

DRAFT

Legend: .(Proposed New Rules)

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§415.251. Purpose.

The purpose of this subchapter is to reduce the use of restraint and seclusion as much as possible and to ensure that:

(1) the least restrictive methods of intervention are used and that, wherever possible, alternatives are first attempted and determined ineffective; and

(2) the rights and well-being of individuals are protected during the use of restraint or seclusion for:

(A) a behavioral emergency; or

(B) non-violent, non-self-destructive behavior.

§415.252. Application.

This subchapter applies to the following types of facilities:

(1) a state hospital or a state center operated by the Department of State Health Services;

(2) a psychiatric hospital licensed under Texas Health and Safety Code, Chapter 577 (relating to Private Mental Hospitals and Other Mental Health Facilities) to the extent and as provided by Chapter 134 of this title (relating to Private Psychiatric Hospitals and Crisis Stabilization Units);

(3) a hospital providing mental health services that is licensed under Texas Health and Safety Code, Chapter 241 (relating to Hospitals) to the extent and as provided by Chapter 133 of this title (relating to Hospital Licensing);

(4) a crisis stabilization unit licensed under Texas Health and Safety Code, Chapter 577 (relating to Private Mental Hospitals and Other Mental Health Facilities) and Chapter 134 of this title (relating to Private Psychiatric Hospitals and Crisis Stabilization Units);

(5) the Waco Center for Youth;

(6) a community mental health service provider governed by Chapter 412, Subchapter G, of this title (relating to Mental Health Community Services Standards); and

(7) the Texas Center for Infectious Disease, to the extent that mental health services are provided by that facility pursuant to its authority, under Texas Health and Safety Code, §13.004, to receive an individual who is mentally ill and who is infected with tuberculosis.

§415.253. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Advanced practice registered nurse or APRN--A registered nurse authorized by the Texas Board of Nursing to practice as an advanced practice registered nurse.

(2) Behavioral emergency--A situation involving an individual who is behaving in a violent or self-destructive manner and in which preventive, de-escalative, or verbal techniques have been attempted and determined to be ineffective or clearly would be ineffective and it is immediately necessary to restrain or seclude the individual to prevent:

(A) imminent probable death or substantial bodily harm to the individual because the individual is attempting to commit suicide or inflict serious bodily harm; or

(B) imminent physical harm to others because of acts the individual commits.

(3) Chemical restraint--The use of any chemical, including pharmaceuticals, through topical application, oral administration, injection, or other means, for purposes of restraining an individual and which is not a standard treatment for the individual's medical or psychiatric condition.

(4) Chief executive officer (CEO)--The highest ranking administrator of a facility or such person's designee.

(5) Clinical timeout--A procedure in which an individual, in response to verbal suggestion from a staff member, voluntarily enters and remains for a period of time in a designated area from which the individual is not prevented from leaving.

(6) Competence--Demonstrated knowledge, skill, and ability.

(7) Continuous face-to-face observation--An in-person line of sight that is maintained in an uninterrupted manner and is free of distraction.

(8) Declaration for mental health treatment--A document making a statement of preferences or instructions for mental health treatment as set forth in Texas Civil Practice and Remedies Code, Chapter 137.

(9) DSHS--The Department of State Health Services.

(10) Emergency medical condition--A non-psychiatric medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or a threat to the health or

safety of a pregnant woman or her unborn child.

(11) Episode--The time period from the initiation of restraint or seclusion until the release of the individual.

(12) Face-to-face--Describes a contact with an individual that occurs in person. Face-to-face does not include a contact made through the use of video or telecommunication conferencing or technologies, including telemedicine.

(13) Facility--An entity to which this subchapter applies as identified in §415.252 of this title (relating to Application).

(14) Individual--Any person receiving mental health services from a facility.

(15) Initiate--The first overt act to restrain or seclude an individual.

(16) Legally authorized representative (LAR)--A person authorized by law to act on behalf of an individual with regard to a matter described in this subchapter, and who may include a parent, guardian, managing conservator of a minor individual, guardian of an adult individual, or person with activated power of attorney for health care decisions.

(17) Mechanical restraint--Any device, material, or equipment that immobilizes or reduces the ability of the individual to move his or her arms, legs, body, or head freely.

(18) Personal restraint--Any manual method by which a person holds or otherwise bodily applies physical pressure that immobilizes or reduces the ability of the individual to move his or her arms, legs, body, or head freely.

(19) Physician assistant--A person who is licensed under Texas Occupations Code, Chapter 204.

(20) PRN--As needed (pro re nata).

(21) Protective device--Device used to prevent injury or to permit wounds to heal.

(22) Quiet time--A procedure in which an individual, on the individual's own initiative, enters and remains for a period of time in a designated area from which the individual is not prevented from leaving.

(23) Registered nurse--A person who is licensed under Texas Occupations Code, Chapter 301, and who has demonstrated the clinical competencies required by this subchapter.

(24) Restraint--The use of any personal restraint or a mechanical device that immobilizes or reduces the ability of the individual to move his or her arms, legs, body, or head freely.

(25) Seclusion--The involuntary separation of an individual from other individuals for

any period of time and the placement of the individual alone in an area from which the individual is prevented from leaving.

(26) Seclusion room--A hazard-free room or other area in which direct observation of an individual can be maintained and from which the individual is prevented from leaving.

(27) Staff member--A person directly involved in an individual's care, including professionals granted privileges by the facility, full-time and part-time employees, and contractors.

(28) Supportive device--A device voluntarily used by an individual to posturally support the individual or to assist the individual who cannot obtain or maintain normal bodily functioning.

(29) Treating physician--The physician assigned by the facility and designated in the individual's medical record as the physician responsible for the coordination and oversight of the implementation of an individual's comprehensive treatment plan and who is:

(A) licensed as a physician by the Texas Medical Board in accordance with Texas Occupations Code, Chapter 155; or

(B) authorized to perform medical acts under an institutional permit at a Texas postgraduate training program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Texas Medical Board.

(30) Treatment team--A group of staff members, the individual, and LAR who work together in a coordinated manner for the purpose of providing comprehensive mental health services to an individual.

§415.254. General Requirements for Use of Restraint or Seclusion.

(a) Prohibition. Except as provided by this subchapter, the use of restraint or seclusion is prohibited.

(b) Use of personal or mechanical restraint or seclusion. The use of personal or mechanical restraint or seclusion is permissible on the facility's premises or for transportation of an individual only if implemented:

(1) in accordance with this subchapter;

(2) in accordance with, and using only those safe and appropriate techniques as determined by the facility's written policies or procedures and training program as specified in subsection (e) of this section;

(3) by staff who have been trained in accordance with the applicable requirements specified in §415.257 of this title (relating to Staff Training);

(4) in connection with the applicable evaluation and monitoring requirements specified in §415.266 of this title (relating to Observation, Monitoring and Care of the Individual in Restraint or Seclusion Initiated in Response to a Behavioral Emergency);

(5) in accordance with the applicable initiation and physician order requirements specified in section §415.260 of this title (relating to Initiation of Restraint or Seclusion in a Behavioral Emergency);

(6) in accordance with §415.259(c) of this title (relating to Special Considerations, Responsibilities, and Alternative Strategies) the alternative strategies to using restraint and seclusion documented in the treatment plan;

(7) when less restrictive interventions (such as those listed in the safety plan if there is one) are determined ineffective to protect other individuals, the individual, staff, or others from harm;

(8) when the type or technique of restraint or seclusion used is the least restrictive intervention that will be effective to protect the other individuals, the individual, staff, or others from harm; and

(9) is discontinued at the earliest possible time, regardless of the length of time identified in a physician's order.

