

**CHAPTER 13. USE OF RESTRAINTS  
IN TREATING PATIENTS/RESIDENTS**

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**Authority**

The provisions of this Chapter 13 issued under sections 201(2) and (8) and 202 of the Mental Health and Mental Retardation Act of 1966 (50 P. S. §§ 4201(2) and (8) and 4202); and sections 105, 112, and 113 of the Mental Health Procedures Act (50 P. S. §§ 7105, 7112 and 7113), unless otherwise noted.

**Source**

The provisions of this Chapter 13 adopted October 28, 1977, effective November 28, 1977, 7 Pa.B. 3199, unless otherwise noted.

**Cross References**

This chapter cited in 55 Pa. Code § 5100.15 (relating to contents of treatment plan).

**§ 13.1. Scope.**

This chapter is applicable in institutions operated by the Department, regardless of the type of facility, patient/resident composition, or services covered. Facilities covered include Youth Development Centers, Youth Forestry Camps, Restoration Centers, State general hospitals and State-operated institutions for the mentally ill or mentally retarded.

**§ 13.2. Definition of restraints.**

(a) Restraints include devices and techniques designed and used to control acute or episodic aggressive behavior or involuntary movement of patients/residents. Restraints do not include general protective security measures adopted in various institutions, including locked wards; special security measures adopted in Youth Development Centers and Youth Forestry Camps, maximum security State hospital or forensic units in State mental hospitals; or specific security measures ordered by a court. Restraints can be classified according to the method used to control behavior as:

- (1) Mechanical restraints.
- (2) Chemical restraints.

- (3) Seclusion.
  - (4) Exclusion.
  - (5) Psychological restraints.
- (b) Restraints may also be classified based on whether they are designed to control one of the following:
- (1) Involuntary movement or lack of muscular control due to organic causes or conditions.
  - (2) Acute or episodic aggressive behavior.
- (c) The intent with which restraints are used distinguishes the categories in subsection (b)(1) and (2). Procedures for employing restraints, as defined in §§ 13.4 and 13.5 (relating to use of restraints to control involuntary movement due to organic causes or conditions and use of restraints to control acute or episodic aggressive behavior) depend upon whether acute or episodic aggressive behavior or involuntary action is controlled.

### § 13.3. Policy.

- (a) Restraints shall be employed only when necessary to protect the patient/resident from injuring himself or others, or to promote normal body positioning and physical functioning.
- (b) Restraints shall not be employed as punishment, for the convenience of staff, as a substitute for program, or in any way that interferes with the treatment program. Restraints shall not be applied unless other available techniques or resources have failed, and the least possible restrictions shall be used.
- (c) Individual program plans, developed for patients/residents in accordance with applicable statutes and regulations, shall have goals and methods aimed at treating and eliminating behavior necessitating the use of restraints. Efforts shall similarly be made by employees to reduce the need for restraints by utilizing therapeutic approaches such as goal planning aimed at redirecting and releasing aggression through healthy channels, counseling, and withdrawing a patient/resident from an overstimulating environment.
- (d) The Superintendent/Director is administratively responsible for insuring that restraints are imposed only in accordance with this chapter. The Superintendent/Director is responsible for insuring that employees shall know specific procedures, methods and steps to follow in instituting this chapter and that they are familiar with this chapter and the criteria for their application.
- (e) Each institution must prepare a restraint plan describing specific procedures for use by employees in implementing this chapter. The plan must be submitted through the appropriate Regional Deputy Secretary and Regional Program Commissioner for approval by the Executive Deputy Secretary and appropriate program Deputy Secretary. Each plan shall specifically describe a restraint training program including refresher courses to be offered to employees working with patients/residents. The plan must also include a procedure for monitoring the

implementation and application of this chapter. A specific individual or committee may be designated for this purpose.

**§ 13.4. Use of restraints to control involuntary movement due to organic causes or conditions.**

(a) Mechanical restraints controlling involuntary movement or lack of muscular control of patients/residents when due to organic causes or conditions, are to be employed only as part of an individual program plan, upon a finding by a member of the program team trained in the use of restraints that a particular restraint is necessary. The least restrictive restraints adequate to meet the goals in paragraphs (1) and (2) shall be used. These restraints shall be applied in accordance with principles of good body alignment, concern for circulation, and allowance for changes of position or exercise on a regular basis. Mechanical restraints shall do one of the following:

- (1) Prevent a patient/resident from injuring himself and others.
- (2) Promote normative body positioning and physical functioning.

(b) The initial need for restraints shall be reviewed and approved by an individual or committee not directly involved in treatment of that patient/resident. The continued need for the restraint shall be reviewed as part of the review of individual program plans required by applicable statute and regulations.

(c) Mechanical restraints authorized by the program plan shall be employed only as actually necessary to meet the standards and goals stated in this section.

(d) In emergency situations, restraints not part of an individual program plan may be used in accordance with the procedures and standards set forth in § 13.5 (relating to use of restraints to control acute or episodic aggressive behavior).

