Mental Health

SECLUSION AND RESTRAINT USE IN PSYCHIATRIC CRISIS MANAGEMENT

1. **Purpose:** This operating procedure establishes standards, guidelines and expectations for:
   a. managing antecedents and stimuli that lead to escalation of emotions; and facilitating the use of preferred activities to prevent the need for restrictive safety measures;
   b. utilizing restrictive procedures to ensure safety during a psychiatric crisis, and
   c. debriefing the incident after seclusion or restraint is used.

2. **Scope:** All employees providing direct services to people served at Florida State Hospital.

3. **Training Requirements:** Employees working in psychology, social services, rehabilitative services, direct care, psychiatry, medical, nursing, dental, recovery team facilitators/Qualified Mental Health Professionals, security personnel, and other staff providing direct services to residents shall be trained on this operating procedure upon hire during New Employee Education and by their supervisor each time the operating procedure is revised. Direct care, social services staff, physicians, nurses, and Qualified Mental Health Professionals shall be trained on this operating procedure upon hire into the position during Discipline-Specific Education.

4. **References:**
   a. Children and Families Operating Procedure 155-20, Use of Seclusion in Mental Health Treatment Facilities.
   b. Children and Families Operating Procedure 155-21, Use of Restraint in Mental Health Treatment Facilities.
   c. Florida State Hospital Operating Procedure 10-1, Critical Event Reporting.
   d. Florida State Hospital Operating Procedure 75-1, Resident Injury/Event Reporting.
   
   2. Florida State Hospital Operating Procedure 140-1, Procedures for Reporting and Investigating Abuse, Neglect or Exploitation of Florida State Hospital Residents.
   f. Florida State Hospital Operating Procedure 150-6, Suicide and Self-Injury Prevention.
   g. Florida State Hospital Operating Procedure 151-15, Physician Orders.

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h. Florida State Hospital Operating Procedure 150-34, Psychotherapeutic Medication Prescription Standards.

i. Florida State Hospital Operating Procedure 150-56, Assigned Clinical Observation.

j. Florida State Hospital Operating Procedure 225-1, Minimum Staff Training Requirements.

k. Florida State Hospital Operating Procedure 150-14, Medical Restraints and Safety Devices.


m. Florida Statutes, Chapter 394, Florida Mental Health Act.


o. Florida Administrative Code 65E-5, Mental Health Act Regulation.

p. Chapter 916, Florida Statutes Mentally Deficient and Mentally Ill Defendants.

q. Rule 65E-20, Florida Administrative Code, Forensic Client Services Act Regulation.

r. Rule 65E-5, Florida Administrative Code, Mental Health Act Regulation.


u. Florida Administrative Code, Chapter 11B-35.0021, High Liability Proficiencies.

5. Definitions:

a. Antecedent: Something that happens before the observed behavior that caused the behavior.

b. Avoiding: Eluding, evading, or escaping physical contact through the use of body positioning, shifting, stepping, or sliding, without making physical contact with the person.

c. Behavior: The manner of conducting oneself that involves action and response to stimulation. It is often the observable manifestation of how a person communicates and copes with the demands and stresses in the environment.

d. Behavior Support: The ongoing process of providing the least amount of structure necessary for individuals to live, work and play independently; and a set of interventions designed to help people use their own strengths to meet their own needs.

e. Comfort Room: A room that has been physically designed to provide sanctuary from stress, and/or can be a place to experience feelings within acceptable boundaries. The comfort room is used by people voluntarily, though staff members may suggest its use.
f. Debriefing: Formal and systematic questioning of participants regarding a recent event to obtain useful intelligence or information from the participants’ observations and inferences.

g. De-Escalation: The process during which a person begins to calm emotionally.

h. Emergency: A sudden, urgent, usually unexpected occurrence or occasion requiring immediate action. It includes situations where the resident’s behavior is violent and/or aggressive and where the behavior presents an immediate and serious danger to the safety of self, or others.

i. Escalate: The process during which a person’s emotions begin to increase in intensity and magnitude. The resident may start to show signs of discomfort or distress.

j. Personal Safety Plan: A guide to gathering information for the development of strategies to de-escalate stressful situations so that restraint and seclusion can be averted.

k. Personal Safety Plan Notebook: Notebook on each ward or pod that contains completed Personal Safety Plans for every person residing there. Employees utilize the information in the notebook to provide quality services and care.

l. PRN (pro re nata): An individualized, specific order for the care of a resident. It is a treatment order generated only as needed or as a specific circumstance requires. PRN's for the use of seclusion or restraint are not permitted. PRN’s for the use of psychotherapeutic medications will be governed by Florida State Hospital Operating Procedure 150-34, Psychotherapeutic Medication Prescription Standards.

m. Protective Medical Device: A special category of mechanical restraint that includes devices, or combinations of devices, to restrict movement for purposes of protection from falls or complications of physical care. Its use is for medical and post-surgical care or for off unit transport. Devices include Geri-chairs, Posey vests, mittens, belted wheelchairs, sheeting and bed rails. The requirements for the use and documentation of use of these devices are different from the requirements for the emergency use of restraints in behavior management and are not addressed in this operating procedure.

n. Redirecting: Changing the focus of the aggressive or maladaptive behavior without making any physical contact.

o. Restraint: Restraint includes manual and mechanical restraint used to control dangerous behavior. A manual restraint is any physical contact utilizing one’s own body to restrict another person’s freedom of movement and normal access to their body, and cannot be easily removed by the restrained person. A mechanical restraint is any mechanical device (material or equipment) attached or adjacent to the person’s body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to control the behavior or to restrict the individual’s freedom of movement and is not a standard treatment for the person’s medical or psychiatric condition. Physically holding a person, as described under manual restraint above, during a forced medication procedure is considered a manual restraint. Protective medical devices used for medical and post-surgical care and restraint devices used solely for off unit transport are excluded from this definition and operating procedure.

q. Seclusion: The involuntary isolation of a resident in an area that the resident is
prevented from leaving. The prevention may be by physical barrier or by a staff member placed
or acting in a manner as to prevent the resident’s egress. For the purposes of this procedure,
seclusion does not refer to isolation due to a resident’s medical condition or symptoms, or the
confinement, in forensic facilities, to bedroom areas during normal hours of sleep when there is
not an active order for seclusion.

r. Stimulus or Trigger: Anything, as an act or event, that serves to incite, initiate or
precipitate an action, feeling, thought, reaction or series of reactions. It may make a person feel
emotionally and/or physically uncomfortable or distressed.

6. Standards:

a. At all times, employees are expected to treat others with dignity and respect and
engage in proactive positive interaction.

b. When a resident’s behavior(s) show(s) signs of escalating, employees are expected to:

   (1) use information from the resident’s Personal Safety Plan;

   (2) work as part of a team;

   (3) manage their own emotions before attempting to assist others in managing theirs;

   (4) use verbal, vocal and non-verbal elements to communicate in an empathetic,
       authentic and assertive manner;

   (5) utilize non-coercive techniques for gaining cooperation. Coercive techniques
       are prohibited;

   (6) adhere to the following principles of touch when physically intervening:

       (a) ask permission to touch or excuse self for touching,

       (b) touch as little as possible for as short a time as necessary,

       (c) touch slowly with open and relaxed hands, and

       (d) guide by touching between the shoulder and elbow.

   c. The following standards apply when restrictive procedures are used to manage a
      psychiatric crisis:

       (1) Seclusion and mechanical restraint shall only be used in emergencies as
defined in paragraph 5h.

       (2) The manual holding of a resident is permitted for the purpose of conducting
physical examinations or tests and providing treatment. However, residents do have the right to
refuse treatment. This includes the right to refuse physical examinations, tests, or medication.
Holding a resident in a manner that restricts the resident’s movement against the resident’s will
is considered restraint. Manually restraining a resident can be just as restrictive, and just as
dangerous, as restraining methods that involve devices.

