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 and their managers and administrators.

   (For the purpose of this operating procedure, the term “psychiatrist” and “physician” shall also refer to the appropriate Advanced Registered Nurse Practitioner or Physician Assistant/Clinical Associate.)

3. **References:**
   b. Florida Statutes, Chapter 394, Mental Health
   c. Florida Statutes, Chapter 916, Mentally Deficient and Mentally Ill Defendants
   d. Florida Administrative Code 11B-35, Training Programs
   e. Florida Administrative Code 59A-3, Hospital Licensure
   f. Florida Administrative Code 65E-5, Mental Health Act Regulation
   g. Florida Administrative Code 65E-20, Forensic Client Services Act Regulation
   h. Children and Families Operating Procedure 155-20, Use of Seclusion in Mental Health Treatment Facilities
   i. Children and Families Operating Procedure 155-21, Use of Restraint in Mental Health Treatment Facilities
   j. Children and Families Operating Procedure 155-26, Safe and Supportive Observations of Residents

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This Operating Procedure supersedes: Operating Procedure 155-22 dated August 24, 2017

OFFICE OF PRIMARY RESPONSIBILITY: Clinical Services

DISTRIBUTION: See Training Requirements Matrix
k. Florida State Hospital Operating Procedure 10-1, Critical Event / Incident Reporting

l. Florida State Hospital Operating Procedure 75-1, Resident Injury/Event Reporting

m. Florida State Hospital Operating Procedure 140-1, Procedures for Reporting and Investigating the Abuse, Neglect or Exploitation of Florida State Hospital Residents

n. Florida State Hospital Operating Procedure 150-6, Suicide and Self-Injury Prevention

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

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

q. Florida State Hospital Operating Procedure 151-15, Physician Orders

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

s. CARF Behavioral Health Standards Manual, 2017

4. 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; through 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 participant’s 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. Justification: Part of the seclusion/mechanical restraint ‘assessment’ process in which a unit-based staff who is knowledgeable of the event, notifies a designated Administration individual and
responds to Administration’s questions as to why the particular restrictive procedure was used rather than less restrictive actions. The intent is to ensure that all least restrictive measures were attempted first.

k. Mandt: The Mandt System is a comprehensive, integrated approach to preventing, de-escalating, and, if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others.

l. 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.

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

n. PRN (pro re nata): An individualized, specific order for the care of the resident. It is a treatment order generated only as needed or as a specific circumstance requires. THERE SHALL BE NO PRN’s for the use of seclusion or restraint or for psychotherapeutic medications.

o. 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.

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

q. 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. Any manual restraint will not exceed fifteen (15) minutes in duration. 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.

r. Restrictive Procedures: Seclusion and Restraint.

s. Seclusion: The involuntary isolation of a resident in an area that the resident is prevented from leaving. The prevention may be a 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 include 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.

t. 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.
5. 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 any or all of 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/or

         (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 6.H.

      (2) A ‘manual hold’ 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.

      (3) 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 as restrictive, and as dangerous as other restraining methods that involve mechanical devices.

      (4) Persons with mental health problems have a high prevalence of traumatic experiences. Their response to trauma ranges from intense fear, helplessness, inability to cope, to psychosis. The experience of being placed in seclusion or in restraints is traumatizing.

      (5) Seclusion and restraint practices shall be guided by the following principles of trauma-informed care:

         (a) assessment of traumatic histories and symptoms;
(b) recognition of culture and practices that are re-traumatizing;
(c) processing the impact of a seclusion or restraint on the individual; and
(d) addressing staff training needs to improve knowledge and sensitivity.

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

(7) 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 the least amount of physical and verbal interaction that is necessary to ensure safety during the use of a restrictive procedure.

(8) Only approved restraint devices shall be used 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. These are 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 area.

(b) Emergency Restraint Chair. A chair specifically designed to restrain an individual who is in danger of hurting himself or others during a severely agitated episode. Use of the emergency restraint chair is limited to a maximum of two (2) hours; only one (1) use per twelve (12) hours.