*Examples:* Mechanical restraints which may be made part of the individual program plan include but are not limited to protective helmets, supportive body bands, posey belts, wheelchair vests, bed rails, and similar protective devices and body position devices, when used to prevent danger to the patient/resident or others from his involuntary actions.

**Cross References**

This section cited in 55 Pa. Code § 13.2 (relating to definitions of abuse); and 55 Pa. Code § 5320.54 (relating to seclusion and restraints).

**§ 13.5. Use of restraints to control acute or episodic aggressive behavior.**

(a) *General policy.* Restraints designed to control acute or episodic aggressive behavior of patients/residents shall be employed only in accordance with the procedures and standards set forth in subsection (b). Individual program plans shall attempt to treat the behavior necessitating the use of restraints. Employees shall attempt to prevent this behavior by recognizing indications of impending behavior and intervening in a positive, constructive manner to prevent hyperactivity or assaultiveness.

(b) *Standards.*

(1) Restraints shall be used to control acute or episodic aggressive behavior when a patient/resident is acting in a manner as to be a clear and present danger to himself, to other patients/residents, or to employes, and only when less restrictive measures and techniques have proven to be or are less effective.

(2) The use of restraints, the conduct necessitating the restraint, and alternative methods which were unsuccessful in controlling the behavior shall be noted in the patient's/resident's chart. The monitoring of patients/residents under restraint shall be recorded in the chart.

**Cross References**

This section cited in 55 Pa. Code § 13.2 (relating to definitions of abuse); and 55 Pa. Code § 13.4 (relating to use of restraints to control involuntary movement due to organic causes or conditions).

**§ 13.6. Mechanical restraints.**

(a) *Definitions.* Mechanical restraints used to control acute or episodic aggressive behavior include anklets, wristlets, camisoles, muffs, mitts with lock buckles, wrist straps, head straps, restraining sheets and other similar devices.

(b) *Procedures.*

(1) Qualified mental health professional staff designated by the Superintendent/Director may order use of mechanical restraints for a period not to exceed 2 hours. A physician shall be promptly notified. This initial order may not be renewed or extended by anyone before a physician examines the patient prior to doing so.

(2) A patient's/resident's treatment plan should indicate to the extent possible which physical restraints may and may not be utilized in an emergency and should call attention to possible physical problems which should be monitored. A patient/resident who is subject to mechanical restraints should be checked at least every 15 minutes by staff. Physical needs shall be met promptly.

(3) Opportunity for movement or exercise shall be provided for a period of not less than 10 minutes during every 2 hours in which the restraints are employed.

(4) The patient's/resident's chart shall document that this subsection has been followed.

**§ 13.7. Chemical restraints.**

(a) *Definition.* Chemical restraint shall mean the use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior by a patient/resident. Drugs administered on a regular basis, as part of the treatment plan and for the purposes of treating the symptoms of mental, emotional or behavioral disorders and for assisting the patient/resident in gaining self control over his impulses, are not to be considered chemical restraints.

(b) *Procedures.*

(1) No chemical restraints may be administered except upon the order of the physician.

(2) A telephone order may be accepted for medication intended for use as a chemical restraint in an emergency situation only. A physician shall examine the patient/resident within 1 hour of the telephone order with due attention being paid to prior mental and physical status and his history. Until a physician arrives, appropriate staff shall monitor the patient's/resident's physical well being.

(3) In a nonemergency situation, a physician shall examine the patient/resident prior to ordering medication as a chemical restraint with due attention being paid to the patient's/resident's prior mental and physical status and his history before drugs are administered. Medication shall be administered at intervals and dosages whereby adequate attention can be rendered to the patient's/resident's mental, physical and motor responses and vital signs.

(4) Once the level of medication appropriate to the circumstances has been determined, the patient's/resident's vital signs must be monitored at appropriate intervals, and the patient/resident followed and seen by a physician at periods appropriate to the circumstances, but at least every 12 hours. For mental health facilities monitoring of vital signs shall be conducted at least once in every 30 minute period.

(5) Proper documentation relating to the effect of the medication shall be recorded by appropriate personnel.

(6) The Superintendent/Director or his designee is responsible for monitoring all medications administered to a patient/resident for the purpose of chemical restraint.

**§ 13.8. Seclusion.**(a) *Definition.*(1) *Seclusion.*

(i) The placement of a patient/resident in a locked room may be used as a therapeutic technique only.

(ii) The patient's/resident's request to spend time in a private unlocked room is not to be considered seclusion and shall be granted if feasible and not therapeutically contra indicated. Quarantine or other preventive health measures are not considered seclusion.

(iii) In mental health facilities children under the age of 14 requiring seclusion shall be continuously monitored within or just outside the seclusion area by mental health personnel, and the room shall not be locked or otherwise secured. Soft inanimate objects shall be made available to the patient to permit the venting of aggression.