(3) There is a high prevalence of traumatic experience among persons who receive
mental health services. The response to trauma can include intense fear and helplessness, a
reduced ability to cope, and an increased risk to exacerbate or develop a range of mental health
and other medical conditions. The experience of being placed in seclusion or being restrained
is potentially traumatizing. Seclusion and restraint practices shall be guided by the following
principles of trauma-informed care: assessment of traumatic histories and symptoms;
recognition of culture and practices that are re-traumatizing; processing the impact of a
seclusion or restraint on the individual; and addressing staff training needs to improve
knowledge and sensitivity.

(4) The health and safety of the resident shall be the primary concern of staff at all
times. When a resident demonstrates a need for immediate medical attention in the course
of an episode of seclusion or restraint, medical priorities shall supersede psychiatric
priorities, including the immediate discontinuation of the use of seclusion or restraint, if
medically necessary.

(5) Restrictive procedures shall not be used as punishment, for the convenience of
staff, or as a substitute for treatment programs. They are only used to ensure the safety of
everyone during a psychiatric crisis. Staff shall use only the amount of physical and verbal
interaction that is necessary to ensure safety during the use of a restrictive procedure.

(6) Approved Restraint Devices. Only approved restraints shall be used as
mechanical restraint devices by personnel who are trained in the application and removal of the
devices. The types of restraint devices authorized for use include:

(a) Posey Twice as Tough Double Key Lock Ankle and Wrist Cuffs. Mechanical restraint devices used to immobilize movement in which a resident is in a supine position on a covered mattress, with wrists and ankles secured to four points on a bed that is secured to the floor in a designated restraint area.

(b) Exceptions to the list of approved restraint devices may be made by an
internal review committee consisting of clinical staff. This committee shall define parameters
and training for use of that approved exception. Approved exceptions will be reported to the
Chief of Mental Health Treatment Facilities on a monthly basis.

(7) When Mandt procedures and standard mechanical restraint devices are not
sufficient in ensuring everyone’s safety, security personnel are authorized to use techniques
and devices that are established by the Criminal Justice Standards Commission under Florida
Administrative Code, Chapter 11B-35.0021, High Liability Proficiencies, and comply with
standards and requirements set forth by Department of Children and Families operating
procedures.

(8) The criterion for release from a restrictive procedure is that the resident no
longer presents an immediate danger to self or others, rather than the passage of a time period.
Within 15 minutes of reaching the specified behavioral criteria, the resident shall be released
from restraint. Sleep is an indication that the resident no longer poses an imminent danger to
self or others.
(9) The decision to use a restrictive procedure shall not be based on the fact that the procedure was used before or solely on a history of dangerous behavior.

(10) All employees are required to make an immediate report to the Florida Abuse Registry (1-800-962-2873 / 1-800-96-ABUSE) when implementation of the restrictive procedure places the resident at risk, when the frequency of these procedures appears to be excessive and/or exploitive, or if abuse or neglect is suspected or witnessed during the procedure.

(11) Seclusion and restraint may not be ordered simultaneously.

(12) There shall be no standing or PRN (pro re nata) orders for using seclusion or restraints.

(13) PRN’s for the use of psychotherapeutic medications will be governed by Florida State Hospital Operating Procedure 150-34, Psychotherapeutic Medication Prescription Standards.

(14) **Do not restrain an individual in a prone position.** Prone containment will be used only when required by the immediate situation to prevent imminent serious harm to the individual or others. To reduce the risk of positional asphyxiation, the individual will be repositioned to a sitting, standing, or supine position as quickly as possible. Responders will pay close attention to respiratory function of the individual during containment and restraint.

(15) **Do not place any object over an individual’s face.** In situations where precautions need to be taken to protect staff against biting and spitting, staff should wear gloves, masks, or clear face shields when possible for purposes of infection control.

(16) Seclusion shall not be used for residents exhibiting suicidal or self-injurious behaviors or those who have other known medical conditions which preclude the safe application of this modality (such situations shall be determined by the physician on a case-by-case basis).

d. Following each occurrence of a restrictive procedure, employees are expected to:

   (1) work as part of a team;

   (2) assess any unmet needs that may have led to the emergency;

   (3) refrain from blaming or accusing others for causing the incident.

7. **Staff Training:** Staff must be trained as part of orientation and subsequently on an annual basis. Staff responsible for the following actions will demonstrate relevant competency in the following areas before participating in a seclusion or restraint event or related assessment, monitoring or provision of care during an event:

   a. strategies designed to reduce confrontation and to calm and comfort people, including the development and use of a personal safety plan,

   b. use of nonphysical intervention skills as well as bodily control and physical management techniques based on a team approach,

   c. observing for and responding to signs of physical and psychological distress,
d. safe use of manual restraint technique and safe application of restraint devices,

e. monitoring the physical and psychological well-being of the person who is restrained or secluded, including but not limited to: respiratory and circulatory status, skin integrity, vital signs, and any special requirements associated with the 1-hour face-to-face evaluation,

f. clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary,

g. the use of first aid techniques, and

h. certification in the use of cardiopulmonary resuscitation and recertification every two (2) years or in accordance with certification requirements.

8. Procedure:

a. Section 1 – Personal Safety Plan Procedure:

(1) Completing the Personal Safety Plan (Attachment 1):

(a) The assigned Social Services staff shall review and update documentation, contact family, observe and interview the resident to complete the Personal Safety Plan within 60 hours of admission or transfer within Florida State Hospital (from one unit to another), after each restrictive procedure and annually. The interviewer shall identify:

1. resident’s description of their own appearance and behavior when experiencing little or no distress;

2. events, people or situations that may ‘trigger’ negative emotions and make the resident angry or very upset;

3. a history of physical, emotional or sexual abuse or other trauma;

4. any warning signals that he/she is losing control of emotions;

5. resident’s suggestions for strategies for separating him/her from triggers or stimuli;

6. resident’s suggestions for strategies or plans for assisting in their de-escalation or calming down;

7. resident’s preference of staff and manner of physical contact that may prevent further escalation and assist in de-escalation;

8. resident’s preference regarding the manner of conducting night-time room checks;

9. information about previous experience with seclusion and/or restraint;

10. resident’s preference of restrictive procedures that may be necessary to ensure safety;
information that may assist others in reducing the traumatic effects of restrictive procedures should they become necessary;

12. medical conditions that may affect choices of restrictive procedures;

13. who shall receive notification if restrictive procedures are used;

14. which registered nurse the resident prefers to talk to following a restrictive procedure; and

15. need for services addressing issues identified from interview.

(b) The Social Services staff shall file the original Personal Safety Plan in the resident’s ward chart/medical record, provide a copy to the resident, submit a copy to the Unit Treatment Rehabilitation Supervisor III or equivalent, and file a copy in the Personal Safety Plan Notebook on the appropriate ward or pod within two (2) days of completion of the Plan.

(c) If the resident wants someone notified of seclusion/restraint events, the Social Services staff shall have him/her complete a consent form. A copy of this form shall be filed in the resident's ward chart behind the Personal Safety Plan.

(d) The Social Services staff shall report the information obtained from the Plan at the initial recovery team meeting, including potential issues that were identified. The Social Services staff shall sign and indicate the date the Plan was shared with the team on the Signature Page For Personal Safety Plan (Attachment 2).

(e) The Social Service staff shall provide a copy of the signature page to the Unit Treatment Rehabilitation Supervisor III. Another copy shall be filed in the Personal Safety Plan Notebook which is located on the appropriate ward/pod. The original signature page is filed behind the Personal Safety Plan within seven (7) calendar days.

