HEALTH SERVICES BULLETIN NO**. 15.05.10** **Page 1 of 13**

SUBJECT: PSYCHIATRIC RESTRAINT

EFFECTIVE DATE: 05/21/2021

I. POLICY:

It is the policy of the department that the special treatment procedure of psychiatric restraint be used with appropriate written clinical justification and in accordance with relevant laws and professional standards. The least restrictive alternative principle shall apply in the use of psychiatric restraint.

These standards and responsibilities apply to both the Department staff and Comprehensive Health Care Contractor (CHCC) staff.

II. PURPOSE:

A. To ensure the physical and emotional safety of inmates who require psychiatric restraint.

B. To prevent the use of psychiatric restraint as punishment, and to protect the well-being and dignity of the inmate.

C. To specify methods and procedures for the proper use of psychiatric restraint.

III. DEFINITIONS:

A. **Agitation**: Physical or verbal behaviors that health care staff determine to be an indicator of possible danger to self or others.

B. **Ambulatory Restraints**: Refers to leather or vinyl (or made of similar soft material) wrist cuff and straps and optional leg restraints. Ambulatory restraint permits limited mobility for the inmate.

C. **Clinical Lead**: The on-site clinical staff member who directs the clinical activities of staff involved in the psychiatric restraint intervention.

D. **Emergency Treatment Order**: The use of psychotropic medications without an inmate's informed consent that is restricted to emergency situations in which the inmate presents an immediate danger of causing serious bodily harm to self or others, and where no less intrusive or restrictive intervention is available or would be effective. Such treatment may be provided upon the order of a physician with concomitant order for admission to a certified isolation management room and placement on self-harm observation status.

E. **Episode of Restraint**: A single episode of restraint commences once the application of restraint is authorized. An episode of restraint is considered terminated after thirty (30) minutes of calm behavior while in restraints followed by thirty (30) minutes of calm behavior after release from restraints (sixty [60] minutes continuous calm behavior).

F. **Four-Point Restraint**: A psychiatric restraint technique in which an inmate's wrists and ankles are secured to a restraint bed with leather or vinyl (or made of similar soft material) cuffs and straps. The inmate will be restrained in a supine (face up) position on a restraint bed. A leather or vinyl strap may be fastened across the inmate's chest and anchored to the side of the bed (five [5] point restraint). An additional leather or vinyl strap may be fastened across the inmate's lower thighs and anchored to the side of the bed (six [6] point restraint) if needed.

G. **Isolation Management Room**: A cell in an infirmary area or a mental health inpatient unit intended to provide a safe environment for inmates who may present a risk of self-injury. An isolation management room must meet the standards for certification of isolation management rooms in accordance with Procedure 404.002, Isolation Management Rooms and Observation Cells.

H. **Leg Restraint (Ambulatory)**: A leather or vinyl (or made of similar soft material) ankle cuff with connecting strap which allows ambulation but limits the ability of the inmate to run or engage in aggressive kicking.

I. **Multidisciplinary Services Team**: A group of staff representing different professions and disciplines, which has the responsibility for ensuring access to necessary assessment, treatment, continuity of care and services to patients in accordance with their identified mental health needs, and which collaboratively develops, implements, reviews and revises an "Individualized Service Plan", DC4-643A, as needed.

J. **Other Psychiatric Restraint Devices**: Psychiatric restraint devices (e.g., mittens, restraint net, etc.) other than four (4) point restraint and ambulatory restraints (as defined in this health services bulletin) may be utilized only after the institutional health services staff have received written authorization from the Office of Health Services to use such restraint devices. The institutional health services administrator must keep such authorization on file.

K. **Personal Restraint**: The application of physical body pressure or grasp by another person, typically security staff, to the body of the inmate in such a way as to limit or control the physical activity of the inmate.

L. **Protective Helmet**: Used to protect the head of an inmate who is engaging in head banging or biting. The helmet shall have a face guard and a chin strap.

M. **Psychiatric Restraints**: Devices, procedures, or techniques used to restrict movement or behavior as to greatly reduce or eliminate the ability of an individual to harm him/herself or others.

