



Visionary Leadership for Psychiatric-Mental Health Nurses Around the World

INTERNATIONAL SOCIETY OF PSYCHIATRIC-MENTAL HEALTH NURSES

HCFA Letter, August 1999

August 27, 1999

Ms. Donna Shalala
Secretary
Health Care Financing Administration
Department of Health and Human Services, Attention: HCFA-3018-IFC
7500 Security Blvd.
P.O. Box 7517
Baltimore, MD 21244

Dear Ms. Donna Shalala,

I am writing on the behalf of the International Society of Psychiatric-Mental Health Nurses (ISPAN) to provide you with our comments and recommendations on the recent HCFA document (HCFA – 3018 – IFC) on Patient Rights, Conditions of Participation, specific to the use of seclusion and restraint. The ISPAN organization is comprised of psychiatric-mental health nurses who engage in clinical practice and research with patients of all ages at every stage of the continuum of psychiatric care. Additionally, we are the psychiatric-mental health nursing organization that represents subspecialty focused practice in child and adolescent psychiatric-mental health nursing and psychiatric consultation liaison nursing in non-psychiatric settings. Our membership also comprises the majority of the educators in psychiatric-mental health nursing programs. Several of our members have been intensely involved in the restraint issue and have been involved in testifying at Senate hearings and worked with the CBS investigation (Unsafe Havens), addressing the care of children in treatment facilities, especially when restraints were involved in the care of these children.

The use of patient restraint, whether it is four-point restraint in a seclusion room or the use of a posey vest to restrain a patient in a chair to prevent a fall, is a clinical decision that must be based on specific criteria. We endorse the use of constant observation for persons in restraint. For many of us, the requirement of constant observation while in restraints is already part of the procedure in most behavioral health care units. The assessment and evaluation of a patient within one hour of being placed in restraints by an attending physician has not been a universal requirement. This has not been a requirement because of the perceived burden such a requirement would place on some institutions that are 1) not connected to a teaching hospital and therefore, lack 24 hours physician coverage, 2) rural, geographically remote, or 3) for other reasons lack immediate access to physician

assessment. However, psychiatric emergencies must be considered to be as important as medical emergencies and warrant the same immediate attention.

Restraint of patients on non-behavioral health units is often employed to protect the acutely or chronically confused patient from climbing out of bed and falling and or dislodging tubes or devices that could produce a life threatening event if removed without skill by a healthcare provider. The current definition of restraint makes this posey vest is a restraint and would require constant observation on a medical surgical unit or in a nursing home. We have concerns regarding staffing patterns and compliance. One potential outcome would be less restraint but more injury related to falls and wandering into unsafe areas. This could result in much more harm to patients than the use of restraint that is carefully decided, implemented, monitored and re-evaluated. The Joint Commission on Accreditation of Hospitals Organization (JCAHO) has strict standards about the use of restraint and has made a distinction between restraint used on a behavioral care unit and on a medical surgical unit. We have recently reviewed JCAHO's revisions and endorse their principles that will be in their next handbook.

The issue of licensed and qualified personnel is addressed on page 36079 of the HCFA document. This issue of which health care professionals are regarded as qualified to make the decision to restrain must be carefully considered and, then made absolutely clear. More careful definition is required to clearly identify the appropriate channels for clinical accountability. We believe that the registered nurse is the best-qualified professional to assess the patient and then select the most appropriate intervention at the least restrictive level to protect the patient, staff, roommate(s) and visitors. In behavioral health units, the registered nurse certified as a psychiatric nurse is the best qualified professional to make the assessment and decision to restraint. This certified psychiatric nurse brings knowledge and skills to the decision to restrain that are based on a combination of education, training, and standardized testing that ensures a high level of competence and care that can be relied on across all types of institutions locations, and patients.

We propose that caregiver staff needs orientation and then annual education (to assess competency as in CPR) in aggression management with special emphasis on seclusion and restraint in behavioral health units and health agencies that specifically address behavioral interventions (i.e. substance abuse units, partial treatment facilities, and long term care facilities). The hospitals that utilize "floating psychiatric beds", staff also must attend and participate in aggression management with emphasis on restraints and patient rights. We suggest mandatory content regarding assessment and intervention in the cycle of aggression, symptom recognition, verbal intervention skills and the critical thinking strategies designed to select the least restrictive intervention best suited to the presenting needs of the patient. Staff also needs basic defensive and offensive physical skill simulation training along with the proper use and implementation of both chemical and mechanical restraint. Further training needs to address agency specific zero tolerance policies and the organizational response to the needs of staff involved in incidents of aggression.

The issue of increasing everyone's awareness of the possibility of restraint related trauma, injury and death must be captured and studied to determine what other methods can be employed, therefore we recommend a mandatory tracking/reporting system of sentinel events that occur during a restraint episode or when the patient is in restraints to an independent agency. In closing, I want thank you for your focused review and consideration of ISPN's endorsements, comments and recommendations. Please contact me if our organization can be of any further assistance, as I would like to assure you that ISPN members are and will continue to be actively engaged in advocating for the rights of patients in treatment and for their safety.

Sincerely,

Susan L.W. Krupnick MSN, RN, CARN, CS
President- ISPN