Administrative Policies and Procedures: 19.9

Subject:	**Psychiatric Emergency Use of Mechanical Restraint**
Authority:	TCA 33-3-120; 37-5-105, 37-5-106; *Children's Health Act of 2000*
Standards:	**COA**: PA-BSM 1-5; PA-RPM 2; **JCAHO Behavioral Health Standard**: TX.7.1 (2001), Rules of Mental Health and Developmental Disabilities Division of Mental Health Services Chapter 0940-3-9, Use of Isolation, Mechanical Restraint, and Physical Holding Restraint in Mental Health Residential Treatment Facilities
Application:	To all Department of Children's Services Employees and Contract Providers excluding the Youth Development Center.

Policy Statement:

DCS is committed to preventing and reducing the use of mechanical restraint of the children/youth it serves. Mechanical restraint may be used only in an emergency situation when the child/youth, due to his/her current behavior, poses an imminent risk of harm to himself/herself or others. This policy applies to all children and youth in DCS custody regardless of adjudication. Mechanical restraint will not be used as a means of punishment, discipline, coercion, convenience or retaliation or for lack of staff presence or competency.

Purpose:

To set clear minimal standards and expectations for providers and DCS employees in order to maintain a safe and therapeutic environment for children and youth in all care settings. The use of mechanical restraint is seen as a restrictive intervention and one that poses a risk to the psychological and/or physical well-being of a child/youth.

Procedures:

A. DCS Responsibility and Oversight	DCS will provide guidance through policy and oversight of contract providers to ensure that psychiatric emergency mechanical restraint is used only when necessary and only under defined conditions and procedures.
B. Psychiatric Emergency Mechanical Restraint	Psychiatric emergency mechanical restraint is the application of a mechanical device, material, or equipment attached or adjacent to the child/youth's body, including ambulatory restraints, which the child/youth cannot easily remove and that restrict freedom of movement or normal access to the child/youth's body. The following are not considered psychiatric emergencies and are considered acceptable: 1. Restrictive devices or manual methods employed by a law enforcement agent or other public safety officer to maintain custody, detention, or public safety during the transport or other public interface situations of a child/youth under

	the jurisdiction of the criminal justice system or juveniles with charges in the juvenile justice system (also refer to DCS Policies ***31.19, Use of Mechanical Restraints***, and ***31.15 Guidelines for Transportation of Child/Youth by Regional Employees***; 2. Restraints for the medical immobilization, adaptive support, or medical protection; or 3. Restrictive devices administratively ordered to ensure the safety of the child/youth or others when an involuntary committed child/youth will be transported by law enforcement or emergency medical personnel.
C. Use of Psychiatric Emergency Mechanical Restraint	1. Psychiatric emergency mechanical restraint is allowed only in facilities contracted by the Department of Children's Services and licensed as a Mental Health Residential Treatment Facility for Children and Youth (Chapter 094-5-37). Moreover, the use of mechanical restraint for psychiatric emergency purposes will be permitted only in those facilities that are ***Joint Commission on Accreditation of Health Care Organizations (*JCAHO)** accredited and approved to utilize this emergency measure. All JCAHO standards and procedures will be met when a mechanical restraint is used in an emergency situation. 2. The facility will receive formal approval by DCS in the use of Psychiatric emergency mechanical restraint in general. 3. The facility will have an organizational philosophy that works to prevent, reduce, and eliminate the use of all restraints and prevent emergencies that have the potential to lead to the use of restraints. 4. Staffing levels and resources are set to minimize circumstances that give rise to emergency situations that may require the use of restraint, and that maximize safety when mechanical restraint will be used. 5. In these cases, the use of mechanical restraint is allowed only in the case of an emergency, when the child/youth is at imminent danger of self-harm or of harming others and no other option exists to protect the safety of the child/youth and staff members. 6. Mechanical restraint is an emergency safety intervention, not a therapeutic technique and will be implemented in a manner designed to protect the child/youth's safety, dignity and emotional well-being.
D. Local Procedures and Protocols	1. Each contract provider agency using psychiatric emergency mechanical restraint will have written policies and procedures that articulate the intent of creating a safe, nurturing, and therapeutic environment, protect the rights of children/youth, and respect the ethnic, religious, and identified treatment parameters for each individual child/youth in care. 2. Policies and procedures will adhere to and comply with applicable licensure rules, all applicable state/federal statutes, as well as generally accepted best practice standards set forth by national accreditation organizations.