(f) The Unit Treatment Rehabilitation Supervisor III or equivalent shall require all direct care personnel providing direct care services to residents to read the Personal Safety Plan and sign the Signature Page for Personal Safety Plan.

(g) All employees providing services to the resident inside and outside the unit will review the Personal Safety Plan. A copy of the Personal Safety Plan shall be given to all employees who provide direct services to the resident outside the unit. Supervisory personnel shall ensure that all employees serving the resident are made aware of the information contained on the Plan, and utilize the information on the Plan to prevent and manage potential psychiatric crises according to the guidelines below.

(2) Utilizing the Personal Safety Plan:

(a) When a resident is at “baseline”, he or she is not experiencing distress and should appear and behave as described on the Personal Safety Plan. Pay attention to potential triggers/stimuli and resident’s behaviors so you can respond appropriately and prevent any escalation.

(b) When a trigger, stimulus or antecedent is identified, anticipate warning signs. As soon as warning signs are noted, staff shall immediately intervene by gaining the resident’s cooperation and separating the resident and the trigger. Separating may require
avoiding, redirecting or releasing. Speak in a calm, soft voice and address the resident by name. Follow the principles of touch described in paragraph 6b(6).

(c) Once the stimulus, trigger or antecedent is removed and the resident is emotionally stable, the resident may want to talk. To the extent possible, allow the resident to talk to people that have been identified/listed in their Plan. Otherwise, provide staff that can show empathic listening and support. Communicate with understanding, honesty and without judgment. Staff shall take note of all information that may be useful in preventing emotional escalation in the future.

(d) After all efforts to separate the resident from the upsetting stimulus are unsuccessful, offer strategies that are identified on the Personal Safety Plan. Do not ask the resident why they are behaving as they are. Allow at least 30 seconds for the resident to respond to requests for cooperation. Cue positive behavior such as ‘Put down the chair.’ instead of giving negative commands such as ‘Don’t throw the chair.’ If the strategy selected is ineffective in de-escalating emotions, continue to offer other options. Offer at least three (3) strategies or options identified in Personal Safety Plan.

(e) If a resident refuses court ordered medication or treatment in emergency circumstances, attempt to gain compliance from the resident. When a resident refuses treatment, identify someone the resident trusts to convince him or her that complying with the treatment is in his or her best interest, or give the resident time to calm before administering the treatment. The decision to manually restrain someone to administer emergency treatment should be a last resort.

(f) Document on a progress note when a resident’s behavior escalates. Documentation should factually describe the following:

1. what happened before the escalation, including identified triggers
2. what happened during the escalation, including behaviors demonstrated
3. how employees intervened,
4. how the resident responded to employee’s intervention. Include specific information from the Personal Safety Plan in the documentation.

(3) Updating the Personal Safety Plan:

(a) The Unit Personal Advocate assigned to the resident shall document in the monthly progress note any triggers or precipitating incidents occurring on the assigned shift. The Personal Advocate shall report this information at the earliest regularly scheduled Recovery Team meeting.

(b) The Social Services staff shall review and update the Personal Safety Plan in conjunction with the Recovery Team after each restrictive procedure and annually.

(c) Any employee who is providing services that address issues derived from the Personal Safety Plan shall document progress toward meeting the identified objective and report progress to the Recovery Team. The service provider shall make recommendations to revise the plan based on information obtained during service provision and assessment.
b. Section 2 – Procedure for Using Seclusion and Restraint:

(1) Implementing the Use of Seclusion or Restraint:

(a) 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 by the physician, other licensed independent practitioner (Advanced Registered Nurse Practitioner) or registered nurse. When a resident presents imminent danger and a physician is not immediately available, seclusion or restraint may be initiated prior to a physician’s written order.

(b) For seclusion and mechanical restraint, a physician must conduct and document a face-to-face examination within one (1) hour of implementation, determine immediacy of danger and write an order authorizing use of the procedure or directing release. For manual restraint, a registered nurse will conduct and document the face-to-face examination within one (1) hour, and consult with a physician and document consultation on Form 607 (Attachment 3).

(c) The face-to-face examination conducted and documented by the physician or registered nurse within one (1) hour shall be documented in the Seclusion/Restraint Initial Assessment, Form 607 (Attachment 3), and include assessment of the resident’s mental status and physical condition, a review of the clinical record for any pre-existing medical diagnosis and/or physical conditions including trauma history which may contraindicate the use of seclusion or restraint, a review of medication orders including an assessment of the need to modify such orders during the period of seclusion or restraint, and assessment of the need or lack of need to elevate the head and torso during mechanical restraint. The comprehensive examination must determine that the risks associated with the use of seclusion or restraint are significantly less than not using it.

(d) The physician’s written order shall:

1. be written on the Physician’s Restraint Order (Attachment 4, Form 236) or Physician’s Seclusion Order (Attachment 5, Form 237) and included in the medical record;

2. specify the facts and behaviors presenting immediate and serious danger and identify the time of implementation and expiration of the authorization;

3. specify the type of restrictive procedure;

4. specify the positioning of the resident during restraint for respiratory and other medical safety considerations as well as consideration of previous trauma history;

5. include any special care monitoring instructions, including medical risk for consideration of age and fragility issues;

6. include a description of behavior indicating the need to release the resident.

(e) Each written order for Seclusion or Posey Twice as Tough Double Key Lock Ankle and Wrist Cuff is limited to four (4) hours. The original order may only be renewed up to a total of 24 hours, in accordance with these limits. While it is encouraged that a physician perform another face-to-face assessment prior to renewing an order, an Advanced Registered Nurse Practitioner or a Registered Nurse may telephone the physician with the reports of his/her
assessment and request that the original order be renewed for another time period, not to exceed the 24 hour limit. If seclusion or restraint is still absolutely necessary at the end of the 24 hour limit, the resident must be seen by a physician and his/her assessment documented before seclusion or restraint can be re-ordered.

(f) If a physician’s order is not obtained within one (1) hour of implementation, the resident must be released. A resident released due to lack of a physician’s order or without the nursing approval and assessment as described in paragraph (2) of this section may not be placed in seclusion or restraint within the following twelve (12) hours without first obtaining authorization from an Advanced Registered Nurse Practitioner or Registered Nurse.

(g) Every order continuing the use of seclusion or restraint shall be made only after a face-to-face evaluation by a physician, Advanced Registered Nurse Practitioner, or Registered Nurse and is documented in Form 606 (Attachment 6).

(h) The highest level employee available who is trained in restraint application and removal may implement the use of seclusion or restraint. The employee shall consider information in the person’s Personal Safety Plan such as medical conditions, restrictive procedure preferences, and ways to reduce the traumatic effect of the procedure.

(i) Prior to or immediately after placing a resident in seclusion or restraint, staff will search him or her for potentially dangerous or contraband objects. The search shall be conducted by a staff member of the same gender, if at all possible; and who meets criteria described in the resident’s Personal Safety Plan. Any potentially dangerous/contraband objects shall be removed and documented in the resident’s ward chart. A witness to the search shall be present and documentation shall include the name of the witness(es).

(j) The resident must be clothed appropriately for dignity, comfort and temperature and at no time shall be placed in seclusion or restraint in a nude or semi-nude state.

(k) Each initial seclusion or restraint occurrence shall have a corresponding progress note written by the appropriate direct care staff involved in the procedure. The documentation shall include the following:

1. description of the environment and resident’s appearance and behavior prior to and during the crisis;

2. description of attempts to gain cooperation in separating the resident and trigger or the reason this was not attempted;

3. description of physical contact with the resident, including any manual restraint methods used during any type of restraint or seclusion;

4. name(s) of who conducted the search, the results of the search, item(s) removed and name(s) of the witness(es); and

5. date and time of implementation, staff’s signature and job title. Time ending shall be included for manual restraint.