(c) Facility requirements. A facility's use of restraint and seclusion is prohibited unless:

(1) the facility adopts, implements, and enforces written policies and procedures, in accordance with this subchapter, governing the use of restraint and seclusion;

(2) the facility adopts, implements, and enforces a staff training program that meets the requirements of §415.257 of this title; and

(3) staff members of the facility are trained and have demonstrated competence in the use of restraint and seclusion in accordance with the facility's written policies and procedures and training program before assuming direct care duties and before performing restraint and seclusion on the individual.

(d) Policy notification. Upon admission of an individual, or as soon as possible thereafter, the facility shall notify each individual and each individual's legally authorized representative (LAR) of the facility's policies related to the use of restraint and seclusion.

(e) This subchapter represents minimum standards. The facility may, through its written policies and procedures, adopt more stringent standards that are consistent with this subchapter and do not conflict with:

(1) department rules;

- (2) state or federal laws; and
- (3) applicable accreditation standards.

§415.255. Prohibited and Restricted Practices.

(a) The following practices are prohibited:

(1) a personal or mechanical restraint shall not be used that:

(A) obstructs the individual's airway, including a procedure that places anything in, on, or over the individual's mouth or nose;

(B) impairs the individual's breathing, including applying pressure to the individual's torso or neck;

(C) restricts circulation;

(D) secures an individual to a stationary object while the individual is in a standing position;

(E) causes pain to restrict an individual's movement (pressure points or joint locks); and

(F) inhibits, reduces, or hinders the individual's ability to communicate.

(2) a chemical restraint.

(b) A prone or supine hold shall not be used during a restraint. Should an individual become prone or supine during a restraint, then any staff member involved in administering the restraint shall immediately transition the individual to a side lying or other appropriate position.

(c) Neither restraint nor seclusion shall be used:

(1) as a means of discipline, retaliation, punishment, or coercion;

(2) for the purpose of convenience of staff or other individuals; or

(3) as a substitute for effective treatment or habilitation.

(d) Seclusion shall not be used for the management of non-violent, non-self-destructive behavior.

§415.256. Mechanical Restraint Devices.

(a) If a facility's policies and procedures permit the use of mechanical restraint, only commercially available or departmentally approved devices specifically designed for the safe and comfortable restraint of humans shall be used. Any alteration of commercially available devices or independent development of devices must:

(1) be based on the individual's special physical needs, if any (e.g., obesity or physical impairment);

(2) take into consideration any potential medical (including psychiatric) contraindications, including, without exception, any history of physical or sexual abuse;

(3) be approved by a committee whose membership and functions are specified in the bylaws of the medical staff of the facility; and

(4) be described fully in writing, with a copy of the description forwarded to the DSHS medical director for behavioral health for review. Such altered or independently developed device may not be used by the facility unless and until its use is approved, in writing, by the DSHS medical director for behavioral health.

(b) A staff member shall inspect a device before and after each use to ensure that it is clean, in good repair, and is free from tears or protrusions that may cause injury. Damaged devices shall not be used to restrain an individual and shall be repaired or discarded.

(c) Regardless of their commercial availability, the following types of devices shall not be used to implement restraint:

(1) those with metal wrist or ankle cuffs;

(2) those with rubber bands, rope, cord, or padlocks or key locks as fastening devices;

(3) long ties (e.g., leashes);

(4) bed sheets;

(5) gags; and

(6) spit hoods, or anything that obstructs an individual's airway, including a device that places anything in, on, or over the individual's mouth or nose.

(d) Except as otherwise permitted in this subsection, all forms of restraint, as well as a form of restraint in conjunction with seclusion, are intended to be used independently of one another. The physician shall document the clinical justification in the individual's medical record for the simultaneous use of more than one mechanical device, a mechanical device and personal restraint, a mechanical device and seclusion, or personal restraint and seclusion.

(e) The following are approved mechanical devices.

(1) Anklets--Padded bands of cloth or leather that are secured around the individual's ankles or legs using hook-and-loop (e.g., Velcro®) or buckle fasteners and attached to a stationary object (e.g., bed or chair frame). The device shall not be secured so tightly as to interfere with circulation, or so loosely as to permit chafing of the skin.

(2) Arm splints or elbow immobilizers--Strips of any material with padding that extend from below to above the elbow and which are secured around the arm with ties or hook-and-loop (e.g., Velcro®) tabs. If appropriate under the circumstances, they shall be secured so that the individual has full use of the hands. The device shall not be secured so tightly as to interfere with circulation, or so loosely as to permit chafing of the skin.

(3) Belts--A cloth or leather band that is fastened around the waist and secured to a stationary object (e.g., chair frame) or used for securing the arms to the sides of the body. The device shall not be secured so tightly as to interfere with breathing or circulation.

(4) Camisole--A sleeveless cloth jacket that covers the arms and upper trunk and is secured behind the individual's back. The device shall not be secured so tightly as to interfere with breathing or circulation or to cause muscle strain. Staff shall exercise caution when using this device, if at all, because it may impair balance and the individual's ability to break a fall.

(5) Chair restraint--A padded stabilized chair that supports all body parts and prevents the individual's voluntary egress from the chair without assistance (e.g., tabletop chair, Geri-chair). When wristlets or anklets are used to restrict movement from the chair, the devices must not be secured so tightly as to interfere with breathing or circulation.

(6) Enclosed bed--A bed with high side rails or another type of side enclosure and, in some cases, an enclosure (e.g., mesh or rails) over the bed that prevents the individual's voluntary egress from the bed without assistance.

(7) Helmet--A plastic, foam rubber, or leather head covering, such as a sports helmet, that may include an attached face guard. The device shall be the proper size and the chinstrap shall not be so tight as to interfere with breathing or circulation.

(8) Mittens--A cloth, plastic, foam rubber, or leather hand covering such as boxing and other types of sport gloves that are secured around the wrist or lower arm with elastic, hook-and-loop (e.g., Velcro®) tabs, ties, paper tape, pull strings, buttons, or snaps. The device shall not be secured so tightly as to interfere with circulation.

(9) Restraining net--Mesh fabric that is placed over an individual's upper and lower trunk with the head, arms, and lower legs exposed; the net shall be secured over a mattress to a bed frame and shall never be placed over the individual's head. The restraining net shall be loose enough to allow some movement. The device shall not be secured so tightly as to interfere with breathing or circulation.

(10) Restraint bed--A stretcher of steel frame construction with a fabric cover. The restraint bed shall have an adjustable backrest and a padded mat which shall be used under the individual's head and upper body to prevent injury. Approved wristlets, anklets, and belts shall be used to safely and securely limit the individual's physical activity.

(11) Restraint board--A padded, rigid board to which an individual is secured face-up, unless that position is clinically contraindicated for that individual, in which case a clinically indicated position will be used and documented. This device shall not be used to restrain an individual in a behavioral emergency except when necessary to promptly transport an individual to another location.