	3. Any contract provider that uses psychiatric emergency mechanical restraint will develop and employ policies and procedures that ensure compliance with this policy. 4. Policies and Procedures will identify: ♦ Approved techniques for the safe and appropriate application and removal of mechanical restraints; ♦ Devices, materials, and /or equipment that are approved by the contract provider for use as mechanical restraint; ♦ Licensed independent practitioners by profession who are responsible for authorizing mechanical restraint; ♦ Required elements in the order for mechanical restraint; and ♦ Minimal and physical elements that will be assessed. 5. No policy or procedure may authorize the removal of clothing from a child/youth, other than that which is determined to place the child/youth or others at risk, in conjunction with the use of mechanical restraint. 6. Policies and procedures will require staff to receive training prior to conducting psychiatric emergency mechanical restraints (refer to Section O. of this policy). 7. The agency will inform the child/youth and his/her legal guardian(s) of the policy regarding the use of psychiatric emergency mechanical restraint during emergency situations that may occur while the child/youth is in the program. The communication will be in a manner that the child/youth and his/her legal guardian(s) understand. This information will be communicated both orally and in writing. 8. The facility's policy will provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization. This information will be prominently posted and displayed and include specific information detailing how to place a toll-free call to the State Protection and Advocacy organization.
E. Initial Assessment	Upon the child or youth's placement into a facility, an initial assessment (which may incorporate information and assessments prior to admission into the facility) will take place to obtain information about the child/youth that could help minimize the psychiatric emergency use of mechanical restraint. The assessment will include identification of: a) Techniques, methods or tools that will help the child/youth control his or her behavior. When appropriate, parents, family members and placement staff may assist in the identification of such techniques; b) Pre-existing medical conditions or physical disabilities and limitations that would place the child/youth at greater risk during restraint; and c) History of sexual or physical abuse or trauma that would place the child/youth at greater psychological risk during restraint.

F. Initiation of Psychiatric Emergency Mechanical Restraint	1. Assessment of need: Prior to the psychiatric emergency use of mechanical restraint, the child/youth will have an assessment that supports the use of mechanical restraint as necessary to ensure the physical safety of the child/youth or a person nearby and that all less restrictive interventions have been ineffective or determined to be inappropriate. 2. A licensed independent practitioner (see definition within **Glossary**) may initiate psychiatric emergency mechanical restraint. 3. In the absence of a licensed independent practitioner, psychiatric emergency mechanical restraint may be initiated by a licensed practical nurse, a registered nurse or by mental health personnel. 4. A licensed independent practitioner who has been trained in the psychiatric emergency use mechanical restraint will be contacted immediately for order of the mechanical restraint if a licensed independent practitioner did not initiate it.
G. Orders for the Psychiatric Emergency Use of Mechanical Restraints	1. Only a licensed independent practitioner who has been trained in the psychiatric emergency use of mechanical restraint may order the use of mechanical restraint. The order will be for the least restrictive intervention possible that is most likely to be effective. 2. If psychiatric emergency mechanical restraint is ordered, the order will specify: a) The type of restraint device(s) to be used; b) The number of points of restraint; c) The licensed independent practitioner's name and credentials; d) The date and time when the order was obtained; and e) The maximum length of time the intervention was ordered. 3. If the licensed independent practitioner who ordered the use of psychiatric emergency mechanical restraint is not the child/youth's treating physician, the treating physician will be consulted as soon as possible. In addition, the consultation will be documented in the child/youth's record. 4. If the order for mechanical restraint is verbal order will be received by a registered nurse or a licensed practical nurse and signed by the ordering licensed independent practitioner within twenty-four (24) hours of the order. 5. A new order is required if there is a change in the intervention utilized, including increasing the number of points of restraint or the application of additional restraint devices. If the use of mechanical restraint has been discontinued, it may be used again only with a new order, even if a previously ordered time limit has not expired. 6. ***Orders for the use of psychiatric emergency mechanical restraint are time-limited to thirty (30) minutes for children/youth of all ages***. Restraints lasting longer than this time frame require clinical justification (obtained through direct evaluation of the child/youth by the licensed independent practitioner) for continuation and require a new order. ***Psychiatric emergency mechanical restraint can be reordered for up to an additional thirty (30) minutes***.