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

(9) 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 Florida Administrative Code, Department of Law Enforcement, Criminal Justice Standards and Training Commission, Chapter 11B-35, Training Programs, and comply with standards and requirements set forth by Department of Children and Families operating procedures.

(10) The criterion for release from a restrictive procedure is that the resident no longer presents an imminent 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.

(11) 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. Staff will consider the resident’s developmental, abuse and trauma history in any potential intervention.

(12) 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.
(13) Seclusion and restraint may not be ordered simultaneously.

(14) There is NO standing or PRN (pro re nata) orders for using seclusion or restraints or psychotherapeutic medications.

(15) The use of leg and ambulatory restraints is prohibited in the Civil side of the hospital.

(16) The use of non-metal security devices to transport a forensic resident inside the secure perimeter of a forensic facility is for security purposes and shall be exempt from this operating procedure. The use of transport devices for security purposes shall be authorized by a resident's recovery team based on the resident's assessed security risk. Security risk factors include a propensity for or a history of assaultive or aggressive behavior, escape, or other types of behaviors that would compromise the safety of the resident or others. Documentation of the resident's security risk and need for a secure transport device shall be provided in the resident's medical record.

(17) The use of psychotherapeutic medications will be governed by Florida State Hospital Operating Procedure 150-34, Psychotherapeutic Medication Prescription Standards.

(18) 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.

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

(20) 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.

(21) When ordering physical restraints, the resident's medical conditions must also be addressed and monitored. For example, elevate head of bed in a resident who has gastroesophageal reflux disease; for a resident who is vomiting, have the resident lie on their side; and for a pregnant resident, assess the risks versus benefits of applying restraints, etc. These must be documented in the Rationale section of the Physician's Order form.

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; and

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

e. Levels of Observation. There are circumstances when an enhanced level of observation is warranted to ensure the safety of residents and staff. There are also times when situations may warrant a staff member leaving their assigned post to respond to an emergency situation. If a staff member assigned to provide special observation observes an emergency situation that requires immediate intervention to protect residents or staff from serious injury, they may take the necessary steps to assist and then return to their previously assigned post to continue their observation.
6. 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 escalation, avoid confrontation, calm and comfort people, and develop and use a Personal Safety Plan.

   b. Use of nonphysical intervention skills

   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. Identification of specific behavioral changes that indicate the restraint or seclusion is necessary or no longer necessary.

   g. The use of first aid techniques.

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

   i. Use of bodily control and physical management techniques based on a team approach.

7. Procedure:

   a. Section 1 – Personal Safety Plan Procedure:

      (1) Completing the Personal Safety Plan (Form 325):

      The assigned direct care supervisory staff shall complete or update the Personal Safety Plan with the resident in accordance with the requirements of the Personal Safety Plan Guidelines. This includes the completion upon initial admission, transfer from one unit to another, and/or after each manual/seclusion/mechanical procedure or annually if no seclusion or restraint events.

      (2) Utilizing the Personal Safety Plan:

      (a) When a resident is at “baseline,” it means that resident is not experiencing distress and should appear and behave as described in the Personal Safety Plan. Pay attention to potential triggers/stimuli/antecedents and resident’s behaviors in order to be able to anticipate and respond appropriately and prevent any escalation.

      (b) As soon as warning signs and/or escalation 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 3.B.6.
(c) Once the stimulus/trigger/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 who are identified/listed in their Personal Safety Plan. Otherwise, provide staff who 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) If all attempts at de-escalation are unsuccessful, offer other strategies that may be identified in the Personal Safety Plan. Do not question ‘why’ they are behaving as they are. Be patient. Allow the resident time to respond to requests for cooperation. Cue with positive behavior such as “please put down the chair” instead of giving negative commands such as “don’t throw the chair.” Attempt at least three (3) strategies or options identified in the Personal Safety Plan.

(e) When a resident refuses treatment, identifying someone the resident trusts to work with, may be helpful. If at all possible, allow the resident time to calm before administering or discussing the treatment. The decision to manually restrain someone to administer treatment should be a last resort.

