restraint)		0900		Order is for 1 hour, beginning when restrictive event began with manual restraint
	0900	7/1 @ 0800			3 hours (mechanical restraint)	1200		
	1030		Release from restraint to seclusion					
	1200	7/1 @ 0800		4 hours (seclusion)		1600		
	1600	7/1 @ 0800			4 hours (seclusion)	2000		
	1950	7/1 @ 0800		4 hours (seclusion)		2350		Clock “reset” (order obtained early)
	2040	7/1 @ 0800	Return to 4-point bed restraint (more restrictive)	1 hour (manual & mechanical restraint)		2140		Event time still the same; new S&R entry note, same flow sheet
	2105	7/1 @ 0800	Addition of chest strap (more restrictive)	1 hour (mechanical restraint & chest strap)		2205		As above; Psychiatry must still assess by 2140 due to restraint at 2040
	2115	7/1 @ 0800			3 hours (mechanical restraint & chest strap)	7/2 @ 0105		Order takes effect at 2205

Date	Time	Event Initiated	Event Description	Telephone Order	Face-to-Face Order	Order Expiration	CMO Notification	Notes
RESTRICTIVE EVENT 1 (CONTINUED)								
7/2	0030	7/1 @ 0800	Chest strap removed		4 hours (mechanical restraint)	0430	Required due to 16h continuous seclusion and/or restraint	Pt seen in lieu of TO; clock “reset”
	0430	7/1 @ 0800		4 hours (mechanical restraint)		0830	Required due to 8h continuous restraint	
	0545		Release from restraint to seclusion					
	0830	7/1 @ 0800			4 hours (seclusion)	1230		
	0945		Release from seclusion; escorted to room with manual restraint	3 minutes (manual restraint)				Separate documentation of manual restraint required
RESTRICTIVE EVENT 2								
7/2	1335	7/2 @ 1335	Seclusion initiated; no manual restraint required; Psychiatry staff present		4 hours (seclusion)	1735		
	1555		Release from seclusion					

Training Requirements*

Oregon State Hospital (OSH) will provide training to staff about restrictive interventions which meets regulatory requirements and as directed by OSH’s Education Department.

1. All staff with direct patient care responsibilities and any other staff involved in the use of seclusion or restraint must receive ongoing training and demonstrate competency and understanding of the following:
    - OSH philosophy, goals, and policies regarding the use of seclusion or restraint;
    - techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion, possible medical conditions, history of trauma, age or developmental variables, and cultural issues that may contribute to aggressive behaviors;
    - how staff behaviors affect patient behaviors;
    - non-physical intervention skills including, but not limited to, de-escalation and collaborative problem solving;
    - choosing the least restrictive intervention based on the patient’s medical or behavioral status or condition;
    - how information gathered about the patient may be used to inform use of pre-escalation skills or restrictive interventions;
    - techniques including self-protection, safe containment, and voluntary movement restrictions;
    - signs of physical or psychological distress in a patient who is being secluded or restrained;
    - principles related to manual and mechanical restraint, and the safe application, use, monitoring, and discontinuation of the use of restraints;
    - viewpoints of patients who have experienced seclusion or restraint;
    - cardiopulmonary resuscitation (CPR); and
    - first aid techniques.
2. In addition to the training described above, Nursing Services staff must receive ongoing training and demonstrate competence in the following:
    - monitoring and taking appropriate action to protect the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to: respiratory and circulatory status, range of motion in the extremities, skin integrity, and vital signs;
    - checking for nutritional or hydration needs, and meeting those needs;
    - addressing hygiene and elimination needs;

- recognizing readiness for discontinuing seclusion or restraint, including observing and reporting specific behavioral changes that indicate seclusion or restraint is no longer necessary, and how these relate to individual release criteria;
- helping a patient meet behavior criteria for the discontinuation of seclusion or restraint;
- recognizing when to contact the physician/NP or emergency medical services in order to evaluate or treat the patient's physical or mental status.

3. Junction City Nursing Services management must be annually trained and demonstrate competency to complete the one-hour face-to-face assessment as described in OSH Policy 6.003, “Seclusion or Restraint”. Training must also include content to:
   - evaluate the patient's immediate situation,
   - the patient's reaction to the intervention,
   - the patient's medical and behavioral condition (including a complete review of systems assessment, behavioral assessment, review and assessment of the patient’s history, medications, most recent lab results, etc.), and
   - the need to continue or terminate the restraint or seclusion.

*NOTE: These are established by Centers for Medicare and Medicaid Code of Federal Regulations (CFR) in 42 CFR § 482.13(f).