	7. Time-limited orders do not mean that the use of mechanical restraint will be applied for the entire length of time for which the order is written. Mechanical restraint should be used only for the minimum amount of time necessary. 8. Psychiatric emergency mechanical restraint may not be ordered on a PRN basis or as a standing order. 9. Mechanical restraint may not be used simultaneously with seclusion.
H. Monitoring	1. There will be an ongoing assessment of the use of psychiatric emergency mechanical restraint for a child/youth that justifies its continuation. To continue use, the justification will indicate that the behavioral criteria for release have not been met. All results of monitoring will be documented in the child/youth's individual record. Use of psychiatric emergency mechanical restraint will be monitored as outlined below: a) Staff trained in the monitoring of psychiatric emergency mechanical restraint will monitor the individual child/youth in mechanical restraint; b) The child/youth will be continuously monitored; c) Monitoring will be by direct visual observation and staff will remain in the immediate physical presence of and in the same room as the child/youth. 2. Assessment of the child/youth should include: a) Behavior justifying continued need for seclusion; b) Signs of any injury associated with the application of mechanical restraint; c) Nutrition, hydration; d) Range of motion in the extremities and circulation; e) Vital signs; f) Hygiene and elimination; g) Physical and psychological status and comfort; and h) Readiness for discontinuation of restraint.
I. Criteria for Release	Behavioral criteria for release from psychiatric emergency mechanical restraint will be specified by a licensed independent practitioner or a licensed mental health professional that can authorize initiation of psychiatric emergency mechanical restraint. The behavioral criteria will be communicated to the child/youth as soon as possible during the mechanical restraint procedure.
J. Termination	Psychiatric emergency mechanical restraint will be terminated when the behavior justifying its use no longer exists or if the face-to-face assessments required by this policy do not occur. Immediate release will occur with any threat to the child/youth's physical or emotional well-being.
K. Follow-Up Assessment	Within one (1) hour of the initiation of the use of psychiatric emergency mechanical restraint, a licensed independent practitioner or a trained registered nurse trained in accordance with 0940-3-9-.18 will see and assess the child/youth's condition.

	This assessment will be conducted regardless of the length of time the child/youth is in mechanical restraint.
L. Medical treatment for injuries and reporting	1. If a child/youth is injured as a result of the use of mechanical restraint, staff will immediately obtain medical treatment for that child/youth. 2. The facility will report serious occurrences that result from the use of mechanical restraint to the Department of Children's Services (DCS), the Department of Mental Health (DMH), the Disability Law & Advocacy Center of Tennessee (DLAC), and the Centers for Medicare and Medicaid Services, if applicable. Serious occurrences will be reported no later than close of business the next business day following the incident and will include: a) A child/youth's death; b) Serious injury to the child/youth; c) Suicide attempt by the child/youth; or d) Injuries to staff.
M. Debriefing	1. The child/youth and staff will participate in a debriefing about the mechanical restraint episode. The debriefing should take place as soon as possible but no longer than twenty-four (24) hours after the mechanical restraint occurred. 2. Parents, legal guardians and/or DCS employees will be provided the opportunity to participate in a discussion with appropriate staff about the episode that precipitated the use of mechanical restraint. 3. The debriefing is used to: a) Identify what led to the emergency incident and what could have been handled differently; b) Ascertain that the child/youth's physical well-being, psychological comfort, and right to privacy were addressed; c) Counsel the child/youth involved for any trauma that may have resulted from the incident; and d) When indicated, modify the child/youth's treatment plan.
N. Notification	1. The Department of Children's Services will be notified of all incidents of psychiatric emergency mechanical restraint as outlined in DCS policy ***1.4, Incident Reporting.*** 2. If more than one episode of psychiatric emergency mechanical restraint is ordered for a child/youth within twenty-four (24) hours, the contract provider agency will report this to the DCS Medical Director or designee through the Incident Reporting process outlined in DCS Policy ***1.4, Incident Reporting*****,** for further review. 3. Until and unless Termination of Parental Rights has occurred (TPR), the child/youth's parents will be notified of the occurrence of any psychiatric emergency mechanical restraint.