N. **Risk Assessment Team**: A team that evaluates the risk for violence potentially posed by inmates on a mental health inpatient unit. The risk assessment team shall consist of a staff member from mental health, security, and classification.

O. **Restraint Bed**: Any bed utilized for psychiatric restraint must meet the following criteria:

1. Is located in an isolation management room.
2. Is anchored to the floor.
3. Is of one-piece construction (no springs).
4. Is constructed so that leather or vinyl wrist, leg cuffs, and chest strap may be secured at the sides of the bed.
5. Has no features to which something can be tied higher than eighteen (18) inches above the floor.
6. Has a plastic-covered mattress or integrated padding.

P. **Seclusion**: Involuntary placement of an inmate in a locked housing cell or other designated area within a mental health inpatient treatment unit.

Q. **Security Lead**: The ranking member of the Security restraint team who oversees and directs Security staff in the application of psychiatric restraint.

R. **Self-harm Observation Status**: Refers to a clinical status ordered by a physician, clinical associate, or advanced registered nurse practitioner that provides for safe housing and close monitoring of inmates who are determined to be suicidal or at risk for serious self-injurious behavior, by mental health staff, or in the absence of mental health staff, by medical staff in accordance with Procedure 404.001, Suicide and Self-Injury Prevention.

S. **Self-Injurious Behavior**: Self-directed behavior that has the potential to cause physical injury as assessed by mental health or, in their absence, medical staff.

T. **Time-Out**: An inmate may request **voluntarily** to remove him/herself from a potentially stimulating situation by going into a locked or unlocked housing cell or designated room. Time-out is indicated when the inmate realizes she/he is potentially at risk for losing self-control. Staff may suggest to the inmate that she/he consider if

she/he might benefit from time-out. The purposes of time out are for the inmate to maintain self-control over her/his behavior and to reduce environmental stimulation.

U. **Thirty (30) Minute Rule**: A secluded or restrained inmate must remain calm for thirty (30) continuous minutes (excluding periods of sleep) to be released from seclusion or psychiatric restraint.

V. **Wrist Restraints**: Leather or vinyl (or made of similar soft material) waist belt and wrist cuffs used to restrict the movement of an inmate's hands and arms.

IV. LEAST RESTRICTIVE ALTERNATIVE PRINCIPLE:

A. When clinical staff determines that an inmate is becoming agitated and/or may present a risk that may pose imminent danger to self or others, efforts will be made to reduce the level of risk through the least restrictive means possible that will provide for the safety of the inmate and others. If possible, the intervention will also help the inmate to regain self-control.

B. Staff will give consideration to each of the following levels of intervention when determining the least restrictive alternative to provide for the safety of the inmate and others:

1. Verbal counseling.
2. Time Out (voluntary) – As defined in section III., "T".
3. In an inpatient mental health unit, it may be appropriate to house an inmate who displays symptoms of agitation in a single housing cell when the inmate does not present indications that she/he is a danger to him or herself and does not present an imminent risk to harm others.
4. When an inmate in an inpatient unit displays behavior that presents a risk to staff and/or other inmates due to direct threats toward others, or the clinical staff determine that an inmate's behavior impedes the treatment of other inmates, a clinical staff member can order seclusion for that inmate.
5. Placement on self-harm observation status when the inmate presents an imminent risk of harm to self.
6. Personal restraint.
7. Ambulatory restraint.
8. Four (4) point restraint (plus chest and/or leg straps if necessary).
9. Emergency Treatment Order (ETO) may be appropriate when risk is imminent and where no less intrusive or restrictive intervention is available or would be effective.

C. There may be situations when less restrictive interventions would be insufficient. When psychiatric restraints or seclusion are ordered, the documentation that less

restrictive alternatives were considered and the clinical rationale for the use of restraints must be recorded in the inpatient record.