(2) Authorizing the Use of Seclusion or Restraint: The Advanced Registered Nurse Practitioner or Registered Nurse shall assess the need for the procedure. Based on the results
of the assessment, he or she shall verbally approve or disapprove. If approved, the Advanced Registered Nurse Practitioner or Registered Nurse shall proceed with the following:

(a) contact a physician within 15 minutes of implementation to receive a verbal order;

(b) inform the resident of the behavior that presents immediate danger and behavior that will result in release. Document such information in the narrative section of Form 606 (Attachment 6) with seclusion or mechanical restraint, and document in the ‘Other Comments’ section of the Seclusion/Restraint Initial Assessment (Form 607) with manual restraint;

(c) assess and document the resident’s condition in the Seclusion/Mechanical Restraint Nursing Assessment (Form 606, see Attachment 6) within one (1) hour of implementation;

(d) a Registered Nurse shall complete the one (1) hour face-to-face assessment (Form 607) in lieu of the Seclusion/Mechanical Restraint Nursing Assessment when manual restraint is implemented.

If disapproved, the Advanced Registered Nurse Practitioner or Registered Nurse shall direct the release of the resident and immediately document rationale for disapproval in the Progress Notes in the medical record.

(3) Monitoring People in Seclusion or Restraint:

(a) Observation: Observation must be at least every 15 minutes for seclusion and continuous for restraint. The resident’s condition must be documented at least every 15 minutes by trained staff for behavior, potential injury, respiration, and circulation. Staff shall document their observations, and sign their name, date and time of the observation on the Seclusion/Restraint Flow Sheet (Form 605, see Attachment 7). A nurse shall observe the resident at least one (1) time per hour, and document results of the observation in the General Physical Condition section on Form 605. If the procedure continues over shifts, a nurse shall obtain the resident’s blood pressure at least one (1) time per shift, and document results in a progress note. More frequent observations and documentation may be indicated based on need. Examples are, but not limited to, cardiac conditions, seizure disorders, asthma or behavioral conditions.

(b) It is not necessary to complete the Seclusion/Restraint Flow Sheet (Form 605) when manual restraint lasts less than 15 minutes.

(c) Care: All efforts shall be made to ensure the safety, comfort and dignity of the resident while in the restrictive procedure.

1. A resident’s right to privacy shall be respected with considerations for safety being a primary concern. A restrained resident must be located in an area not subject to view by other residents and where the restrained resident is not exposed to potential injury by other residents.

2. The resident must be clothed appropriately for temperature, comfort, safety and dignity before placement in seclusion or restraint.
3. The resident shall receive meals at regular times. For those in restraint, the devices shall be adjusted in order for meals to be eaten safely and comfortably. Only a spoon should be allowed as an eating utensil.

4. The resident shall be offered fluids at least every two (2) waking hours.

5. Residents shall be allowed to toilet themselves in the most normal manner possible. Use of the toilet, urinal or bedside commode shall be dictated by behavior. In cases of restraint or seclusion rooms without toileting facilities, toileting shall be allowed upon reasonable demand but must be offered at least once every waking hour. Staff of the same gender should be present, unless otherwise indicated on the Personal Safety Plan.

6. If needed, the resident may receive a bath based on behavior and condition. If in restraint, the bath shall be given by staff of the same gender, unless otherwise indicated on the Personal Safety Plan.

(d) A progress note shall be written by the shift supervisory level staff at the end of the shift if the procedure continues over shifts. It shall summarize:

1. the resident’s physical status and condition during the shift, summarizing the physical assessment/care provided as recorded on the Seclusion/Restraint Flow Sheet, Form 605;

2. the resident’s progress toward demonstrating the behavior that no longer presents immediate danger;

3. any significant information to include physical status, behaviors, and special precautions; and

4. any communications regarding the need for continuing the procedure.

(e) The employee assigned to monitor the resident in seclusion or restraint shall complete the Seclusion/Restraint Flow Sheet by following the instructions on the front of the sheet.

(4) Releasing from Seclusion or Restraint:

(a) A resident shall be released as soon as he or she no longer appears to present an imminent danger to self or others and meets the behavioral criteria for its discontinuation. Every resident in seclusion or restraint shall be informed of the behavior that caused the seclusion or restraint and the behavior and conditions necessary for release. Within 15 minutes of reaching the specified criteria, the resident shall be released from seclusion or restraint. The resident shall have time for structured cooling off based on information in his or her Personal Safety Plan. After release, employees shall continue to observe the resident and provide behavior support to ensure that he or she returns to baseline.

(b) Upon release from seclusion or mechanical restraint, a nurse shall observe, evaluate and document on Form 606 (see Attachment 6) the resident’s physical and psychological condition.
(c) A progress note shall be written by the releasing staff at the end of the seclusion or mechanical restraint procedure. It shall include:

1. the date and time of release;
2. the resident’s physical condition;
3. a description of options offered for structured cooling off, and the resident’s response to the options offered; and
4. if the procedure termination occurs due to sleep, the note shall so indicate.

(d) The time and date the restrictive process was terminated shall also be recorded on the Seclusion/Restraint Flow Sheet by the staff assigned monitoring responsibilities at that time.

c. Section 3 - Post Event Debriefing Procedure:

(1) Debriefing with the resident. After a resident is released from a restrictive procedure, a Registered Nurse shall offer him or her an opportunity to discuss and process the event.

(a) The Registered Nurse conducting this debriefing shall be:

1. independent of the seclusion and restraint event (the Registered Nurse may be on a different shift);
2. selected for this debriefing based on the preference of the resident restrained or secluded, and a staff member who is respected and trusted sufficiently for the resident to be open and honest; and
3. identified for this role on the Personal Safety Plan, when possible.

(b) The time of the debriefing is based on the following factors:

1. when the resident becomes sufficiently calm and alert to effectively participate;
2. as soon as possible, and preferably not later than 24 hours following the seclusion or restraint episode;
3. as identified on the Personal Safety Plan, when possible; and
4. prior to the Recovery Team meeting with the resident, when possible.

(c) The debriefing interview is conducted one-to-one between the Registered Nurse and the resident and shall identify the following:

1. unmet needs, antecedents, stimuli or triggers that may have caused the resident to become angry or upset;
2. de-escalation options that were offered and why they were not effective; and

3. possible alternative behaviors and healthy coping strategies that may effectively minimize or negate future use of restraint should similar situations, thoughts or emotions recur.

(d) The resident debriefing interview is documented on Florida State Hospital Clinical Debriefing Form (Resident) (Form 188A, see Attachment 8). If the resident refuses to engage in the interview within 24 hours after being released from the procedure, the Registered Nurse shall so document in the medical record progress notes. The Registered Nurse shall make another attempt to re-engage him or her and document refusals in the medical record and debriefing results on the Form 188A, Florida State Hospital Clinical Debriefing Form (Resident). File Form 188A in the medical record.

(e) The debriefing interview with the resident held after a manual restraint is used to administer emergency treatment does not include questions regarding a psychiatric crisis. Instructions on Form 188A indicate which questions must be asked when manual restraint is used to administer emergency treatment.

(f) The Registered Nurse will submit a copy of the completed Form 188A, Florida State Hospital Clinical Debriefing Form (Resident), to the Qualified Mental Health Professional on the day the debriefing occurred.

(2) Debriefing with staff involved: The Unit Director or designee shall conduct a post event debriefing with the staff involved in the event.

(a) This debriefing shall be held as soon as possible, but not later than four (4) hours following implementation of seclusion or restraint for a psychiatric crisis and by close of business the following work day when manual restraint is used to administer emergency treatment.

(b) The debriefing shall include discussion of:

1. the physical and emotional safety of all involved parties and the need for immediate support services;

2. information documented;

3. the behavior of the resident before and during the procedure;

4. the behavior of employees involved before and during the procedure;

5. possible alternatives for managing future crisis situations; and

6. ways to resume pre-crisis environment on the unit.