(12) Restraint chair or gurney--A chair or gurney manufactured for the purpose of transporting or restraining an individual who must remain restrained during transport.

(13) Ties--A length of cloth or leather used to secure approved mechanical restraints (e.g., mittens, wristlets, arm splints, belts, anklets, vests) to a stationary object (e.g., bed or wheelchair frame) or to another approved mechanical restraint. Ties shall not be secured so tightly as to interfere with breathing or circulation.

(14) Transport jacket--A heavy canvas sleeveless jacket that encases the arms and upper trunk, fastens with hook-and-loop (e.g., Velcro®) tabs and roller buckles, and is held in place with a strap between the legs. The device shall be used only as a temporary measure during transport.

(15) Vest--A sleeveless cloth jacket that covers the upper trunk and is fastened in the back or front with ties or hook-and-loop tabs (e.g., Velcro®). The vest may be secured to a stationary object (e.g., bed or chair frame). The vest and ties shall not be secured so tightly as to interfere with breathing or circulation.

(16) Wristlets--Padded cloth or leather bands that are secured around the individual's wrists or arms using hook-and-loop (e.g., Velcro®) or buckle fasteners and attached to a stationary object (e.g., bed frame, chair frame, or waist belt). The device shall not be secured so tightly as to interfere with circulation or so loosely as to permit chafing of the skin.

§415.257. Staff Training.

(a) The facilities to which this subchapter applies shall ensure that all staff members are informed of their roles and responsibilities under this subchapter and are trained and demonstrate competence accordingly.

(b) The training program shall:

(1) be standardized throughout each facility;

(2) emphasize the importance of reducing and preventing the unnecessary use of restraint and seclusion;

(3) be evaluated annually, which shall include evaluation to ensure that the training program, as planned and as implemented, complies with the requirement of this section;

(4) incorporate evidence-based best practices;

(5) provide information about declarations for mental health treatment, including:

(A) the right of individuals to execute declarations for mental health treatment; and

(B) the duty of staff members and other health care providers to act in accordance with declarations for mental health treatment to the fullest extent possible.

(c) Before assuming job duties involving direct care responsibilities, and at least annually thereafter, all staff members must receive training and demonstrate competence in at least the following knowledge and applied skills that shall be specific and appropriate to the population(s) the facility serves:

(1) using team work, including team roles and techniques for facilitating team communication and cohesion;

(2) identifying the causes of aggressive or threatening behaviors of individuals who need mental health services, including behavior that may be related to an individual's non-psychiatric medical condition;

(3) identifying underlying medical, physical, and emotional conditions;

(4) identifying medications and their potential effects;

(5) identifying how age, weight, developmental level or functioning, gender, culture, ethnicity, and elements of trauma-informed care, including history of abuse or trauma and prior experience with restraint or seclusion, may influence behavioral emergencies and affect the individual's response to physical contact and behavioral interventions;

(6) explaining how the behavior of staff members can affect an individual's behavior and how the behavior of individuals can affect a staff member;

(7) applying knowledge and effective use of a range of early intervention, de-escalation, mediation, problem-solving, and other non-physical interventions, such as clinical timeout and quiet time; and

(8) recognizing and appropriately responding to signs of physical distress in individuals who are restrained or secluded, including the risks of asphyxiation, aspiration, and trauma.

(d) Before any staff member may initiate any restraint or seclusion the staff person shall receive training and demonstrate ongoing competence in:

(1) safe, appropriate, and effective methods, initiation, and use of seclusion as a last resort in a behavioral emergency;

(2) safe, appropriate, and effective methods, initiation and application, and use of personal restraint as a last resort in a behavioral emergency;

(3) safe, appropriate, and effective methods, initiation and application, and use of mechanical restraint devices as a last resort in a behavioral emergency or as a protective or supportive device, and knowledge of the mechanical restraint devices permitted under §415.256 of this title (relating to Mechanical Restraint Devices) and approved by the facility; and

(4) management of emergency medical conditions in accordance with the facility's policies and procedures and other applicable requirements for:

(A) obtaining emergency medical assistance; and

(B) obtaining training in and using techniques for cardiopulmonary respiration and removal of airway obstructions.

(e) Before assuming job duties, and at least annually thereafter, a registered nurse who is authorized to perform assessments of individuals who are in restraint or seclusion shall receive training, which shall include a demonstration of competence, or demonstrate ongoing competence in:

(1) monitoring cardiac and respiratory status and interpreting their relevance to the physical safety of the individual in restraint or seclusion;

(2) recognizing and responding to nutritional and hydration needs;

(3) checking circulation in, and range of motion of, the extremities;

(4) providing for hygiene and elimination;

(5) addressing physical and psychological status and comfort, including signs of distress;

(6) assisting individuals in de-escalating, including through identification and removal of stimuli, if known;

(7) recognizing when continuation of restraint or seclusion is no longer justified by a behavioral emergency; and

(8) recognizing when to contact emergency medical services to evaluate and/or

treat an individual for an emergency medical condition.

(f) Before assuming job duties, and at least annually thereafter, staff members who are authorized to monitor, under the supervision of a registered nurse, individuals during restraint or seclusion shall receive training that shall include a demonstration of competence, or shall demonstrate ongoing competence in:

- (1) monitoring respiratory status;
- (2) recognizing nutritional and hydration needs;
- (3) checking circulation in, and range of motion of, the extremities;
- (4) providing for hygiene and elimination;
- (5) addressing physical and psychological status and comfort, including signs of distress;
- (6) assisting individuals in de-escalating, including through identification and removal of stimuli, if known.
- (7) recognizing when continuation of restraint or seclusion is no longer justified by a behavioral emergency; and
- (8) recognizing when to contact a registered nurse.

(g) Physicians, and physician assistants, and registered nurses who are authorized to perform evaluations of individuals who are restrained or secluded shall receive training that shall include a demonstration of competence, or demonstrate the competencies described in subsections (e) and (f) of this section, and shall receive training that shall include a demonstration of competence, or demonstrate competence, in:

- (1) identifying restraints that are permitted by the facility, by this subchapter, and by other applicable law;
- (2) identifying stimuli that trigger behaviors that meet the criteria for a behavioral emergency;
- (3) identifying medical contraindications to restraint and seclusion; and
- (4) recognizing psychological contraindications to restraint and seclusion, such as sexual abuse, physical abuse, neglect, and trauma.

(h) When a staff member's duties change, the facility shall reassess the staff member's training and competence and require and ensure the staff member's retraining, as required under this subchapter, based upon the facility's reassessment and the staff member's new duties.

(i) The facility shall maintain documentation of training for each staff member. Documentation shall include the date that training was completed, the name of the instructor, a list of successfully demonstrated competencies, the date competencies were assessed, and the name of the person who assessed competence.

§415.258. Actions to be Taken to Release from Restraint or Seclusion in a Medical or Environmental Emergency.

(a) Emergency medical condition. If an individual experiences an emergency medical condition while in restraint or seclusion, the staff member providing continuous face-to-face observation of the individual or other staff member must release the individual from restraint or seclusion as soon as possible, as indicated by the emergency medical condition.

(1) The facility shall ensure that the individual's emergency medical condition is promptly addressed and that aid is rendered to the extent possible in accordance with the facility's policies and procedures for management of emergency medical conditions.