O. Agency Service Quality Oversight

1. **Training**

The contract provider will identify specific staff, based on their job responsibilities, who may be involved in the use of psychiatric emergency mechanical restraint. Staff will be appropriately trained and demonstrate competency in the correct application and safe usage of mechanical restraint. Only trained staff members who are qualified by education, training and experience may successfully demonstrate in practice the techniques they have learned from managing emergency safety situations. Staff will be trained and demonstrate competency before assuming direct care responsibilities that include the use of psychiatric mechanical restraint. The contract provider will ensure that staff are trained and competent in the following areas:

a) Upon being hired and every six (6) months thereafter:

- Medical/physical and psychological risks associated with the use of mechanical restraint;
- Contract provider policies and procedures regarding mechanical restraint;
- Needs and behaviors of the population served;
- Techniques to identify staff and child/youth behaviors, events, and environmental factors that may trigger emergency safety situations;
- Use of non-physical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations;
- Specific approved techniques for the safe and appropriate application and removal of mechanical restraint;
- Use of approved devices, materials, and/or equipment as mechanical restraints;
- Recognition of negative effects of use of mechanical restraint including signs of distress, and actions to take if negative effects or signs of distress occur;
- Procedures for conducting a comprehensive child/youth specific and episode specific review;
- Liability and other legal issues;
- Applicable state and federal law and rules; and
- Procedures to address problems associated with the use of mechanical restraint.

b) The contract provider agency will identify specific registered nurse(s) who may be responsible for the assessment of the child/youth's condition within one (1) hour of the initiation of a mechanical restraint. The contract provider agency will ensure that they are adequately trained and are competent in the following areas:

- Anticipation of adverse medical/physical and psychological responses which have been identified in the risk assessments;

- Anticipation of adverse medical/physical and psychological response(s) based upon current condition of the child/youth;
- Identification and management of adverse medical/physical and psychological response(s) resulting from the use of mechanical restraint; and
- Identification and utilization of the child/youth's mental preparedness to self-regulate and objectively appraise the mechanical restraint

2. **Agency Internal Review**

a) All contract provider agencies will incorporate an internal review process of all restraints in their facility as mandated by DMH licensing and JCAHO standards.

b) The internal review process will involve weekly review of all restraints lasting longer than the allowed time frames as well as any restraint that involved injuries to the child/youth or staff.

3. **Performance Improvement Activities**

The contract provider agency will engage in ongoing performance improvement activities that focus on the reduction of the use of mechanical restraint. Information obtained through the review processes will be considered, at least quarterly, in the identification of specific performance improvement activities and in the evaluation of the effectiveness of performance improvement activities.

a) Contract provider agencies, in conjunction with DCS, will compile aggregate data yearly on the incidents of psychiatric emergency mechanical restraint to include:

- Total number of children served by the provider;
- Total number of bed days for which the provider is contracted;
- Total number of unduplicated children/youth who were mechanically restrained;
- Total number of incidents of psychiatric emergency mechanical restraint (with the average length of each restraint as well as the total number by gender, race and age group); and
- A description of how this data was used throughout the reporting year to identify trends with staff, both individually and as a group, in order to reduce the use of mechanical restraint.

b) Contract provider agencies should ensure that a routine process is in place to address the use of crisis intervention and mechanical restraint in individual and/or group supervision with all direct service and clinical staff. Such supervision will focus on analyzing individual interventions as well as patterns of intervention to identify ways to increase the effective use of prevention methods and further reduce the use of psychiatric emergency mechanical restraint.