(c) The debriefing interview is documented on the Florida State Hospital Administrative Debriefing Form (Form 97, Attachment 9).

(d) The debriefing interview with staff involved held after a manual restraint is used to administer emergency treatment does not include questions regarding a psychiatric crisis.
crisis. Instructions on Form 97 indicate which questions must be asked when manual restraint is used to administer emergency treatment.

(e) The Unit Director or designee will submit the completed Florida State Hospital Administrative Debriefing Form to the Qualified Mental Health Professional on the day the debriefing occurred.

(3) Debriefing with Recovery Team: The Recovery Team shall conduct a debriefing following the restrictive procedure.

(a) The Recovery Team shall meet with the resident to debrief the restrictive procedure by 1200 hours (noon) the next work day and document review on Florida State Hospital Clinical Debriefing Form (Recovery Team) (Form 188B, Attachment 10).

1. the events that precipitated the use of seclusion or restraint;

2. ascertain that the individual’s physical well-being, psychological comfort, and right to privacy were addressed;

3. counsel the resident for any trauma that may have resulted from the incident;

4. assist the individual in identifying alternative methods for handling crisis situations or in understanding the need for treatment;

5. revise the Recovery Plan, as needed, to include services or interventions to prevent future need for restrictive procedures

6. revise the Personal Safety Plan as needed, and

7. contact the person(s) identified on the Personal Safety Plan.

(b) the Clinical Debriefing Form (Recovery Team), Form 188B, shall be filed in the medical record. The Qualified Mental Health Professional, shall provide copies of Florida State Hospital Clinical and Administrative Debriefing Forms to the Unit Director on the day the Recovery Team debriefing occurs. If the Clinical Debriefing Form (Resident) (Form 188A) is not complete at this time, the Qualified Mental Health Professional will forward it to the Unit Director on the same day it is received from the Registered Nurse.

(4) Debriefing with Leadership:

(a) The Unit Director shall forward copies of Florida State Hospital Clinical and Administrative Debriefing Forms to the supervising Assistant Hospital Administrator by 1200 hours (noon) the next work day after they are received from the Qualified Mental Health Professional.

(b) The Assistant Hospital Administrator shall conduct a review within seven (7) work days after the implementation of the restrictive procedure.

1. The review shall involve, at a minimum, the Assistant Hospital Administrator, Unit Director and the Florida State Hospital Resident Advocate or designee.
2. Everyone involved in the review shall sign at the bottom of the Florida State Hospital Administrative Debriefing Form, in the Leadership Review section.

3. The Unit Director shall ensure implementation and tracking of actions resulting from the entire debriefing process.

(Signed original on file in Central Health Information Services)

DIANE R. JAMES
Hospital Administrator

12 Attachments:
1. Personal Safety Plan (Form 325)
2. Signature Page for Personal Safety Plan (Form 325A)
3. Seclusion/Restraint Initial Assessment (Form 607)
4. Physician’s Restraint Order (Form 236)
5. Physician’s Seclusion Order (Form 237)
6. Seclusion/Mechanical Restraint Nursing Assessment (Form 606)
7. Seclusion/Restraint Flow Sheet (Form 605)
8. Clinical Debriefing Form (Resident) (Form 188A)
9. Administrative Debriefing Form (Form 97)
10. Clinical Debriefing Form (Recovery Team) (Form 188B)
11. Seclusion/Restraint Flow Chart
12. Provide Emergency Treatment to Residents/Use of Manual Restraint (Flow Chart)

SUMMARY OF REVISED, ADDED OR DELETED MATERIAL

February 8, 2010 -- This procedure was changed to revise wording for congruency between policy and forms instructions; and Attachments 3, 4 and 5 were revised.

May 17, 2010 – This procedure was changed to add a requirement on page 10, section b. (1) (b) that the nurse consults with a physician and documents consultation when conducting the initial assessment on a resident when manual restraint was implemented. The instruction box in Attachment 3 was revised to include the same. Attachments 4 and 5 were revised to more effectively reflect requirement on page 10 b. (1) (d). Attachments updated to reflect current forms.
This information is intended only to be helpful and can be changed or updated per request at any time.

**Baseline:** Describe what appearance and behavior is like when experiencing little or no stress.

**Triggers/Stimuli:** What are some of the things that make you (resident) angry or very upset? What are triggers?

- [ ] Called names or made fun of
- [ ] No one listening to your concern
- [ ] Contact with upsetting person
- [ ] Forced to do something
- [ ] Someone lying about me

- [ ] Being touched
- [ ] Yelling
- [ ] Noise or sounds
- [ ] Lack of privacy
- [ ] Physical force

- [ ] Physical discomfort
- [ ] Fault-finding
- [ ] Being threatened

- [ ] Being isolated
- [ ] Security in uniform
- [ ] Being restrained
- [ ] Other

Please explain all items checked:

Do you have a history of physical, emotional or any other trauma? YES or NO:
If yes explain:

**Escalation:** Please describe warning signals, for example, what other people may notice when you are losing control?

- [ ] Sweating
- [ ] Refusing meds
- [ ] Being Rude
- [ ] Not eating
- [ ] Not taking care of self
• Crying
• Yelling
• Not talking
• Breathing hard
• Injuring self
• Swearing
• Pacing
• Hurting others
• Avoiding others
• Running
• Clenching
• Clenching fists
• Throwing objects

Please explain all items checked:

**De-escalation:** Calming Strategies: What helps calm the person when upset?

- [ ] Reading religious/spiritual readings
- [ ] Doing artwork/painting/drawing
- [ ] Going for a walk with staff/Exercise
- [ ] Calling a friend or family member
- [ ] Voluntary time in the comfort/quiet room
- [ ] Dark room (dimmed lights)

- [ ] Drinking a beverage
- [ ] Listening to music
- [ ] Taking shower
- [ ] Talking with peers on unit

- [ ] Watching TV
- [ ] Talking to staff
- [ ] Reading a book
- [ ] Punching a pillow

- [ ] Pacing
- [ ] Medication
- [ ] Lying down
- [ ] Deep Breathing
- [ ] Other

Please explain all items checked:

**Employee Behavior:** When you are upset, please explain what staff should do or NOT do to prevent further escalation and or assist in de-escalation.
PERSON’S NAME & NUMBER:

Physical Contact Preference: Do you (resident) prefer being touched or not being touched when upset? (During interview, explain principles of touch described in policy.)

Room Checks: Room checks are done nightly. What can be done to make your room checks more comfortable?

CRISIS:
Restrictive Procedures: Has the person ever been secluded? [ ] Yes [ ] No
Has the person ever been restrained? (Check all that apply.)
[ ] Never [ ] Physically Restrained [ ] Mechanically Restrained [ ] Chemically Restrained
Has the person ever witnessed or assisted while others were secluded or restrained? [ ] Yes [ ] No
Please explain if “yes” was checked for any above items:

If it becomes necessary, as a last resort, rank procedures below in order of preference with 1 indicating most preferred and 5 for least preferred.

[ ] Physical hold [ ] Seclusion [ ] Mechanical restraint [ ] Medication by mouth [ ] Medication by injection
In extreme emergencies seclusion or restraint may be used as a last resort. What would help reduce the traumatic effect of restrictive procedures if they should be used to ensure your safety? (e.g., personality characteristics that are calming or frightening, preferred gender)

What medications have been especially helpful when upset? Please describe.

Medical Conditions. What physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc. exist that could affect choices of restrictive procedures?

POST-CRISIS:
Family Notification: In the event that a restrictive procedure is used, who, if anyone, should be contacted? If a name is listed, consent must be given by person signing a release of information form to be placed in the medical record and updated periodically. (Please verify that the notification person is listed on the current Authorization for Release form.)
Name and telephone number of person to be contacted:
Which registered nurse(s) do you prefer to talk to following a restrictive procedure?