(2) Unlocking the seclusion room door or fully releasing the restraints ends the episode.

(3) If the situation continues to meet the criteria for a behavioral emergency after the individual's emergency medical condition is addressed, a staff member must obtain a new order for restraint or seclusion.

(b) Emergency evacuation. If an emergency evacuation or evacuation drill occurs while an individual is in restraint or seclusion, staff members shall implement the facility's established procedures to ensure the individual's safety.

§415.259. Special Considerations, Responsibilities, and Alternative Strategies.

(a) Special considerations. Before ordering restraint or seclusion, the physician shall take the following into consideration:

(1) information about the individual that could contraindicate or otherwise affect the use of restraint or seclusion;

(2) information obtained during the initial assessment of each individual at the time of admission or intake, including, but not limited to:

(A) pre-existing medical conditions or any physical disabilities and limitations, including, without limitation, substance use disorders, obesity, or pregnancy, that would place the individual at greater risk during restraint or seclusion;

(B) any history of sexual abuse, physical abuse, neglect, or trauma that would place the individual at greater psychological risk during restraint or seclusion;

(C) any history or trauma that would contraindicate seclusion, the type of restraint (personal or mechanical), or a particular type of restraint device for the individual;

(D) cultural factors; and

(E) information contained in an advance directive for mental health treatment, if there is one.

(b) Staff member responsibilities. Staff members shall:

(1) respect and preserve the rights of an individual during restraint or seclusion. Rights of individuals are described in Chapter 404, Subchapter E, of this title (relating to Rights of Persons Receiving Mental Health Services);

(2) provide an environment that is protected and private from other individuals and that safeguards the personal dignity and well-being of an individual placed in restraint or seclusion;

(3) ensure that undue physical discomfort, harm or pain to the individual does not occur when initiating or using restraint or seclusion;

(4) use only the amount of physical force that is reasonable and necessary to implement a particular restraint or seclusion; and

(5) use psychoactive medication in an emergency only in accordance with Chapter 414, Subchapter I of this title (relating to Consent to Treatment with Psychoactive Medication). Physically holding an individual during a forced administration of a psychoactive medication, including for court-ordered medication, constitutes personal restraint.

(c) Alternative strategies. The treatment team shall review and, when appropriate, implement and document alternative strategies for dealing with behaviors in each of the following circumstances:

(1) in any case in which behaviors have necessitated the use of restraint or seclusion for the same individual more than two times during the individual's facility or program admission, or within any 30-day period, whichever period is shorter;

(2) when two or more separate episodes of restraint or seclusion of any duration have occurred within the same 12 hour period; and

(3) when an episode of restraint or seclusion has continued for more than the maximum time permitted under §415.261(b) of this title (relating to Time Limitation on an Order for Restraint or Seclusion Initiated in Response to a Behavioral Emergency).

(d) Treatment plan modification. If the circumstances described in subsection (c)(1) - (3)

of this section recur or continue after treatment team review of alternative strategies under subsection (c) of this section, the treatment team shall consult with the facility medical director or designee to explore alternative treatment strategies and a written modification of the individual's treatment plan.

§415.260. Initiation of Restraint or Seclusion in a Behavioral Emergency.

(a) Initiation.

(1) Only staff authorized by the facility's policies and procedures and who have met the training requirements of §415.257 of this title (relating to Staff Training) and demonstrated competency in the facility's restraint and seclusion training program, may initiate personal restraint in a behavioral emergency.

(2) Only a physician or registered nurse may initiate mechanical restraint or seclusion.

(b) Physician's order. Only a physician member of the facility's medical staff may order restraint or seclusion.

(1) The physician's order for restraint or seclusion shall:

(A) designate the specific intervention and procedures authorized, including any specific measures for ensuring the individual's safety, health, and well-being;

(B) specify the date, time of day, and maximum length of time the intervention and procedures may be used, consistent with the time limitations provided for under §415.261 of this title;

(C) describe the specific behaviors which constituted the behavioral emergency which resulted in the need for restraint or seclusion;

(D) describe the less restrictive interventions attempted and the reasons they were determined to be ineffective and/or unlikely to protect the individual or others from harm; and

(E) be signed and dated, including the time of the order, by the physician or the registered nurse who accepted the prescribing physician's telephone order.

(2) If restraint or seclusion was ordered by telephone, the ordering physician shall personally sign and date the telephone order, including the time of the order, within 24 hours of the time the order was originally issued.

(3) If the physician who ordered the intervention is not the treating physician, the physician ordering the intervention shall consult with the treating physician or physician designee as soon as possible. The physician who ordered the intervention shall document the

consultation in the individual's medical record.

(c) Face-to-face evaluation.

(1) Except as authorized by paragraph (4) of this subsection, a physician or a registered nurse, who is trained to assess medical and psychiatric stability with demonstrated competence, other than the registered nurse who initiated the use of restraint or seclusion, shall conduct a face-to-face evaluation of the individual within one hour following the initiation of restraint or seclusion to personally verify the need for restraint or seclusion.

(2) At a facility accredited as a residential treatment program, such as Waco Center for Youth, a physician or a registered nurse who is trained to assess medical and psychiatric stability with demonstrated competence, other than the registered nurse who initiated the use of restraint or seclusion shall conduct the face-to-face evaluation within two hours following the initiation of restraint or seclusion unless the individual is released prior to the expiration of the original order. If the individual is released prior to the expiration of the original order, the physician or registered nurse, shall conduct the face-to-face evaluation within 24 hours.

(3) The face-to-face evaluation includes, but is not limited to, an assessment of the:

- (A) individual's immediate situation;
- (B) individual's reaction to the restraint or seclusion;
- (C) individual's medical and behavioral condition; and
- (D) need to continue or terminate the restraint or seclusion.

(4) A physician may delegate the face-to-face evaluation to a physician assistant who is:

- (A) privileged to practice in the facility or that portion of the facility to which this subchapter applies; and
- (B) under the clinical supervision of a physician appointed by the facility's medical staff and privileged to practice in the facility or that portion of the facility.

(5) If a physician assistant to whom the physician has delegated the face-to-face evaluation or a registered nurse who has conducted the face-to-face evaluation, in his or her professional judgment determines that the physician should evaluate the individual due to circumstances that are outside the physician assistant's or registered nurse's scope of practice or expertise, the physician assistant or registered nurse shall contact a physician and request that the physician perform a face-to-face evaluation of the individual. The physician assistant or registered nurse shall document the determination in the individual's medical record.

(6) If the face-to-face evaluation is conducted by a registered nurse or physician assistant, the registered nurse or physician assistant shall consult the physician who is responsible for the care of the individual as soon as possible after the completion of the one hour face-to-face evaluation and document the consultation in the individual's medical record.

§415.261. Time Limitation on an Order for Restraint or Seclusion Initiated in Response to a Behavioral Emergency.

(a) Original order. A physician may order restraint or seclusion for a period of time not to exceed:

- (1) 15 minutes for personal restraint;
- (2) one hour for mechanical restraint or seclusion for individuals under the age of 9;
- (3) two hours for mechanical restraint or seclusion for individuals ages 9 - 17; and
- (4) four hours for mechanical restraint or seclusion for individuals age 18 and older.