V. PSYCHOTROPIC MEDICATION:

A. Psychotropic medication can be utilized in conjunction with any of the interventions noted above.

B. Any use of an emergency treatment order for involuntary medication must be in accordance with guidelines referenced in health services bulletin 15.05.19, Psychotropic Medication Use Standards and Informed Consent:

1. Choice of medication to be used will be based on the assessed clinical presentation of the inmate.
2. A physician's order must accompany each use of an emergency treatment order.
3. Such involuntary treatment shall be limited to a particular episode of imminent danger to self or others.
4. Standing orders, "as needed" (PRN) orders and neuroleptics as a decanoate preparation are prohibited for use as an emergency treatment order.
5. The need for periodic involuntary medication (three [3] or more involuntary doses of psychotropic medication in a twenty-four [24] hour period) may indicate a need for referral to a crisis stabilization unit or from a crisis stabilization unit to a mental health treatment facility.

C. The use of psychiatric restraints may be necessary in order to safely administer an emergency treatment order. Clinical staff will determine the level of restraint needed to ensure the safety of the inmate and staff for administration of the emergency treatment order. Such use must be accompanied with an admission to an infirmary level of care, such as an isolation management room, in accordance with Ch. 33-602.210 F.S.

VI. SECLUSION:

A. A clinical staff member may authorize placement of an inmate on an inpatient unit into a secure cell to seclude that inmate from staff and other inmates when less restrictive interventions have been ineffective.

B. When the situation permits, a psychiatrist, non-psychiatric physician, or other prescribing provider (e.g., advanced practice registered nurse , clinical associate) will provide a written or verbal order for seclusion. Seclusion may be authorized by a psychologist, psychological specialist, registered nurse, or licensed practical nurse (a non-prescribing clinical staff member), in that order of availability, if a prescribing

clinician is not immediately available. If a non-prescribing clinical staff member authorizes seclusion, then nursing staff must begin the process of obtaining a physician's order for seclusion within one (1) hour of initiating seclusion.

C. Clinical staff should authorize seclusion only when the inmate exhibits behavior that presents a potential risk to the safety of staff or other inmates, or the inmate's behavior creates a disruption to the inpatient mental health unit treatment milieu sufficient to significantly interfere with the treatment of other inmates. Seclusion is utilized to reduce environmental stimulation, provide for the safety of staff and other inmate's and to minimize disruptions to the therapeutic milieu.

D. A secluded inmate must have access to drinking water and a toilet. Typically, an inmate would be secluded in a housing cell. The rationale for the use of seclusion must be noted in the medical record. Secluded inmates must be observed every fifteen (15) minutes at minimum with documentation on the "Observation Checklist," DC4-650. The inmate shall be released from seclusion when the thirty (30) minute rule is met.

E. Any inmate who has been placed on seclusion, regardless of the length of seclusion, will be referred to the inpatient unit's Risk Assessment Team and the inmate's Multidisciplinary Services Team for review at the next regularly scheduled meetings. The Multidisciplinary Service Team will conduct a review of the seclusion incident to guide future interventions. The review will include a discussion of:

1. What actions might clinical and/or security staff be able to utilize to reduce the potential need for seclusion or restraint in the future?
2. What actions might the inmate be able to utilize to reduce the potential need for seclusion or restraint in the future?

F. The chief health officer/ institutional medical director must review any inmate who has remained in seclusion for five (5) days. Any inmate who has remained in seclusion for ten (10) days must be referred to the Statewide Psychiatric Director or the Regional Mental Health Consultant for review. Accommodations must be made to provide secluded inmates with at least the minimum hours of planned scheduled services as delineated in Procedure 404.004, *Mental Health Inpatient Multidisciplinary Treatment and Services*.

VII. CRITERIA FOR PSYCHIATRIC RESTRAINT:

A. Psychiatric restraint may be utilized only for inmates on an inpatient (including infirmary) level of care status.

B. Psychiatric restraint may be indicated when one (1) of the following criteria are met:

1. The inmate presents an imminent danger to self.
2. The inmate presents a danger to staff providing for her/his care and/or custody needs while located in an isolation management room or other clinical care area in an inpatient mental health unit.
3. The inmate demonstrates behavior indicating a likelihood that she/he will create an unsafe condition within an isolation management room, such as by damaging or altering the cell or its contents and no lesser restrictive intervention appears to be feasible.