At what point after a crisis is the person ready to talk to a registered nurse about the incident?
[ ] 1 hour [ ] 4 hours [ ] next shift [ ] next day [ ] other

RECOVERY PLANNING:
List issues identified that may require services and need to be addressed on the Recovery Plan.

Signatures and dates below indicate that resident [ ] received [ ] declined a copy of the plan, and indicates an agreement to enter into a partnership for safety.

Date: ____________________________ Date: ____________________________

**CONFIDENTIAL & PRIVILEGED INFORMATION*** FOR PROFESSIONAL USE ONLY**
FLORIDA STATE HOSPITAL, CHATTAHOOCHEE, FL 32324

Form 325 (Revised) Apr 2010
Office of Primary Responsibility: Office of Social Services

Attachment 1
Page 2 of 2
Operating Procedure 155-22
SIGNATURE PAGE FOR PERSONAL SAFETY PLAN

INSTRUCTIONS: This form indicates employees who have read the Personal Safety Plan of the person named below. It is filed in the Personal Safety Plan Notebook on the ward or pod where the person named below resides. This form is not to be filed in the resident’s medical record or ward chart.

Resident’s Name and Number: ____________________________________________________________

Date Personal Safety Plan shared with Service Team __________________________ (Date)

Social Services Staff Signature: __________________________________________________________

By signing below, the employee indicates that he or she has read the above named person’s Personal Safety Plan and agrees to use the information to prevent and manage psychiatric crises.

Signature, Title, Date  Signature, Title, Date

Signature, Title, Date  Signature, Title, Date

Signature, Title, Date  Signature, Title, Date

Signature, Title, Date  Signature, Title, Date

Signature, Title, Date  Signature, Title, Date

Signature, Title, Date  Signature, Title, Date

Signature, Title, Date  Signature, Title, Date

Signature, Title, Date  Signature, Title, Date

Signature, Title, Date  Signature, Title, Date

Signature, Title, Date  Signature, Title, Date

Signature, Title, Date  Signature, Title, Date

**CONFIDENTIAL & PRIVILEGED INFORMATION***FOR PROFESSIONAL USE ONLY**

FLORIDA STATE HOSPITAL, CHATTAOOCHEE, FL 32324

Form 325A, Apr 05  
Office of Primary Responsibility: Office of Social Services  
Attachment 2  
FLORIDA STATE HOSPITAL  
Operating Procedure 155-22
Date/Time In ____________________________

Please check type: __________ Seclusion
   ______ Posey Twice As Tough Double Key Lock Ankle and Wrist Cuffs Restraint
   ______ Manual Restraint
   ______ Other Device Only Upon Approval by Internal Review Committee (Specify device) ____________________________

Situation that led to Seclusion/Restraints: ________________________________________________________________

1. Resident’s mental condition/behavior: ________________________________________________________________

2. Review of clinical records for any contraindications to seclusion/restraints (Include review of pre-existing medical diagnosis or physical condition, trauma history, allergies, current diagnoses & medications and need to modify medications): _____

3. Review of any risks associated with use of seclusion/restraints: ____________________________________________

4. Review need or lack of need to elevate head and torso during mechanical restraint: __________________________

5. Physical Assessment:
   Vital Signs: __________________________________________________
   HEENT: ______________________________________________________
   Heart & Lungs: ________________________________________________
   Skin: _________________________________________________________
   Musculoskeletal & Extremities (Assess the areas affected by the restraint device. Include range of motion, pain, swelling): ________________________________

6. Subjective Physical Complaints: _________________________________________________________________

7. Other Comments: ____________________________________________________________

Signature and Stamp                                                                                                                 Date and Time

INSTRUCTIONS: To be completed by Physician, ARNP, or Physician Assistant after face-to-face assessment within one (1) hour of Initial (and 24th hour if continued restraint/seclusion is necessary) seclusion/restraint. A Registered Nurse shall complete for manual restraint, consult a physician and document Consultation under item 7.

To be filed in Flow Sheet Section of Ward Chart. Reference Florida State Hospital Operating Procedure 155-22.

ADDRESSOGRAPH: ** CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY **

Form 607, (Revised) May 2010 FLORIDA STATE HOSPITAL SECLUSION/RESTRAINT INITIAL ASSESSMENT
Office of Primary Responsibility: Clinical Director

Attachment 3
Operating Procedure 155-22
### ORDERS

**CHECK ONLY ONE:**

- **Initial Restraint Process with face-to-face Initial Assessment (within 1 hour).** (Up to 4 hours maximum period if resident does not meet release criteria.)
- Continued Restraint Process (renewal after 4 hours maximum period, if resident does not meet release criteria.)
- Continued Restraint Process with face-to-face Initial Assessment (New order after 24 hours period AND resident does not meet release criteria.)

**Implementation Date & Time:**

**Place in restraint**

- **bed**
- **other:**

**Positioning:**

- supine position only
- special positioning (consider medical, respiratory, trauma history needs: __________________________

**Monitoring:**

- standard monitoring on Form 605/S/R Flow Sheet
- special monitoring: __________________________

**RELEASE CRITERIA:**

Sleep indicates that the resident no longer poses an imminent danger. Release within 15 minutes of meeting Release Criteria.

---

**INSTRUCTIONS:** Prescriber enters all restraint order information. Order must include behavioral rationale and release criteria. If additional information is needed, a progress note should be entered on the Medical/Psychiatric Progress Notes in the chart. Original to be filed in the Orders section of ward chart. Reference Florida State Hospital Operating Procedures 151-15 and 155-22.
**ORDERS**

<table>
<thead>
<tr>
<th>Check ONLY ONE:</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Initial Seclusion Process with Initial Assessment (within 1 hour). (Up to 4 hours maximum period if resident does not meet release criteria.)</td>
<td>Describe specific behavior(s) presenting immediate danger requiring seclusion.</td>
</tr>
<tr>
<td>___ Continued Seclusion Process (renewal after 4 hours maximum period, if resident does not meet release criteria.)</td>
<td></td>
</tr>
<tr>
<td>___ Continued Seclusion Process with face-to-face Initial Assessment (resident continues to require seclusion after a 24-hour period)</td>
<td></td>
</tr>
</tbody>
</table>

**Observation**

Place resident in Seclusion for protection of self or others for up to 4 hours with:

___ CVO  ___ 15 minute checks

___ Other: ___________________________________

Implementation Date & Time: ___________________

**Monitoring:**

___ standard monitoring on Form 605/S/R Flow Sheet

___ special monitoring: _______________________

---

**RELEASE CRITERIA:**

Sleep indicates that the resident no longer poses an imminent danger. Release within 15 minutes of meeting Release Criteria.

---

See Progress Notes for additional information.

This will certify that the above orders on this date are not being used: to substitute for behavioral or other programs; as a punishment; to suppress personality-related behavior; for the convenience of the staff; for experimental purposes.

<table>
<thead>
<tr>
<th>PHYSICIAN’S/ADVANCED REGISTERED NURSE PRACTITIONER’S SIGNATURE &amp; ID #</th>
<th>DATE &amp; TIME:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NURSE’S SIGNATURE</th>
<th>DATE &amp; TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**INSTRUCTIONS:** Prescriber enters all seclusion order information. Order must include behavioral rationale and release criteria. If additional information is needed, a progress note should be entered on the Medical/Psychiatric Progress Notes in the chart. Original to be filed in the Orders section of ward chart. Reference Florida State Hospital Operating Procedures 151-15 and 155-22.