(b) Renewed order. If the original order has not yet expired and the registered nurse has evaluated the individual face-to-face and determined the continuing existence of a behavioral emergency, the registered nurse must contact the physician. The physician shall conduct a face-to-face evaluation before issuing or renewing an order that continues the use of the restraint or seclusion. A physician may renew the original order provided it would not result in the use of:

- (1) personal restraint beyond 15 minutes total;
- (2) mechanical restraint or seclusion beyond two hours total for individuals under age 9;
- (3) mechanical restraint or seclusion beyond four hours total for individuals ages 9 - 17; or
- (4) mechanical restraint or seclusion beyond eight hours total for individuals age 18 and older.

(c) Renewal documentation. The physician shall document the clinical justification for continuing the restraint or seclusion before issuing or renewing an order that continues the use of restraint or seclusion.

§415.262. Family Notification.

(a) The CEO or CEO's designee shall notify the individual's legally authorized

representative if any, or authorized family member of each episode of restraint or seclusion initiated for the management of a behavioral emergency as follows:

(1) except as provided by 42 Code of Federal Regulations, Part 2, and subsection (c) of this section, a staff member shall notify as soon as possible, but no later than 12 hours following the initiation of the restraint or seclusion, the legally authorized representative of a minor under age 18 who is not or has not been married.

(2) except as provided by subsection (c) of this section, in cases in which the adult individual has consented to have one or more specified family members informed regarding the individual's care, and the family member or members have agreed to be informed, a staff member will inform the family member or members of the restraint or seclusion episode within the time frame determined by prior agreement between the individual and specified family member(s).

(b) The date and time of notification and the name of the staff member providing the notification must be documented in the individual's medical record. The documentation shall include any unsuccessful attempts, the phone number called, and the name(s) of person(s) with whom the staff member spoke.

(c) As permitted by Texas Health and Safety Code, §611.0045(b), a professional may deny an individual's legally authorized representative access to any portion of an individual's record if the facility determines that the disclosure of such portion would be harmful to the individual's physical, mental, or emotional health.

§415.263. Safekeeping of Personal Possessions During Mechanical Restraint or Seclusion.

(a) The individual's right to retain personal possessions and personal articles of clothing may be suspended during mechanical restraint or seclusion when necessary to ensure the safety of the individual or others as described in Chapter 404, Subchapter E of this title (relating to Rights of Persons Receiving Mental Health Services).

(b) An inventory of any personal possessions or personal articles of clothing temporarily taken from the individual shall be listed in the individual's medical record. The inventory shall be witnessed by two staff members who shall sign or authenticate this list in individual's medical record. If personal articles of clothing are taken from the individual, appropriate other clothing shall be issued.

(c) The items shall be kept in a locked place.

(d) Upon release of the individual from a restraint, seclusion, or combination of the two, the individual, if willing, and two staff members shall be asked to sign documentation in the individual's medical record indicating the status of items returned and the date and time the items were returned.

(e) If the individual is unwilling to sign the documentation, a staff member shall

document the refusal in the individual's medical record and list the items that were returned to the individual, the time they were returned, and the staff member who returned the items.

§415.264. Restraint Off Facility Premises or for Transportation.

(a) All off-premises transport. A registered nurse or physician assistant, as appropriate to the individual's clinical condition and the requirements of this subchapter, shall accompany the staff member(s) transporting an individual off premises when there is reason to believe that during the time away from the facility the individual may require:

- (1) .medical attention;
- (2) .administration of medication; or
- (3) .restraint.

(b) Excursion off facility premises. A staff member may not restrain an individual being transported off facility premises unless the individual meets the criteria for a behavioral emergency, a physician orders the restraint, and transport is medically necessary with documented clinical justification.

(1) If restraint is required while an individual is on an excursion off facility premises, the staff member initiating the restraint shall contact a registered nurse to assist in obtaining a physician's order for the restraint as soon as feasible within the applicable timeframes prescribed in this subchapter.

(2) The staff members on the excursion shall implement, monitor, document, and report, in accordance with the requirements of this subchapter, any episode of restraint that occurs off premises.

(c) Restraint initiated prior to transportation. A staff member may not restrain an individual being transported prior to departure unless the situation meets the criteria for a behavioral emergency or the individual has been determined and documented manifestly dangerous according to Subchapter G of this Chapter (relating to Determination of Manifest Dangerousness) within one month prior to transportation, a physician orders the restraint, and transport is medically necessary with documented clinical justification.

(1) If a behavioral emergency exists and a physician orders restraint prior to departure, at least one of the staff members accompanying the individual to the destination facility shall be a registered nurse.

(2) A female staff member shall accompany a female individual.

(3) If the duration of transport exceeds the maximum allowable duration of restraint on the original order, and a behavioral emergency continues to exist, or the person has been determined manifestly dangerous within one month prior to transportation, the registered

nurse may either obtain a physician's telephone order to renew the restraint or obtain a new order for restraint, and renewal, as soon as feasible but within the applicable timeframes prescribed in this subchapter.

(4) Staff members accompanying the individual from the originating facility shall implement, monitor, document, and report, in accordance with the requirements of this subchapter, a restraint that is ordered and implemented prior to transportation. If transportation is for the purposes of transfer to another facility, staff at the originating facility must fax the required documentation to the destination facility on the day of transport. Staff members at the destination facility are responsible for filing the documentation in the individual's medical record at the destination facility.

(d) Restraint initiated during transportation. If restraint is required following departure, a registered nurse shall obtain a physician's order from the originating facility for any restraint as soon as feasible within the applicable timeframes prescribed in this subchapter. If a registered nurse is not present during transportation, the staff member initiating any restraint shall contact a registered nurse to obtain a physician's order for the restraint as soon as possible within the applicable timeframes prescribed in this subchapter.

(1) If an individual is restrained during transportation, the staff member accompanying the individual shall implement, monitor, document, and report the episode of restraint in accordance with the requirements of this subchapter, and shall ensure that all documentation required under this subchapter relating to the restraint, including the physician's order, is transmitted to the destination facility within 24 hours following the time the individual is delivered to the destination facility.

(2) Staff members at the originating facility shall document and report restraint that is ordered and implemented during transportation. Staff members at the destination facility shall maintain documentation of the restraint at the destination facility.

(e) Comfort during transportation. The staff members shall provide an individual in restraint during transport the care required under §415.266(c) of this title (relating to Observation, Monitoring, and Care of the Individual in Restraint or Seclusion Initiated in Response to a Behavioral Emergency).

§415.265. Communicating with the Individual During Restraint or Seclusion Initiated in Response to a Behavioral Emergency.

(a) As soon as feasible after restraint or seclusion has been implemented in response to a behavioral emergency, the staff member shall refer to the individual's declaration for mental health treatment, if any, as a reference in determining and implementing an individual's preferences. The staff person shall communicate reassurance and commitment to the individual's safety on an ongoing basis, including inquiring as to how the staff member can assist the individual to de-escalate.

(b) Communication with the individual shall be conducted in a language or by a method

that is understandable to the individual (e.g., American Sign Language, Spanish, Vietnamese) and that accommodates the individual's method of communication (e.g., releasing a hand of an individual who communicates using American Sign Language).

(c) A staff member shall document in the individual's medical record all attempts to communicate with the individual and the individual's response to these attempts.