VIII. GENERAL CONSIDERATIONS FOR THE USE OF PSYCHIATRIC RESTRAINT:

A. Any inmate who presents an imminent risk of injury to self must be placed on self-harm observation status within a certified Isolation Management Room (IMR) by an order from the psychiatrist or psychiatric clinician.

B. When less restrictive interventions do not provide enough external control to allow the inmate to assume adequate self-control, psychiatric restraint may be utilized.

C. Use of psychiatric restraint devices requires placement in a certified isolation management room.

D. Psychiatric restraints shall not be used as punishment, as an aversive stimulus, as a substitute for proper staff supervision, or as a means of controlling an overly active inmate when her/his over-activity poses no threat.

E. A clinical staff member must authorize the use of psychiatric restraint. When the situation permits, a psychiatrist, non-psychiatric physician, or other prescribing provider (e.g., advanced practice registered nurse, clinical associate) will provide a written or verbal order for the use of psychiatric restraint.

F. In an emergency, restraints may be authorized by a psychologist, psychological specialist, or registered nurse (a non-prescribing clinical staff member) in that order of availability if an authorized clinician is not immediately available. If a psychologist, psychological specialist or registered nurse authorizes the use of psychiatric restraints, then nursing staff must begin the process of obtaining an order for psychiatric restraint within fifteen (15) minutes of initiating restraints.

G. Clinical staff will determine the type of restraint to be utilized to best provide for the safety of the inmate and others in the least restrictive manner (see section “IV”).

H. The clinical lead staff member will advise the security lead staff member of any medical concerns/complications which may need to be taken into consideration when restraining the inmate.

I. Security staff will apply the necessary restraints as authorized by clinical staff.

J. Potentially dangerous items such as belts, scarves, shoes, and jewelry shall be removed from the inmate when s/he is restrained.

K. Personal restraint will be utilized only for relatively brief periods of time, such as while an injection of medication is administered or pending the application of restraint devices.

L. An inmate shall remain clothed when restrained. If the inmate has removed her/his clothing, a blanket or garment will be used to provide cover once the inmate is safely restrained.

M. Any inmate on a mental health inpatient unit who has been placed in psychiatric restraint devices must be referred to the inpatient unit's Risk Assessment Team for review within 3 business days and the inmate's Multidisciplinary Services Team for review at the next regularly scheduled meeting. The Risk Assessment Team will review and evaluate any changes of the inmate's risk of violence stemming from episode of psychiatric restraint. The Multidisciplinary Service Team will conduct a review of the restraint incident to guide future interventions. The review will include a discussion of:

1. What actions might clinical and/or security staff be able to utilize to reduce the potential need for seclusion or restraint in the future?
2. What actions might the inmate be able to utilize to reduce the potential need for seclusion or restraint in the future?

N. A professional manner will be maintained when communicating with an inmate who is being restrained.

1. The lead security or clinical staff member will advise the inmate that security staff will be placing the inmate into psychiatric restraints for her/his protection.
2. Security staff will communicate with the restrained inmate only as necessary to perform their role in applying restraints and in assisting clinical staff providing care to the restrained inmate.
3. The lead security and clinical staff members will calmly and concisely advise the inmate how to comply/assist with the use of restraint (e.g., "hold your arm still") and other communication necessary to provide for the inmate's safety and well-being. If feasible, the inmate should be given the opportunity to comply with commands before physical intervention is used

4. Once the inmate is restrained, the lead security or clinical staff will advise the inmate that she/he must remain calm for thirty (30) continuous minutes in order to be released from restraints.

IX. MONITORING AN INMATE IN PSYCHIATRIC RESTRAINT DEVICES:

A. Staff will provide continuous observation of any inmate undergoing psychiatric restraint. Either direct observation or video monitoring equipment may be utilized. Continuous observation will be documented on the DC4-650A, Restraint Observation Checklist, noting behavioral observations every fifteen (15) minutes until the episode of restraint is terminated.

B. Nursing staff will make observations of respiration and satisfactory circulatory status (e.g., respiration rate, nail beds, skin warm to touch, etc.) every fifteen (15) minutes.

C. Nursing staff will check the restraints every sixty (60) minutes for rubbing and excessive looseness or tightness and remind the inmate (if awake) of the thirty (30) minute rule release criteria.

