

## Restraint & Seclusion Legal Requirements

### I. RESTRAINT AND SECLUSION IN RESIDENTIAL TREATMENT CENTERS (RTCs)

#### a. Important Definitions - 42 C.F.R. § 483.352

- i. **Psychiatric Residential Treatment Center:** means a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting.
- ii. **“Residential treatment center”** means a psychiatric institution that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbances who require a self-contained therapeutic, educational, and recreational program in a residential setting. COMAR 10.07.04.02.
- iii. **Restraint:** Means a “personal restraint,” “mechanical restraint,” or “drug used as a restraint.”
- iv. **Personal Restraint:** means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him or her, or holding a resident's hand to safely escort a resident from one area to another.
- v. **Mechanical Restraint:** means any device attached or adjacent to the resident’s body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.
- vi. **Drug Used as a Restraint:** means any drug that: (1) Is administered to manage a resident’s behavior in a way that reduces the safety risk to the resident or others; (2) Has the temporary effect of restricting the resident’s freedom of movement; and (3) Is not a standard treatment for the resident’s medical or psychiatric condition.
- vii. **Emergency Safety Situation:** means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.
- viii. **Emergency Safety Intervention:** means the use of restraint or seclusion as an immediate response to an emergency safety situation.
- ix. **Seclusion:** means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.
- x. **Time Out:** means the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.
- xi. **Serious Injury:** means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

#### b. COMAR and CFR

- i. In Maryland, the use of restraints and seclusion shall be in compliance with 42 CFR §§ 483.352--483.376 Condition of Participation for the Use of Seclusion and Restraint in

**c. Restraint and Seclusion Policy for the Protection of Residents - 42 CFR § 483.356**

- i. Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.
- ii. An order for restraint or seclusion must not result in harm or injury to the resident and must be used only: (i) to ensure the safety of the resident or others during an emergency safety situation; and (ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.
- iii. Restraint or seclusion must not be used simultaneously.
- iv. Emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).

**d. Who Is Authorized to Order a Restraint or Seclusion?**

- i. Under 42 CFR § 483.358, Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 be provided under the direction of a physician. If the resident's treatment team physician is available, only he or she can order restraint or seclusion. Furthermore, the order must be for the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
- ii. Verbal Orders: The verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

**e. Restraint and Seclusion Orders - 42 CFR § 483.358**

- i. Orders for Restraint or Seclusion Must:
  1. Be limited to no longer than the duration of the emergency safety situation; and
  2. Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9.
- ii. Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and facility to assess the physical and psychological well-being of residents,

must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to:

1. The resident's physical and psychological status;
  2. The resident's behavior;
  3. The appropriateness of the intervention measures; and
  4. Any complications resulting from the intervention.
- iii. Each order for restraint or seclusion must include:
1. The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;
  2. The date and time the order was obtained; and
  3. The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use.

**f. Restraint Monitoring Requirements - 42 C.F.R. § 483.362**

- i. Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.
- ii. If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.
- iii. A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.

**g. Seclusion Monitoring Requirements - 42 C.F.R. § 483.364**

- i. Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement.
- ii. If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.
- iii. A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.

**h. Seclusion Room Requirements**

- i. A room used for seclusion must: (1) Allow staff full view of the resident in all areas of the room; and (2) Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets. 42 CFR § 483.364.

**i. Who Must Be Notified When a Resident is Restrained or Secluded?**

- i. The RTC must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention. Additionally, staff must document in the resident's record that the parent(s)/guardian(s) have been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification. 42 CFR § 483.366.

**j. Postintervention Debriefings Requirements – 42 CFR § 483.370**

- i. Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident's parent(s)/legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s)/guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.
- ii. Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of
  - 1. The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;
  - 2. Alternative techniques that might have prevented the use of the restraint or seclusion;
  - 3. The procedures, if any, that staff are to implement to prevent any reoccurrence of the use of restraint or seclusion; and
  - 4. The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.
- iii. Additionally, staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings

**k. Medical Treatment for Injuries Resulting from an Emergency Safety Intervention - 42 C.F.R. § 483.372**

- i. Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

- ii. The RTC must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that: (1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care; (2) Medical and other information needed for care of the resident in light of such a transfer, will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and (3) Services are available to each resident 24 hours a day, 7 days a week.

**I. Staff Obligations When a Resident is Injured During a Restraint or Seclusion – 42 CFR § 483.372**

- i. Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention. Additionally, Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

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