§415.266. Observation, Monitoring, and Care of the Individual in Restraint or Seclusion Initiated in Response to a Behavioral Emergency.

(a) Observation.

(1) A staff member of the same gender as the individual shall maintain continuous face-to-face observation of an individual in mechanical restraint, unless the individual's history or other factors indicate this would be contraindicated (e.g., sexual or physical abuse perpetrated by someone of the same gender, in which case a staff member of the opposite gender may be used).

(2) A staff member who is not physically applying personal restraint shall maintain continuous face-to-face observation of an individual in personal restraint.

(3) A staff member shall maintain continuous face-to-face observation of an individual in seclusion for at least one hour. After one hour, the staff member may monitor the individual continuously using simultaneous video and audio equipment in close proximity to the individual.

(b) Monitoring. Staff shall ensure adequate respiration and circulation of the individual in restraint at all times.

(1) Respiratory status, circulation, and skin integrity must be monitored continuously and documented every 15 minutes (or more often if deemed necessary by the ordering physician). Cardiac status must be monitored and documented hourly (or more often if deemed necessary by the ordering physician).

(2) An assigned staff member must perform range of motion exercises for each extremity, one extremity at a time, for at least five minutes no less frequently than every 60 minutes that an individual is in mechanical restraint.

(c) Care. Staff must provide for the hygiene, hydration, nutrition, elimination needs, and safety of an individual in restraint or seclusion. The individual in restraint or seclusion shall be provided:

(1) bathroom privileges at least once every two hours (or more frequently, if requested and not contraindicated, or otherwise required by the individual's circumstances and physical or medical needs);

(2) an opportunity to drink water or other appropriate liquids every two hours (or more frequently, if requested and not contraindicated, or otherwise required by the individual's circumstances and physical or medical needs);

(3) a bath at least once daily (or more frequently, if clinically indicated or in the presence of incontinence);

(4) medications and medical equipment as ordered;

(5) regularly scheduled meals and snacks served on dishes that are appropriate for safety; and

(6) an environment that is free of safety hazards, adequately ventilated during warm weather, adequately heated during cold weather, and appropriately lighted.

§415.267. Safe and Appropriate Techniques for Restraint or Seclusion.

(a) .A facility shall ensure that:

(1) when personal restraint is used, staff members act to protect the individual's privacy as much as possible without compromising the safety of individuals or staff members during the episode;

(2) if the individual does not calm and mechanical restraint is required, the individual is moved to a protected environment observable by other staff members and away from other individuals as soon as possible;

(3) when a mechanical restraint is used, the individual has a protected environment that is observable by other staff members and is away from other individuals that safeguards the individual's personal dignity and well-being;

(4) the individual is protected (e.g., from assault by others) while in restraint or seclusion; and

(5) the facility uses a seclusion room, as defined in §415.253 of this title (relating to Definitions), for any individual placed in seclusion.

(b) .A facility shall develop and implement policies and procedures to ensure that it is in compliance with the requirements of this section.

§415.268. Actions to be Taken when an Individual Falls Asleep in Restraint or Seclusion Initiated in Response to a Behavioral Emergency.

(a) If the individual appears to fall asleep while in mechanical restraint or seclusion, the registered nurse shall assess the individual to determine if the individual is asleep.

(b) If the individual is determined to be asleep, the registered nurse shall instruct authorized staff to immediately release the individual from restraint or unlock the seclusion room door. Authorized staff shall maintain continuous face-to-face observation until the individual is awake and re-evaluated by the registered nurse.

(c) The registered nurse shall assess the individual upon awakening.

(d) If the individual exhibits behaviors requiring restraint or seclusion upon awakening, the registered nurse shall obtain a new physician's order for any new initiation of restraint or seclusion.

§415.269. Transfer of Primary Responsibility for Individual in Restraint or Seclusion.

(a) At the time of transfer of primary responsibility between staff members for the individual in restraint or seclusion, including transfer of responsibility at the change of shift, the staff member with primary responsibility must meet with the staff member who will assume primary responsibility to review the individual's status. A staff member shall monitor the individual during the transfer process.

(b) The review shall be documented and shall include:

- (1) information regarding the time a restraint or seclusion was initiated;
- (2) the nature of the circumstances requiring restraint or seclusion;
- (3) the current status of the individual's physical, emotional, and behavioral condition;
- (4) any medication administered; and
- (5) the type of care needed.

§415.270. Release of an Individual from Restraint or Seclusion.

(a) Personal restraint. When a personal restraint has been initiated by a staff member, but the individual has not yet been evaluated by a physician, a physician's assistant, or a registered nurse, and the staff member determines that the individual's behavior has changed sufficiently to no longer require the personal restraint, the staff member must immediately release the individual from the restraint but shall remain with the individual until a physician, physician's assistant, or registered nurse has evaluated the individual for release based on a determination that the individual no longer requires the restraint or seclusion.

(b) Mechanical restraint or seclusion. When a mechanical restraint or seclusion has been initiated by a staff member, and the unsafe situation ends, a staff member shall contact a physician, a physician's assistant, or a registered nurse. The physician, physician's assistant, or registered nurse must evaluate the individual for release based on a determination as to whether

the unsafe situation continues. Staff must immediately release an individual whose behavior has been evaluated by a physician, physician's assistant, or registered nurse and determined to no longer require the restraint or seclusion.

§415.271. Actions to be Taken Following Release of an Individual from Restraint or Seclusion Initiated in Response to a Behavioral Emergency.

(a) Immediately following the release of an individual from restraint or seclusion, a staff member shall:

(1) take appropriate action to facilitate the individual's reentry into the social milieu by providing the individual with transition activities and an opportunity to return to ongoing activities;

(2) observe the individual for at least 15 minutes; and

(3) document in the individual's medical record the steps taken and observations made of the individual's behavior during this transition period.

(b) The facility shall conduct or attempt to conduct the debriefings described under subsection (c) of this section. Based on those debriefings, the facility shall:

(1) identify what led to the episode and what could have been handled differently;

(2) identify strategies to prevent future restraint or seclusion of the individual, taking into consideration suggestions from the individual and the individual's declaration for mental health treatment, if any;

(3) ascertain whether the individual's physical well-being, psychological comfort, including trauma, and right to privacy were protected or otherwise addressed, as applicable;

(4) counsel the individual(s) in relation to any trauma that may have resulted from the episode; and

(5) when indicated, make appropriate modifications to the individual's treatment plan and/or the treatment plans of other individuals.

(c) Following an episode of restraint or seclusion, the facility shall conduct, or attempt to conduct, the following debriefings.

(1) Within 24-72 hours after the episode's end, staff members who were involved in the episode, other staff, and supervisors shall debrief together as a support mechanism and to identify successes, problems, or necessary modifications.

(2) Within 24-48 hours after the episode's end, a staff member or members with whom the individual feels comfortable shall conduct a private discussion with the individual, the

individual's LAR, and family members with the consent of the individual.

(3) Within 24-48 hours after the episode's end and when clinically indicated or upon request of individuals who witnessed the restraint, a staff member or members with whom they feel comfortable shall have a private discussion with individuals who witnessed the restraint.