---

**ADDRESSOGRAPH:**

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Form 237, (Revised) May 2010
Office of Primary Responsibility: Clinical Director

FLORIDA STATE HOSPITAL
Attachment 5
Operating Procedure 155-22
NURSING ASSESSMENT—Check type: (For each sheet, check ONE ONLY)

- INITIAL (COMPLETED BY NURSE)
- RELEASE (COMPLETED BY NURSE)
- RENEWAL/CONTINUED USE OF SECLUSION/RERAINT (COMPLETED BY NURSE)

Check renewal time: ____ 4 hr   ____ 8 hr   ____ 12 hr   ____ 16 hr   ____ 20 hr

DATE/TIME OF ASSESSMENT:

ENCIRCLE ONE: Seclusion / Restraint Date/Time In __________________________

RERAINT TYPE: ____ Posey twice as Tough Double Key Lock
____ Other (specify)

1. Resident mental condition/behavior:

2. Assessment (Check all that apply):

   Neurological:  ____ Awake     ____ Alert     ____ Oriented
   Respirations:  ____ Easy/Non-labored     ____ Labored     ____ Audible Sounds (e.g., wheezing, cough)
   Extremities: (Assess the area affected by the restraint device.)
   Skin:  ____ Warm     ____ Dry     ____ Cool     ____ Clammy     ____ Intact
   ____ Non-intact (Describe)
   Skin color:  ____ WNL     ____ Cyanotic     ____ Erythema     ____ Ecchymosis     ____ Pale
   Capillary Refill:  ____ < 3 Seconds     ____ > 3 Seconds
   Nail Bed Color:  ____ WNL     ____ Cyanotic     ____ Pale
   Edema:  ____ None noted     ____ Mild     ____ Moderate     ____ Severe     Location of edema: __________
   Radial/Pedal Pulse (encircle one): Right:  ____ Palpable     ____ Weak     ____ Bounding
   ____ Palpable     ____ Weak     ____ Bounding
   Left:  ____ Palpable     ____ Weak     ____ Bounding
   ____ Palpable     ____ Weak     ____ Bounding
   Range of motion: RUE:  ____ Full     ____ Limited
   LUE:  ____ Full     ____ Limited
   RLE:  ____ Full     ____ Limited
   LLE:  ____ Full     ____ Limited
   Restraint application verified:  ____ Yes    ____ No

3. If a renewal order is received, document the rationale/behavior indicating continued use of restrictive procedure:

4. Narrative Note (Including resident's perspective/comments)

NAME & TITLE (in print) and SIGNATURE  DAE/TIME

INSTRUCTIONS: Complete this form for EACH Initial, Continued/Renewal, or Release order for Seclusion/Mechanical Restraint. Nurse must complete the initial assessment within one (1) hour of Seclusion/Mechanical Restraint and immediately upon release from Seclusion/Mechanical Restraint. Renewal assessment must be completed immediately upon receiving the renewal order, and indicate the renewal time frame on this form.

Form is to be filed in the Flow Sheet section of ward chart.
Reference Florida State hospital Operating Procedure 155.22

*** CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY ***

FLORIDA STATE HOSPITAL, CHATTAHOOCHEE, FL 32324

Form 606, (Revised) Nov 09

Office of Primary Responsibility: Clinical Director

Page 1 of 2

Operating Procedure 155-22
**CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY **

**SECLUSION/RESTRAINT FLOW SHEET**

<table>
<thead>
<tr>
<th>Dangerous Behavior: (completed by Direct Care Staff)</th>
<th>Date (MM/DD/YY):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does behavior continue to indicate immediate danger to self/others as described in physician’s order/Release Criteria? Y/N</td>
<td></td>
</tr>
<tr>
<td>If yes, describe behavior on back of form</td>
<td></td>
</tr>
<tr>
<td>If no, release person according to order. Initials</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breathing/Circulation/Potential for Injury (completed by Direct Care Staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please answer each question with a Y (yes) or N (no). If yes, please notify a nurse immediately and document specific details on the back.</td>
</tr>
<tr>
<td>Is the resident having trouble breathing (e.g., wheezing, grunting, becoming pale or blue)?</td>
</tr>
<tr>
<td>Is the resident complaining of tingling/numbing sensation in hands or feet?</td>
</tr>
<tr>
<td>Is the resident unable to move fingers and toes easily?</td>
</tr>
<tr>
<td>Are there any scratches/cuts or bruises that have developed since the seclusion/restraint?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Provided: (completed by Direct Care Staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toileting offered at least hourly.</td>
</tr>
<tr>
<td>Record number of times</td>
</tr>
<tr>
<td>Voided</td>
</tr>
<tr>
<td>Bowel Movement</td>
</tr>
<tr>
<td>Exercise at least 10 minutes every hour if restrained</td>
</tr>
<tr>
<td>Fluids offered at least every 2 hours</td>
</tr>
<tr>
<td>Record cc’s taken (see “Instructions”)</td>
</tr>
<tr>
<td>Meals - Record % Eaten [100%, 75%, 50%, 25%, 0%]</td>
</tr>
<tr>
<td>Bath offered daily</td>
</tr>
</tbody>
</table>

**INSTRUCTIONS:** Document all in sidereal/military time. Direct care staff complete sections “Dangerous Behaviors,” “Breathing/Circulation/Potential for Injury,” and “Care Provided.” Place asterisk (*) in space to indicate a corresponding progress note on the back of this form. Direct Care staff immediately notifies a nurse of complaints/sickness. Record fluids in actual cc’s (milk carton, Styrofoam cup, 8 oz cups = 240cc; yellow paper cup = 180cc; juice container = 120cc). Nurse initials every hour in the General Physical Condition section.

To be filed in the Flow Sheet section of the medical record.

Reference Florida State Hospital Operating Procedure 155-22.
## General Physical Condition

<table>
<thead>
<tr>
<th></th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature</td>
<td></td>
</tr>
<tr>
<td>Pulse Rate</td>
<td></td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td></td>
</tr>
<tr>
<td>Appearance, Breathing, etc.</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Abnormal</td>
</tr>
<tr>
<td>Skin Temperature and Color</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Abnormal</td>
</tr>
<tr>
<td>Circulation and Skin Condition (around restraints)</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Abnormal</td>
</tr>
</tbody>
</table>

### TIME

<table>
<thead>
<tr>
<th>TIME</th>
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</table>

### DESCRIPTION OF BEHAVIOR INDICATING IMMEDIATE DANGER / SECLUSION/RESTRAINT PROGRESS NOTES

---

**CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY **

Form 605, (Revised) Dec 09
FLORIDA STATE HOSPITAL
Office of Primary Responsibility: Quality Assessment & Planning
SECLUSION/RESTRAINT FLOW SHEET
Attachment 7
Page 2 of 2
Operating Procedure 155-22
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In your opinion, why were you placed in seclusion or restraints?</td>
<td><em>Reason for seclusion or restraint</em></td>
</tr>
<tr>
<td>2. What made you upset?</td>
<td><em>Reason for upset</em></td>
</tr>
<tr>
<td>3. When did you realize you were getting out of control?</td>
<td><em>Date and time of realization</em></td>
</tr>
<tr>
<td>4. What did you expect to happen if your behavior continued?</td>
<td><em>Expected outcome</em></td>
</tr>
<tr>
<td>5. What are the best ways for staff to help calm you down?</td>
<td><em>Suggestions for staff</em></td>
</tr>
<tr>
<td>6. What did staff do to help you during this incident?</td>
<td><em>Staff actions during incident</em></td>
</tr>
<tr>
<td>7. Did anyone make you more upset? If yes, who and what did they do?</td>
<td><em>Individuals and actions that made you upset</em></td>
</tr>
<tr>
<td>8. What more could have been done to keep you from going into seclusion or restraints?</td>
<td><em>Suggestions for prevention</em></td>
</tr>
<tr>
<td>9. Did you get hurt during the procedures? How are you hurt?</td>
<td><em>Details of any injuries</em></td>
</tr>
<tr>
<td>10. How will you handle the situation differently should something similar happen again?</td>
<td><em>Future approach to similar situations</em></td>
</tr>
</tbody>
</table>