(iv) Seclusion shall be used only under the following conditions:

(A) When necessary to protect the patient/resident or others from physical injury.

(B) To decrease the level of stimulation when a patient/resident is in a state of hyperactivity.

(C) When less restrictive measures and techniques have proven ineffective.

(D) Seclusion as defined in this paragraph may not be employed in State center for the retarded.

(2) *Exclusion.* Within mental health/mental retardation facilities the removing of the patient/resident from his immediate environment and restricting him to another area. Exclusion shall only be employed when it is clearly documented that another less restrictive method has been unsuccessful in controlling the unacceptable behavior. Exclusion shall be limited and documented as a therapeutic technique in the resident's individual treatment plan. In mental health facilities children under the age of 14 requiring seclusion or exclusion shall be continuously monitored within or just outside the exclusion area by mental health personnel, and the room may not be locked or otherwise secured. Soft inanimate objects shall be made available to the patient to permit the venting of aggression.

(b) *Procedures.*

(1) In mental health facilities if a patient/resident in voluntary treatment requires seclusion, will not consent to such and requests to be discharged, this request shall be granted unless the procedures and standards of section 302 of the Mental Health Procedures Act (50 P. S. § 7302) regarding emergency involuntary treatment and § 5100.76 (relating to notice of withdrawal) are followed. Similarly, the procedures of section 405 of the Mental Health and Mental Retardation Act of 1966 (50 P. S. § 4405) shall be followed for mentally retarded persons who have been voluntarily admitted, require seclusion, and request to be discharged.

(2) In the case of mental health facilities, authority for seclusion of a patient/resident rests with the Director or his designee. In mental retardation facilities, authority for exclusion rests with the qualified mental retardation professional. In the case of Youth Development Centers, Youth Forestry Camps and all other Departmental institutions authority for seclusion rests with the Superintendent/Assistant Superintendent. Normally, written orders shall precede the placement of a patient/resident in seclusion or exclusion. In emergencies, telephone orders may be accepted, but an order shall be properly countersigned within the time specified by the institution. In no case, however, shall this period exceed 24 hours.

(3) An order for seclusion or exclusion is good for only 24 hours. The time the order is received shall be recorded with the order on the order sheet.

(4) In mental health/mental retardation facilities, telephone orders are not acceptable for continued seclusion or exclusion. The patient/resident shall be

seen by a physician within 24 hours, and the order shall be rewritten and supported by a progress note. In Youth Development Centers and Youth Forestry Camps, the resident/patient must be seen by the Superintendent/Assistant Superintendent who will assess the resident's/patient's needs and seek professional consultation if indicated.

(5) In the absence of a written or telephone order, a patient/resident may be placed in seclusion or exclusion as a protective measure for no more than 1 hour when the action is immediately necessary.

(6) If a patient/resident is placed in seclusion or exclusion as an emergency procedure, the unit program supervisor or appropriate designated program specialist of the area shall be notified immediately.

(7) In mental health/mental retardation facilities, if the nursing supervisor/designated program specialist, after visiting the patient/resident, deems seclusion or exclusion necessary, the attending physician or his delegate shall be notified immediately. In Youth Development Center or Youth Forestry Camp facilities, if the designated program specialist, after visiting the patient/resident, deems seclusion necessary, the Superintendent/Assistant Superintendent shall be notified immediately.

(8) In facilities, the nursing supervisor or designated program specialist shall document his observations fully on an appropriate progress report.

(9) The following procedure is to be followed when a patient/resident is in seclusion:

(i) Potentially dangerous articles will be removed from the patient/resident. This includes articles of clothing if there are reasonable grounds to believe such clothing constitutes a substantial threat to the health or safety of the patient/resident or others.

(ii) The patient/resident will be checked at no less than 15-minute intervals by personnel.

(iii) The physical needs of the patient/resident will be given prompt response.

(iv) Concise and informative written reports concerning the status of the patient/resident will be prepared and retained in the record of the patient/resident in seclusion or exclusion. Daily written reports concerning patient/residents in seclusion or exclusion shall be prepared and sent to appropriate designated staff of the facility. These reports shall include information as follows:

(A) Identifying data concerning name, age, location in building and record number of patient/resident.

(B) Reason for seclusion or exclusion.

(C) Period of time in seclusion or exclusion.

(D) Brief statement regarding status of patient/resident.

(E) Record of time given for attention to personal needs.

**§ 13.9. Psychological restraints.**

(a) Psychological restraints include those therapeutic regimes or programs which involve the withholding of privileges and participation in activities.

(b) Psychological restraints may not affect the right of a patient/resident to basic sustenance, clothing or shelter or communication with appropriate and responsible persons—such as family members, attorneys, physicians, qualified program specialists or clergymen.

(c) In all cases, psychological restraints shall be in the nature of restrictions that are therapeutically based, clinically justified and made part of the treatment plan.

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