(d) The debriefings, and/or attempts, shall be documented in the individual's medical record within 24 hours after the debriefing is conducted or attempted, as applicable. If debriefing is not conducted, the reasons for not completing the debriefing shall be documented. If a debriefing is attempted as required by this section, but cannot be conducted within the specified timeframes, a timeline for completing the debriefing shall be documented, the debriefing shall be held and documented within the timeline documented, and the reasons for not completing the debriefing within the timeframes specified in this section shall be documented.

§415.272. Documenting, Reporting, and Analyzing Restraint or Seclusion.

(a) Facility documentation. The facility shall document the assessment, monitoring, and evaluation of an individual in restraint or seclusion on a facility approved form. Documentation in an individual's medical record shall include:

- (1) the date and time the intervention began and ended;
- (2) the name, title, credentials, and signatures of any staff members present at the initiation of the intervention, with identification of the staff member's role in the intervention, including as an observer, or status as an uninvolved witness, as applicable;
- (3) the name of the individual restrained or secluded and the type of restraint or seclusion used;
- (4) the time and results of any assessments, observation, monitoring, and evaluations, including those required under this subchapter, and attention given to personal needs;
- (5) the physician's documentation of the order authorizing restraint or seclusion in accordance with the requirements of §415.260 of this title (relating to Initiating Restraint or Seclusion in a Behavioral Emergency);
- (6) any specific alternatives and less restrictive interventions, including preventive or de-escalatory interventions that were attempted by any staff member prior to the initiation of restraint or seclusion, and the individual's response to any such intervention;
- (7) the individual's response to the use of restraint or seclusion; and
- (8) other documentation relating to an episode of restraint or seclusion otherwise required under this subchapter.

(b) Report to CEO. Staff members shall report daily to the facility CEO or designee any use of a restraint or seclusion.

(1) The CEO or designee shall take appropriate action to identify and correct unusual or unwarranted utilization patterns on a systemic basis, and shall address each specific use of restraint or seclusion that is determined or suspected of being improper at the time it occurs.

(2) The CEO or designee shall maintain a central file containing the following information:

- (A) age, gender, and race of the individual;
- (B) deaths or injuries to the individual or staff members;
- (C) length of time the restraint or seclusion was used;
- (D) types and dosage of emergency medications administered during the restraint or seclusion, if any;
- (E) type of intervention, including each type of restraint used;
- (F) name of staff members who were present for the initiation of the restraint or seclusion; and
- (G) date, day of the week, and time the intervention was initiated.

(c) Additional reporting in the case of death or serious injury. By the next business day following an individual's death or serious injury, facilities shall report the following information to the appropriate entity designated in subsection (d) of this section.

(1) Each death or serious injury that occurs while an individual is in restraint or seclusion;

(2) Each death that occurs within 24 hours after the individual has been removed from restraint or seclusion; and

(3) Each death known to the facility that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a individual's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

(d) Reporting deaths or serious injury. Facilities shall report the deaths or serious injuries of individuals in restraint or seclusion as follows.

(1) Medicare- or Medicaid-certified facilities shall report a death to the appropriate office for the Center for Medicare and Medicaid Services in accordance with the federal death reporting requirements relating to restraint and seclusion.

(2) Facilities that are neither Medicare- nor Medicaid-certified shall report a death or serious injury to DSHS's medical director for behavioral health.

(3) In addition to reporting in accordance with paragraphs (1) and (2) of this subsection, all facilities licensed under Chapter 133 (relating to Hospital Licensing) or Chapter 134 (relating to Private Psychiatric Hospitals and Crisis Stabilization Units) of this title shall report a death or serious injury to the Patient Quality Care Unit of DSHS's Division for Regulatory Services.

(4) Facilities shall comply with any additional reporting requirements relating to restraint or seclusion to which they are subject, including any applicable reporting requirements under The Children's Health Act of 2000 and federal regulations promulgated pursuant to the Act.

(e) Facility review of data. The facility shall review and analyze, at least quarterly, the data that is required by subsection (b)(2) of this section to identify and correct trends and patterns that may contribute to the use of restraint or seclusion (e.g., disproportionate use of restraint or seclusion with specific populations or shifts).

(f) Continuous improvement. The facility shall use the data continuously to improve and ensure:

- (1) a positive environment that minimizes the use of an involuntary intervention;
- (2) the safety of every individual and staff member;
- (3) the use of restraint and seclusion is implemented in accordance with the requirements of this subchapter;
- (4) that the risks of injury and other negative effects to individuals and staff members are reduced; and
- (5) that policies and training curriculum incorporate the requirements of this subchapter.

(g) On or before November 1, 2014, and quarterly thereafter, any facility that is a Medicare or Medicaid provider shall submit to DSHS the data required by Centers for Medicare and Medicaid Services for hospital-based inpatient psychiatric service measures related to the use of restraint or seclusion.

(h) On or before November 1, 2015, and quarterly thereafter, a facility to which this

subchapter applies shall prepare and submit to DSHS a report, consistent with the *Department of State Health Services Behavioral Interventions Reporting Guidelines* (guidelines) available at: <http://www.dshs.state.tx.us/Licensing-Facilities.shtm>, of the following data from the previous period:

(1) emergency interventions, including:

(A) emergency seclusions:

- (i) number of seclusions;
- (ii) rate of seclusions (per 1,000 bed days);
- (iii) number of seclusions resulting in serious injury;
- (iv) number of seclusions resulting in death; and

(B) emergency personal restraints:

- (i) number of personal restraints;
- (ii) rate of personal restraints (per 1,000 bed days);
- (iii) number of personal restraints resulting in serious injury;
- (iv) number of personal restraints resulting in death; and

(C) emergency mechanical restraints:

- (i) number of mechanical restraints;
- (ii) rate of mechanical restraints (per 1,000 bed days);
- (iii) number of mechanical restraints resulting in serious injury;
- (iv) number of mechanical restraints resulting in death; and

(D) involuntary emergency medication orders:

- (i) number of involuntary medication orders;
- (ii) rate of involuntary medication orders (per 1,000 bed days);
- (iii) number of involuntary medication orders resulting in serious

injury;

(iv) number of involuntary medication orders resulting in death;
and

(2) de-escalation techniques--description of all de-escalation techniques commonly used by the facility in connection with any of the emergency interventions described in paragraph (1) of this subsection.

§415.273. Restraint for the Management of Non-violent, Non-self-destructive Behavior.

(a) If an assessment reveals a non-psychiatric medical condition or symptom that indicates the need for an intervention to protect the individual from harm, the facility shall use the least restrictive intervention that effectively protects the individual from harm. If the intervention is a restraint as defined in this subchapter, it shall only be used in the follow circumstances:

(1) medically necessary;

(2) ordered by a physician;

(3) needed to ensure the individual's safety; and

(4) used only after less restrictive interventions have been considered, or attempted and determined to be ineffective, or are judged to be unlikely to protect the individual or others from harm.

(b) Prior to the application of a restraint for the management of non-violent, non-self-destructive behavior, an assessment of the individual shall be done to determine that the risks associated with the use of the restraint are outweighed by the risks of not using it.

(c) The physician's order for the restraint shall specify:

(1) a time limit on the use of the restraint;

(2) any special considerations for the use of restraint;

(3) the specific type of restraint to be used;

(4) who is responsible for implementing the restraint; and

(5) instructions for monitoring the individual.

(d) The physician shall renew the order as frequently as determined by facility policy, but the time period covered by the order shall not be longer than 24 hours.