Debriefing Date/Time: ___________________  Registered Nurse Signature: ___________________

Person Served Signature: ___________________

**CONFIDENTIAL & PRIVILEGED INFORMATION ** FOR PROFESSIONAL USE ONLY **

CLINICAL DEBRIEFING FORM (RESIDENT)

Attachment 8

Operating Procedure 155-22
**SECTION A**: Debriefing with employees involved in seclusion or restraint event; chaired by the Unit Director or Designated Senior Staff Member, and held within 4 hours after implementation of seclusion or restraint or by noon the next work-day when manual restraint is used to administer emergency treatment. Only ask questions 1, 8, 9, 10, 11, 12, and 13 when manual restraint is used to administer emergency treatment. When form is completed Unit Director gives form to the Qualified Mental Health Professional. **This form is not filed in the person’s medical record/chart.**

Person Secluded or Restrained: ____________________________________  Unit: __________________
Date of Hospital Admission: __________________ Date of Unit Admission/Transfer: _______________

Date of Intervention: ______________  Time Begin: ______________  Time End: ______________

_____Seclusion    _____Mechanical Restraint   _____Manual Restraint      1st Choice on PSP: ___________

1. What were the resident’s actions prior to being placed in the procedure?

2. What was happening in the living area which caused the resident to escalate?

3. Who does the resident respond well to and were they called?

4. What are the de-escalation preferences identified in the Personal Safety Plan?

5. Which de-escalation preferences were used?

6. What was the reaction of the resident to the preferences?

7. If preferences not used, why?

8. What is your recommendation for preventing future crisis situations with this resident?

9. What actions were taken to provide support to the other residents and staff in order to return the unit to pre-crisis environment?

10. Was resident injured during process?  ☐Yes  ☐No  Describe Injury: __________________

11. If resident was injured, was Abuse notified per policy?  ☐Yes  ☐No  Time notified ______________

12. Does Personal Safety Plan review page include signatures of all involved?  ☐Yes  ☐No

13. Did Security assist in the seclusion/restraint?  ☐Yes  ☐No

14. Was the search of resident and room documented?  ☐Yes  ☐No

15. 1st choice intervention used?  ☐Yes  ☐No  If not, why? ____________________________________

Debriefing Date/Time: __________________   Chair Signature/Title: _________________________________

(Involved Staff) Indicate most recent date (mm/yy) of training:

<table>
<thead>
<tr>
<th>Signature &amp; Title:</th>
<th>Mandt</th>
<th>OP 155-22</th>
<th>CPR</th>
<th>1st Aid</th>
<th>Restraint Application</th>
</tr>
</thead>
<tbody>
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Form 97, (Revised) Dec 09
Office of Primary Responsibility: Quality Assessment & Planning

Attachment 9
Page 1 of 2
Operating Procedure 155-22
SECTION B: To be completed by Senior Leaders after review of Form 188 and Form 97, Section A.

Leadership Debriefing date and time: __________________________________________

Leadership Review Comments: ________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Leadership Review: Date & Time: ________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
Person Secluded or Restrained: ______________________________ Unit: __________
Type of Restrictive Procedure: _______ Seclusion _______ Mechanical Restraint _______ Manual Restraint
Date of Procedure: _______________ Time Begin: _______________ Time End: ______________
Dates of previous restrictive procedures in the last 60 days:

1. Review the events that precipitated the restrictive intervention:

2. Ascertain that the resident's physical well-being, psychological comfort, and right to privacy were addressed:

3. Counsel the client for any trauma that may have resulted from the incident:

4. Assist the resident in identifying alternative methods for handling crisis situations or in understanding the need for treatment:

5. Review the Recovery Plan, Personal Safety Plan, debriefing documents, and seclusion/restraint chart documentation. What are the new interventions identified to prevent future psychiatric crisis situations?

6. Family indicated on Personal Safety Plan contacted:
   By Whom: ____________________________ Time and Method of Contact: ________________
   Family’s Response: _______________________________ If not contacted, why?: ___________________
   Meeting Date/Time: ________________ Chair Signature/Title: ___________________________

   Resident’s Signature: ____________________________ Resident’s Comments: __________________

   Participant Signatures/Titles:
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

INSTRUCTIONS: Recovery Team Debriefing chaired by the QMHP no later than 1200 hours the next regular work day. After completing this form, the Qualified Mental Health Professional gives copies of all three (3) debriefing forms to the Unit Director, who reviews them with the Assistant Hospital Administrator and then files them in the unit. This form is filed in the Progress Notes section of the ward chart. Reference Florida State Hospital Operating Procedure 155-22.

ADDRESSOGRAPH:

** CONFIDENTIAL & PRIVILEGED INFORMATION ** FOR PROFESSIONAL USE ONLY **

FLORIDA STATE HOSPITAL, CHATTahoochee, FL 32324

Form 188B, (Revised) Dec 09
FLORIDA STATE HOSPITAL
Office of Primary Responsibility: Quality Assessment & Planning

CLINICAL DEBRIEFING FORM
(Recovery Team)
Attachment 10
Operating Procedure 155-22
Social Services Completes Form 325, PSP, upon admission, transfer, and annually. Gives copy of PSP to UTRSIII, places copy in PSP Notebook, & files original in chart. Reviews & updates PSP & progress notes after every S/R and anytime needed.

Team reads PSP, observes & interacts with resident.

Resident Calm? no

Gain cooperation, separate resident from trigger & de-escalate, and document in chart.

Everyone Safe? no

Implement S/R, conduct & document search, and contact R.N.

Assess need for S/R

Need to Release? no

Nurse contacts physician within 15 minutes
Inform resident of release criteria

Conduct face-to-face assessment within 1 hour, write order & complete Forms 606 & 607 (607 w/ initial order only).

Monitor, provide care & document on Forms 605 & 606 (15 min/hourly)

# S/R Events Lasting More than 4 Hours in Duration

Release within 15 minutes, and document on forms & progress notes.

All involved debrief with Unit Director ≤4 hrs, complete Form 197, give copy to QMHP

Debrief w/resident, complete Form 197 & give copy to QMHP
File original in chart

Recovery Team debriefs by noon next work day, completes Form 197, gives copy to UD, files original in chart

% S/R Standards Met

% Resident Debriefings Held

SLT debrief, complete Form 197 & ensure actions are completed

Psychiatric Crises Prevented and Managed
Provide Emergency Treatment to Residents / Use of Manual Restraint

<table>
<thead>
<tr>
<th>WHO STEP</th>
<th>Resident</th>
<th>Direct Care / Security</th>
<th>Registered Nurse</th>
<th>LIF / Clinical Tx Providers</th>
<th>FSH Leadership</th>
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<td>Resident</td>
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**# Manual Restraint Events**

- Resident complies with emergency txt?
  - yes
  - Manually restrain resident long enough to administer treatment; Administer treatment
  - Discontinue order for manual restraint
  - Manual restraint lasts <15 minutes?
    - yes
    - Monitor, provide care & document on Form 605
    - Conduct face-to-face assessment within 1 hour & complete Form 607
    - Personnel implementing manual restraint write progress note
    - Debrief w/resident, complete Form 197 & give copy to QMHHP File original in chart
    - All involved debrief with Unit Director Recovery Team debriefs
      - Complete Form 197 & give copy to UD (Rec. Team files original in chart)

**% Debriefings Held**

**% S/R Standards Met**

- Administer Treatment

Emergency Treatment Administered

Attachment 12
Operating Procedure 155-22