D. An incidental note will be made in the record hourly to note the inmate's condition, behavior, and monitoring activities.

E. Staff will exercise the inmate's restrained limbs every two (2) hours. One (1) limb will be released at a time and placed back into restraints before releasing the next limb for exercise. Each limb will be exercised for at least one (1) minute.

F. A bedpan or urinal will be offered every two (2) hours.

G. Fluids will be offered every two (2) hours. Staff will prop-up an inmate in four (4) point restraints to minimize the risk of the inmate choking on the fluids.

H. Meals will be offered during regular meal times. Staff will feed the restrained inmate. Staff will prop-up an inmate to a seated position in four (4) point restraints to minimize the risk of the inmate choking.

I. Vital signs shall be taken at the end of the restraint period at a minimum.

X. RELEASE FROM RESTRAINT:

A. The inmate shall be released from ambulatory or four (4) point restraints when the thirty (30) minute rule is met. The individual must remain calm for thirty (30) continuous minutes, that is, not display any verbal or physical signs of agitation,

before releasing her/him from restraints. The clinical lead staff member will determine when the release criteria have been met.

B. Falling asleep while in restraints and remaining calm for thirty (30) minutes does not meet the thirty (30) minute rule.

C. A display of agitation will restart the thirty (30) minute time criterion. The period may be reset as often as the individual displays agitation.

D. Upon release from restraints, the individual will remain under constant visual observation for thirty (30) additional minutes to monitor for continuous calm behavior. Restraints will be reapplied if, within thirty (30) minutes following release from restraints, the individual displays agitation. The restraints will be reapplied under the current restraint order (so long as the order has not expired).

E. An episode of restraints is not considered terminated until she/he exhibits the additional thirty (30) minutes of calm behavior without restraints (for a total of sixty [60] minutes of continuous calm behavior).

XI. ORDERS, TIME LIMITS, AND DOCUMENTATION FOR THE USE OF PSYCHIATRIC RESTRAINT:

A. The order, documented on the DC4-714B, Physician's Order Sheet, must accompany each use of a restraint and cannot be repeated on an as-needed (PRN) basis. The order for restraint must be documented in the infirmary or inpatient record and include the following:

1. Date and time
2. Duration
3. Purpose
4. Release Criteria
5. Authorization for the use of force

B. Documentation of a telephone order must include the content specified above and be countersigned by a physician during the next regular administrative working day.

C. The use of psychiatric restraints, including Emergency Treatment Orders, will be logged on the DC4-781J, *Psychiatric Restraint Log*.

D. Time limitations on the use of psychiatric restraints:

1. The initial restraint order, whether written or verbal, shall be ordered for no longer than four (4) hours.

2. The physician may order additional periods of four (4) hours of restraint if assessment indicates that the inmate has not met the release criteria.
3. If the prescribing clinician is not available, the senior medical staff member on duty shall assess the restrained inmate before the order expires. The results of the assessment shall be conveyed to the on-call physician who may order an additional four (4) hour restraint period.
4. If the inmate has still not met the specified release criteria after twenty-four (24) hours, additional periods of restraint may be ordered ONLY after the following criteria are met:

    a. Physician's personal examination of the inmate.
    b. The physician has authorized the continued use of restraint.
    c. Reasons for continuation are documented in the inpatient record.
    d. The chief health officer/medical executive director approves the continuation of restraint.

5. The regional mental health consultant will be notified within one (1) workday of psychiatric restraint exceeding twenty-four (24) hours.

6. If approved by the chief health officer/medical executive director, restraints may continue to be ordered in four (4) hour segments for up to a total of forty-eight (48) hours (from the time of the initial order for restraints). If restraints are used for longer than forty-eight (48) consecutive hours, the physician must personally consult with the regional medical director, the regional mental health consultant, or the statewide director of psychiatric services prior to ordering additional restraints.

XII. USE OF FORCE DOCUMENTATION:

A. Security personnel are required to videotape psychiatric restraint interventions per "Use of Force," rule 33-602.210, Fla. Admin. Code.

