MedPro Group
a Berkshire Hathaway company

Risk Q&A

Using Seclusion/Restraint for Behavioral Health Patients in Emergency Departments

Question

We are seeing more patients who are having behavioral health emergencies presenting to our emergency department (ED) than ever before. What are the risks associated with using seclusion or restraint when caring for these patients?

Answer

Patient visits to the ED related to behavioral disorders have been growing rapidly in the United States, with 1.7 million episodes of associated patient agitation occurring annually in emergency settings.[1] When treating patients presenting with behavioral health emergencies, using seclusion and restraint may have serious risks and result in adverse outcomes and liability exposure.[2]

Patients who are restrained have experienced blunt chest trauma, aspiration, respiratory depression, and asphyxiation leading to cardiac arrest.[3] Further, research has demonstrated that both patients and healthcare staff have sustained psychological harm, physical injuries, and death from the use of seclusion and restraint.[4]

Thus, the only justification for using these methods in the ED is when all other less restrictive measures have been attempted and failed and the patient is displaying severely aggressive or destructive behaviors that place them and others in imminent danger.[5] The process of using seclusion and restraint is now highly regulated and carefully monitored, with multiple safeguards in place to ensure the physical health and safety of both patients and staff.

To advocate for patients and their safety, federal and professional organizations have issued standards on the use of seclusion and restraint. The standard on restraint and seclusion in the Code

of Federal Regulations (Title 42, Chapter IV, Subchapter G, Part 482.13, Condition of Participation: Patient Rights) states:

> ***Standard: Restraint or seclusion.*** All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.[6]

Additionally, various professional associations and accreditation organizations have made recommendations and issued standards on seclusion and restraint. Examples of some of these recommendations and standards include the following:

- Organizations should be committed to treating all patients with respect and dignity. Decisions related to seclusion and restraint should involve a culturally competent, trauma-informed, and patient-centered approach to care.
- Organizations should have written policies and procedures in place that specify safe techniques for using seclusion and restraint; all policies should comply with federal and state laws and regulations and accreditation standards.
- Seclusion and restraint should be used only when clinically justified or when the patient's behavior threatens the physical safety of the patient, staff, or others. Before considering restraint use, trained healthcare employees should attempt to verbally de-escalate the patient and treat underlying medical or psychiatric conditions.
- Healthcare providers and staff members should never use seclusion or restraint as a method of convenience or to punish or coerce patients.
- Seclusion and restraint should be used for the minimal amount of time necessary and only when less restrictive measures have proven ineffective.
- The use of seclusion or restrain should be based on an individual order from a physician or other authorized provider who is primarily responsible for the patient's ongoing care. Standing orders should not be used for seclusion or restraint.

- Healthcare emergency staff should monitor the physical and psychological needs of secluded or restrained patients. The ED should have protocols in place to ensure the patient's safety while being monitored and evaluated by healthcare staff.
- The use of seclusion or restraint should be carefully documented in patients' health records. Documentation should specify why the seclusion or restraint was necessary and by what means it was administered, any alternative options that were used or considered, periodic patient assessments, and any negative health outcomes as a result of seclusion or restraint.
- Organizations should have training programs in place that focus on de-escalation, trauma-informed care, prevention of seclusion and restraint when possible, and safe techniques when seclusion and restraint are necessary.
- All staff members who provide care to patients who are at risk of harming themselves or others should receive training on behavioral health emergencies and be able to demonstrate competency with the organization's policies and procedures for seclusion and restraint.
- Any deaths related to the use of seclusion or restraint must be reported to the Centers for Medicare and Medicaid Services.[7]

Resources

- Institute for Healthcare Improvement: How Trauma-Informed Care Can Help During Behavioral Health Emergencies
- Institute for Healthcare Improvement: Improving Behavioral Health Care in the Emergency Department and Upstream
- MedPro Group: Checklist: Providing Trauma-Informed Care
- MedPro Group: Improving the Care and Management of Behavioral Health Patients in the Emergency Department
- MedPro Group: Behavioral Health: Risk Resources

Endnotes

[1] Wong, A. H., Ray, J. M., Rosenberg, A., Crispino, L., Parker, J., McVaney, C., … Pavlo, A. J. (2020, January 24). Experiences of individuals who were physically restrained in the emergency department. *JAMA Network Open, 3*(1):e1919381.

[2] Cheney, C. (2018). New research helps ER staff identify patients for restraints. *HealthLeaders*. Retrieved from www.healthleadersmedia.com/clinical-care/new-research-helps-er-staff-identify-patients-restraint

[3] Ibid.

[4] Substance Abuse and Mental Health Services Administration. (n.d.). *Trauma and violence*. Retrieved from www.samhsa.gov/trauma-violence

[5] Reichman, E. F. (2013). Physical restraints (Chapter 194). In *Emergency Medicine Procedures*, Second Edition. McGraw Hill Medical. Retrieved from https://accessemergencymedicine.mhmedical.com/content.aspx?bookid=683&sectionid=45343845#57720163

[6] 42 U.S.C. § 482.13 Condition of participation: Patient's rights. Retrieved from www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482

[7] Crisis Prevention Institute. (2009). *Joint Commission standards on restraint and seclusion/Nonviolent Crisis Intervention® training program.* Retrieved from www.crisisprevention.com/CPI/media/Media/Resources/alignments/Joint-Commission-Restraint-Seclusion-Alignment-2011.pdf; Cheney, C., New research helps ER staff identify patients for restraints; American Psychiatric Nurses Association. (February 2022 [revised]). *Standards of practice: Seclusion and restraint.* Retrieved from https://omsapaprod.wpenginepowered.com/wp-content/uploads/2022/03/APNA-Standards-of-Practice-Seclusion-and-Restraint-2.2022.pdf; American Psychiatric Association. (2022). *Seclusion or restraint.* Retrieved from www.psychiatry.org/getattachment/e9b21b26-c933-4794-a3c4-01ad427eed91/Resource-Document-Seclusion-Restraint.pdf; American College of Emergency Physicians. (2020, February [revised]). *Policy statement: Use of patient restraints.* Retrieved from www.acep.org/patient-care/policy-statements/use-of-patient-restraints/