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

1. What happened before the escalation, including identified triggers or stimuli?
2. What happened during the escalation, including behaviors demonstrated?
3. How staff intervened.
4. How the resident responded to staff’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 their monthly progress note any triggers or precipitating incidents occurring on their assigned shift. The Personal Advocate shall report this information as soon as possible or at the earliest scheduled Recovery Team meeting.

(b) The Direct Care supervisory 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 any ‘Issue’ derived from the Personal Safety Plan shall document the resident’s progress toward meeting the identified objectives and report progress to the Recovery Team. Any service provider may make recommendations to the Recovery Team to revise the plan as necessary.

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 (Form 236 or Form 237) based on the results of a documented personal examination by the Physician or Registered Nurse.

(b) When a resident presents an imminent danger and a Physician is not immediately available, seclusion or restraint may be initiated prior to the written order.

(c) 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 the 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.

(d) 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, and include assessment of the following:

   1. Resident’s mental status
   2. Resident’s physical condition
   3. A review of the clinical record for any pre-existing medical diagnosis and/or physical conditions
   4. A review of resident’s trauma history which may eliminate the use of seclusion or restraint
   5. A review of medication orders including an assessment of the need to modify such orders during the period of seclusion or restraint, and
   6. 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 is significantly less than not using it.

(e) The Physician’s written order shall:

   1. Be written on the Physician’s Restraint Order (Form 236) or Physician’s Seclusion Order (Form 237) and included in the medical record;
   2. Specify the facts and behaviors presenting imminent and serious danger and
   3. identify the time of implementation and expiration of the authorization;
   4. Specify the type of restrictive procedure;
5. Specify the positioning of the resident during restraint for respiratory and other medical safety considerations as well as consideration of previous trauma history;

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

7. Include a description of behavior indicating the need to release the resident.

(f) Any order for manual restraint will not exceed fifteen (15) minutes in duration.

(g) Each written order for seclusion or mechanical restraint is limited to two (2) hours. The original order may only be renewed at two (2) hour intervals up to a total of 24 hours, in accordance with these limits. While it is encouraged that a Physician performs another face-to-face assessment prior to renewing an order, an order by other licensed independent practitioner [Advanced Registered Nurse Practitioner (ARNP) or Physician’s Assistant (PA)] may be permitted by the facility if stated within their protocol. 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.

(h) The use of the emergency restraint chair is limited to one two-hour (2 hours) use; only one (1) use per twelve hours (12 hours). If further restraint is unavoidable and absolutely necessary, an alternate restraint device may be used after a face-to-face evaluation and new order by a physician. The remaining requirements will be the same as any original order.

(i) If seclusion or mechanical restraint is still absolutely necessary at the end of the 24 hour limit, another face-to-face evaluation by a Physician is required and his/her assessment documented before seclusion or restraint can be reordered.

(j) Every order continuing the use of seclusion or mechanical restraint shall be made only after a face-to-face evaluation by a Physician or Registered Nurse and is documented in Form 606.

(k) 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 5.B.1.b. may not be placed in seclusion or restraint within the following 12 hours without first obtaining authorization from a Physician or Registered Nurse.

(l) The highest level employee available who is trained in restraint application and removal may implement the use of seclusion or mechanical restraint and immediately notify the Registered Nurse (RN) so a Physician’s Order for the use of restraints can be obtained. 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.

(m) For any use of mechanical restraint or seclusion, the family/designated individual shall be notified within ten (10) hours of implementation as requested by the resident in the Personal Safety Plan.

(n) For any seclusion or mechanical restraint exceeding 24 hours, the Hospital Administrator shall be notified by the next business day.
(o) 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 condition.

(p) 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, 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.

6. Time ending shall be included for manual restraint.

(2) Authorizing the Use of Seclusion or Restraint: A 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 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 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 Assessment (Form 606) 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 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 a Resident in Seclusion or Restraint:

(a) Observation: Observation must be at least every 15 minutes for seclusion and continuous for restraint.

1. The resident’s condition must be documented at least every 15 minutes by trained staff for behavior, potential injury, respiration, and circulation.
2. Staff shall document their observations, and sign their name, date and time of observation on the Seclusion/Restraint Flow Sheet (Form 605).