	c) Contract provider agencies also should include an assessment of each staff member's effective use of psychiatric emergency mechanical restraint in each applicable employee's annual performance evaluation.
P. Documentation	1. An acknowledgement, in writing, from the child/youth and the parent, guardian or DCS, as appropriate, that he or she has been informed of the facility's policy on the use of mechanical restraint in a psychiatric emergency safety situation will be placed in the child/youth's medical record. 2. If the licensed independent practitioner authorizing the use of psychiatric emergency mechanical restraint is present at the time of the initiation of the restraint, the licensed independent practitioner will document the assessment of need in the child/youth's medical record. 3. If the use of psychiatric emergency mechanical restraint is initiated in the absence of a licensed independent practitioner, a Registered Nurse (RN), Licensed Practical Nurse (LPN), or mental health personnel will document the assessment of need in the child/youth's medical record at the time use of the restraint is initiated. 4. The licensed independent practitioner authorizing the use of mechanical restraint will document in the child/youth's record: a) The rationale for the use of the restraint at the time the verbal/telephone order is authenticated; and b) Behavioral criteria for release from mechanical restraint 5. Staff will document in the child/youth's record all injuries that occur because of mechanical restraint. 6. The follow-up assessment, which occurs within one (1) hour of the initiation of the use of psychiatric emergency mechanical restraint, will be documented by the licensed independent practitioner or registered nurse in the child/youth's record. 7. Compliance with the monitoring requirements will be documented in the child/youth's medical record. At intervals no greater than fifteen (15) minutes, staff will document visual observations of: a) Behavior justifying continued need for mechanical restraint; b) The application of the mechanical restraint; c) Respiration; d) Negative effects of mechanical restraint; and e) Any sign of distress. 8. Before the shift ends, a staff member who initiated the psychiatric emergency mechanical restraint will document in the child/youth's record: a) An assessment of the child/youth's behavior; b) Mental and physical status at the time the child/youth is released; c) The time the mechanical restraint began and ended; and

	d) The name of all staff involved. 9. In accordance with DCS policy ***1.4, Incident Reporting***, the use of psychiatric emergency mechanical restraint will be documented in the **TFACTS** web-based Incident Reporting application (SIR) by the staff person who was most directly involved in the mechanical restraint. Documentation is to include a clear description of the events and behavior leading to the initiation of the psychiatric emergency mechanical restraint including the specific risk of harm to the child/youth spent in mechanical restraint. The documentation is to be completed as soon as practical, but no later than the end of the shift in which the incident of mechanical restraint took place. 10. Notification and/or unsuccessful attempts to notify the parent, guardian, and DCS will be documented in the child/youth's medical record. 11. Evidence of the debriefing will be documented in the child/youth's medical record and include the names of all who participated in the debriefing session. 12. Documentation of the agency's administrative review process will be made available to DCS for Quality Assurance Review. This documentation will include: a) Review of the events precipitating each psychiatric emergency mechanical restraint episode; b) Other techniques attempted to de-escalate the situation; c) Use of authorized procedures; d) Staff training; and e) Any corrective action required as a result of the incident. 13. Documentation that each staff member of the contract provider agency has reviewed all mechanical restraint policies and procedures and agrees to abide by them will be included in each employee's personal file.

Forms:	*None*

Collateral Documents:	***1.4, Incident Reporting*** ***31.15 Guidelines for Transportation of Child/Youth by Regional Employees*** ***31.19, Use of Mechanical Restraints***

Glossary:	
	Definition
Licensed Independent Practitioner:	An individual licensed by the State of Tennessee Health Related Boards as a: ♦ Medical doctor

	♦ Doctor of Osteopathy ♦ Physician Assistant ♦ Certified Nurse Practitioner ♦ Nurse with a master's degree in nursing, who functions as a psychiatric nurse, and is certified to prescribe medication ♦ Psychologist with Mental Health Service Provider designation ♦ Licensed clinical social worker ♦ Licensed professional counselor with Mental Health Service Provider designation ♦ Senior psychological examiner ♦ Other licensed mental health professional that is permitted by law to practice independently. In addition, to be considered a licensed independent practitioner, the individual will be privileged by the hospital medical staff and governing body to authorize the use of restraint.
Mechanical Restraint:	The use of a mechanical device that is designed to restrict the movement of an individual. Mechanical restraint will be defined as handcuffs or wristlets, chains, anklets, or ankle cuffs, or any other DCS approved or authorized device.
Seclusion:	The time-limited placement or confinement of an individual alone in any room or area from which egress is prevented.
Secure Facility	For the purposes of this DCS policy: A Youth Development Center, Detention Center, DMHDD licensed residential mental health facility, psychiatric hospitals