(e) The order for the restraint shall be followed by consultation with the individual's treating physician if the restraint was not ordered by the individual's treating physician. The

consultation shall be documented in the individual's medical record no later than the next business day, except that it shall be done sooner, when an earlier consultation is clinically indicated.

(f) The care of the individual shall be based on a rationale that reflects consideration of the individual's medical needs and health status.

(1) .If the facility has made a clinical determination that its use of restraint for the management of non-violent, non-self-destructive behavior requires a frequency of assessment or an aspect of care or treatment that differs from the provisions of this subchapter governing restraint in a behavioral emergency, facility policies and procedures on the use of restraint for the management of non-violent, non-self-destructive behavior shall address:

(A) the facility's required frequency of assessment of the individual during restraint; and

(B) how the individual's circulation, hydration, elimination, level of distress and agitation, mental status, cognitive functioning, cardiac functioning, skin integrity, nutrition, exercise, and range of motion of extremities are to be assessed and addressed during restraint.

(2) The plan for monitoring the individual and the rationale for the frequency of monitoring shall be documented in the individual's medical record.

(g) A dentist at a facility, including any contractor providing dental services on the facility premises shall not restrain an individual for dental care or rehabilitation unless the restraint is ordered by the individual's physician. The dentist shall maintain a copy of the order in the individual's medical record and shall ensure compliance with the requirements of the order.

(h) Whenever a restraint is ordered by a physician, the ordering physician shall prescribe the frequency of assessment required for the individual during restraint and how the individual's circulation, hydration, elimination needs, level of distress and agitation, mental status, cognitive functioning, cardiac functioning, skin integrity, nutrition, exercise, and range of motion of extremities are to be assessed and addressed during restraint.

§415.274. Permitted Practices.

(a) Escort or brief physical prompt. An individual may be assisted to move from one location to another when guidance is needed if the individual agrees verbally or with gestures and is able to cooperate with the staff member who is attempting to assist the individual to move.

(b) Activities of daily living. A staff member may assist an individual who is willing and able to cooperate with toileting, bathing, dressing, eating, or other personal hygiene activities that normally involve the use of touch.

(c) Immediate danger of harm. A staff member may escort, prompt, or move an individual who is unable to respond in the affirmative or negative or is unable to move due to his or her psychiatric or medical condition if there is an imminent danger of harm to the individual because of a circumstance in the individual's immediate environment.

(d) Immobilization during medical, dental, diagnostic, or surgical procedure. A positioning or securing device used to maintain the position of, limit mobility of, or temporarily immobilize an individual, with the individual's consent, during medical, dental, diagnostic, or surgical procedures and that is a standard part of the procedure is not considered a restraint. The care of the individual shall be based on a rationale that reflects consideration of the individual's medical needs and health status.

(1) Facility policies and procedures on the use of immobilization during medical, dental, diagnostic and surgical procedures shall address:

(A) the frequency of assessment of the individual during immobilization;
and

(B) how the individual's circulation, hydration, elimination needs, level of distress and agitation, mental status, cognitive functioning, cardiac functioning, skin integrity, nutrition, exercise, and range of motion of extremities are to be assessed during immobilization.

(2) The plan for monitoring the individual and the rationale for the frequency of monitoring shall be documented in the individual's medical record.

§415.275. Clinical Timeout and Quiet Time.

(a) The facility shall develop, implement, and enforce policies and procedures that address the use of clinical timeout and quiet time as preventive and de-escalating interventions to prevent a behavioral emergency from occurring and to alleviate or otherwise reduce the necessity for any use of restraint or seclusion.

(b) The policies and procedures shall include the following requirements.

(1) .Clinical timeout. A staff member may suggest that an individual initiate clinical timeout.

(A) Prior to clinical timeout, the staff member suggesting that an individual initiate clinical timeout shall explain to the individual that clinical timeout is voluntary.

(B) Each time an individual uses clinical timeout, a staff member shall document that use in the individual's medical record.

(C) The facility's documentation of any use of clinical timeout shall include a description of the conditions under which the clinical timeout was suggested and the

individual's response to the suggestion.

(D) A decision by the individual to decline to begin, or remain in, clinical timeout or similar interventions may not result in the staff member's use of restraint or seclusion of the individual, unless the initiation and use of the restraint or seclusion is permitted under, and otherwise meets the requirements of, this subchapter. To physically force or use personal restraint or coercion to direct the individual to a clinical timeout areas or to prevent an individual from leaving an area separated from other individuals receiving services, constitutes a restraint and/or seclusion and renders the procedure subject to the requirements for restraint or seclusion, as applicable, described in this subchapter.

(2) .Quiet time. An individual may request the use of quiet time and, unless clinically contraindicated, be granted quiet time.

(A) Under no circumstances may a staff member mandate quiet time for an individual. If a staff member does so, or if the individual wishes to terminate any self-initiated .use of quiet time, and a staff member requires the individual to remain, the situation becomes a restraint and/or seclusion, as applicable, and becomes subject to the requirements for restraint or seclusion, as applicable, described in this subchapter.

(B) Unless a staff member terminates quiet time for clinical reasons, the individual may terminate quiet time at any time. Under no circumstances, except for clinical reasons, may a staff member coerce or force a client out of quiet time. If a staff member does so, the situation becomes a restraint and/or seclusion, and becomes subject to the requirements for restraint or seclusion, as applicable, described in this subchapter.

(C) On every occasion that quiet time is denied or terminated for clinical reasons, a staff member shall document in the medical record the conditions under which the quiet time was denied or terminated.

§415.276. Protective and Supportive Devices.

(a) Voluntary use of protective and supportive devices. A protective or supportive device that is easily removable by the individual without a staff member's assistance is not restraint.

(1) A protective or supportive device may only be used with the consent of the individual.

(2) A supportive device must allow greater freedom of mobility than would be possible without the use of the device.

(3) Use of a protective or supportive device shall be based upon a prior order of a physician, physician's assistant, or advanced practice registered nurse. If the order is given by physician's assistant or advanced practice registered nurse, the use of the protective or supportive device must have been anticipated in the individual's treatment plan and the physician must countersign the order within 24 hours.

(4) If an individual uses a protective or supportive device, the individual's treatment team shall include an occupational or physical therapist and the individualized treatment plan shall specify that a protective or supportive device is to be used and shall:

(A) include any special considerations for the use of the device based on the findings of the comprehensive initial assessment performed at admission or intake;

(B) include an outcome oriented goal;

(C) describe the specific type of device to be used;

(D) specify who is responsible for applying the device;

(E) describe the plan for monitoring the individual; and

(F) reflect periodic assessment, intervention, and evaluation by the treatment team, including the physical therapist, on an ongoing basis.

(5) The facility shall have written policies and procedures that address the proper implementation of this subsection and monitoring requirements with reference to individuals with particular types of protective and supportive devices.

(b) Involuntary use of protective and supportive devices. A protective or supportive device that is not easily removable by the individual without a staff member's assistance constitutes a restraint, and becomes subject to the requirements for restraint or seclusion, as applicable, described in this subchapter.

(c) Protective devices for wound healing. After a wound has healed, the continued use of a protective device constitutes a mechanical restraint and becomes subject to the requirements for restraint or seclusion, as applicable, described in this subchapter.