B. The health care professional granting authorization for restraint shall prepare, date, and sign DC6-232, Authorization for Use of Force. The DC6-232 shall be completed either during or immediately after the shift in which the use of force was authorized. All such reports are to be submitted to the chief health officer/ institutional medical director for review on the next working day and must be submitted to the warden no later than five (5) working days following the incident.

C. Whenever force is used to apply restraint, a detailed written DC6-230, (Institution's) Report of Force Used and DC6-231, Report of Force Used (Staff Supplement) shall be prepared, dated, and signed by the employees using the force either during or

immediately after the shift in which the use of force occurred. All reports must be submitted to the warden no later than five working days after the incident.

D. When the inmate does not offer resistance to the application of psychiatric restraint, complete and submit a DC6-210, Incident Report, in lieu of the DC6-230 and DC6-231.

XIII. PSYCHIATRIC RESTRAINT DEVICE INVENTORY:

A. The health services administrator for each major institution shall ensure that the following equipment is readily available and in good working condition.

B. For each outpatient institution (S-1, S-2, or S-3):

1. Sufficient sets of wrist restraints to meet the needs of the inmate population, but not less than two (2) sets.
2. Sufficient sets of leg restraints to meet the needs of the inmate population, but not less than two (2) sets.
3. One (1) protective helmet with face guard and chin strap in three (3) varying sizes, e.g., small, medium, and large.

C. For institutions with restraint beds, sufficient sets of four (4) point restraints, plus chest and leg straps, to meet the needs of the inmate population, but not less than two (2) sets.

D. For each transitional care unit, crisis stabilization unit, and a mental health treatment facility (S-4 and above):

1. Sufficient protective helmets to meet the needs of the inmate population, but not less than three (3), e.g., small, medium, and large.
2. Sufficient sets of four (4) point restraints, plus chest and leg straps, to meet the needs of the inmate population, but not less than three (3) sets.
3. Sufficient sets of ambulatory wrist (belts and wrist cuffs) and leg restraints to meet the needs of the inmate population, but not less than three (3) sets.

E. The health services administrator shall maintain a monthly inventory of all psychiatric restraint devices available for use and ensure that keys for restraint locks are available in the clinical area for nursing staff to access on an emergency basis. An additional set of keys for all restraint locks will be maintained in the institutional or mental health unit control room.

XIV. TRAINING:

A. The Office of Staff Development will offer mandatory psychiatric restraint use training to all medical, nursing, mental health, and security staff. Training will be developed and delivered through standardized lesson plans.

B. The director of mental health services will review and approve the standardized lesson plan annually.

XV. RELEVANT FORMS AND DOCUMENTS:

A. **DC4-643A,** *Individualized Service Plan*
B. **DC4-650,** *Observation Checklist*
C. **DC4-650A,** *Restraint Observation Checklist*
D. **DC4-714B,** *Physician's Order Sheet*
E. **DC4-781J,** *Psychiatric Restraint Log*
F. **DC6-210,** *Incident Report*
G. **DC6-230,** *(Institution's)Report of Forced Used*
H. **DC6-231,** *Report of Forced Used (Staff Supplement)*
I. **DC6-232,** *Authorization for Use of Force*
J. **HSB 15.05.19,** *Psychotropic Medication Use Standards and Informed Consent*
K. **404.001,** *Suicide and Self-Injury Prevention*
L. **404.002,** *Isolation Management Rooms and Observation Cells*
N. **404.004,** *Mental Health Inpatient Multidisciplinary Treatment and Services*
O. **602.002,** *Use of Force in Correctional Facilities National Commission on Correctional Health Care* *Correctional Mental Health Care Standards & Guidelines for Delivering Services 2003, M-I-01.*
M. Florida Statutes Chapter 394, Florida Administrative Code Chapter 33-404.103, and FAC Chapter 33-602.210.
N. American Correctional Association: **Accreditation Standards Major Institutions 4th Edition** ***(4/07)*** 4-4190, 4-4191.

Director of Health Services Date

This Health Services Bulletin Supersedes: HSB 15.05.10 dated 4/15/91, 10/18/94, 10/18/94, 7/3/96, 4/19/01 and 4/22/08,03/01/13, AND 2/2/16