3. A nurse shall observe the resident at least one (1) time per hour, and document the results of the observation in the General Physical Condition section on Form 605.

4. If the observation 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 of a resident in restraint: 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 safety being the primary concern. A restrained resident must be located in an area not subject to view by other residents or passers by, and where the restrained resident is not exposed to potential injury by other residents. If positioning does not assure privacy, a visual barrier, such as a privacy screen, will be utilized.

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. The restraint 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. Toileting shall be allowed upon reasonable demand but must be offered at least once every waking hour. As much as possible, 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. 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 behavior that no longer presents immediate danger.

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

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

(4) Releasing a resident from Seclusion or Restraint:

(a) Every resident in seclusion or restraint shall be informed of the behavior that caused the seclusion or restraint, and the behavior and conditions/criteria necessary for release.

(b) Within 15 minutes or as soon as resident meets criteria and no longer appears to present an imminent danger to self or others, the resident shall be released from seclusion or restraint. 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.

(c) The resident shall have time for structured cooling off based on information in his or her Personal Safety Plan.

(5) After releasing a resident from Seclusion or Restraint:

(a) Staff shall continue to observe the resident and provide behavior support to ensure that resident returns to baseline.

(b) A nurse shall observe, evaluate and document on Form 606 the resident’s physical and psychological condition.

(c) A progress note shall be written by the releasing staff. The note shall include:

1. The date and time of release.

2. The resident’s physical condition.

3. A description of the options offered for structured cooling off, and the resident’s response to the options offered.

4. If the procedure termination occurs due to sleep, the note shall so indicate.

(d) The date and time 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, the 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.
3. Preferably identified for this role on the Personal Safety Plan, when possible.
4. A Registered Nurse who the resident respects or trusts sufficiently for him/her to be open and honest.

(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.
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.
3. Possible alternative behaviors and health coping strategies that may effectively minimize or negate future use of restraint should similar situations, thoughts or emotions occur.

(d) The resident debriefing interview is documented on the Clinical Debriefing Form (Resident) (form 188A). If the resident refuses to engage in the interview within 24 hours after being released from the procedure, the Registered Nurse shall document in the medical record progress notes.

(e) The Registered Nurse shall make another attempt to re-engage him or her and document refusals in the medical record and debriefing results on Form 188A. File form 188A in the medical record.

(f) 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.

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

(2) Debriefing with staff involved: The Unit Director of 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 close of business the following work day.

(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.
6. Ways to resume pre-crisis environment on the unit.

(c) The debriefing interview is documented on the Administrative Debriefing Form (Form 97).

(d) The debriefing interview with staff involved held after a manual restraint is used to administer emergency treatment does not include questions regarding psychiatric 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 Administrative Debriefing Form (Form 97) 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 within two (2) work days and document review on the Clinical Debriefing Form (Recovery Team) (Form 188B).

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. Advise Unit Treatment Supervisory staff to revise the Personal Safety Plan, as needed.

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 the 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 the 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, a Registered Nurse or other medical staff person, and the Florida State Hospital Resident Advocate or designee. The members will function as the required Oversight Committee.

2. An analysis and countermeasures approach to patterns of use and least restrictive approaches should be considered to reduce the frequency and duration of events.

3. Everyone involved in the review shall sign at the bottom of the Administrative Debriefing Form, in the Leadership Review section.

4. The Unit Director shall ensure implementation and tracking of actions resulting from the entire debriefing process.
8. Training Requirements: A check in the box below indicates which employees within the department are required to read this operating procedure and when they will receive training at Florida State Hospital. Employees within identified departments will also be required to review the policy each time it is updated.

<table>
<thead>
<tr>
<th>Department</th>
<th>Worksite Education</th>
<th>New Employee Orientation</th>
<th>Discipline Specific Training</th>
<th>Annual Update</th>
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Signed Original on file in Quality Improvement Program

BOB QUAM
Chief Hospital Administrator

**SUMMARY OF REVISED, ADDED OR DELETED MATERIAL**

Added psychotherapeutic medications to Paragraph 4.n. and 5.c.(14). Added Paragraph 5.c.(21).