R³ Report | Requirement, Rationale, Reference

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Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

New and Revised Restraint and Seclusion Requirements for Behavioral Health Care and Human Services Organizations

Effective January 1, 2025, The Joint Commission has approved new and revised requirements for behavioral health care and human services organizations who use restraint and seclusion. These requirements underwent a full revision and will replace the current restraint and seclusion requirements. The revisions reduce redundancies, streamline processes, and remove the physical holding of a child or youth requirements.

The revised requirements eliminate the separate "physical holding of a child or youth" requirements and incorporate this concept into the requirements for restraint and seclusion, as physical holding that restricts freedom of movement is a type of restraint. Physical holding restraints can be as dangerous as other types of restraint and should be held to the same requirements, as evidenced by a study that examined data collected over a 26-year period regarding restraint fatalities among children and adolescents in the United States. The study confirms that deaths do occur from physical holding restraints (that is, without any devices). In this study, 63 of 79 reported deaths were from physical holding without mechanical devices (Nunno et al., 2021). Because of the risks involved with physical holding, organizations will follow the same requirements as other types of restraint.

The Joint Commission's definition of restraint has also been revised to clarify what is considered a restraint (which includes physical holding) and what is not. The revised restraint and seclusion requirements only apply to physical interventions that are included in the definitions of restraint or seclusion. The requirements do not apply to the examples provided that do not meet the definition of restraint.

The prepublication version of the requirements will be available online until December 31, 2024. After January 1, 2025, please access the new requirements in the E-dition or standards manual.

Requirement

Standard CTS.05.05.01: For organizations that use restraint or seclusion: The organization has written policies and procedures that guide the use of restraint or seclusion.

EP 1. For organizations that use restraint or seclusion: The organization's policies and procedures regarding restraint or seclusion include but are not limited to the following:

- A definition of what constitutes restraint in accordance with law and regulation or The Joint Commission's definition
- A definition of what constitutes seclusion in accordance with law and regulation or The Joint Commission's definition
- A definition of what constitutes the use of medications as a restraint in accordance with law and regulation or The Joint Commission's definition
- Safe techniques used to implement restraints and seclusion in accordance with law and regulation and those that are prohibited.

- Physician, licensed practitioner, and other staff training requirements and competencies
- Additional staffing requirements for monitoring and assessment
- Information to collect as part of the initial assessment that can minimize the use and impact of restraint and seclusion
- Limiting the use of restraint or seclusion to situations in which there is an imminent risk of an individual physically harming staff, self, or others
- Notification of the individual served and their family, in accordance with law and regulation, of the organization's policy on the use of restraint and seclusion
- Notification of the family of the individual served when restraint or seclusion is initiated (for a child or youth, the parent(s) or guardian), in accordance with law and regulation
- Notification of the administrative and/or clinical leaders when an order for restraint or seclusion is extended beyond the initial order or when an individual served experiences multiple episodes of restraint or seclusion
- The determination of who has authority to order, initiate, and discontinue the use of restraint and seclusion, in accordance with law and regulation
- The requirement that restraint or seclusion is discontinued as soon as is safely possible
- The determination of who can assess and monitor individuals served in restraint or seclusion
- Time frames for assessing and monitoring individuals in restraint or seclusion
- Time-limited orders in accordance with law and regulation
- Post-restraint or seclusion practices (such as debrief, assessment of mental and physical state)
- A plan for providing emergency medical services.
- Reporting injuries and deaths to the organization's leadership and external agencies in accordance with law and regulation
- Documentation of restraint or seclusion
- Data collection on the use of restraint or seclusion and how it is used in performance improvement activities
- Debriefing after an episode of restraint or seclusion

Rationale

To improve safety when using restraint and seclusion, organizations need to develop and implement robust processes. It is important to follow written policies and procedures when it comes to using a high-risk intervention such as restraint and seclusion because of the increased likelihood of harm if implemented inappropriately. Utilizing multifaceted policies and procedures that address safe use of restraint and seclusion, including but not limited to safe techniques, staff training, and debriefing after an event, reduces the risk of harm from the use of restraint or seclusion.

References:*

- Nunno, M.A., McCabe, L.A., Izzo, C.V., Smith, E.G., Sellers, D.E., & Holden, M.J. (2021). A 26-year study of restraint fatalities among children and adolescents in the United States: A failure of organization structures and processes. *Child & Youth Care Forum*, 51, 661–680. https://doi.org/10.1007/s10566-021-09646-w

*Not a complete literature review.

Requirement

Standard CTS.05.05.03: For organizations that use restraint or seclusion: Adequate staffing is maintained to promote therapeutic interventions that decrease the use of restraint and seclusion and maximize safety when restraint or seclusion is used.

Note: Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the "Human Resources Management" (HRM) chapter.

EP 1. For organizations that use restraint or seclusion: The organization bases its staffing on a variety of factors, including the following:

- Staff competencies
- The physical design of the environment
- Acuity levels of individuals served
- Age and emotional, behavioral, and developmental functioning of individuals served

Standard CTS.05.05.05: For organizations that use restraint or seclusion: Staff are trained and competent to minimize the use of restraint and seclusion and, when use is indicated, to use restraint or seclusion safely.

EP 1. For organizations that use restraint or seclusion: The organization trains staff on the use of restraint and seclusion and assesses their competence prior to participating in the use of restraint and seclusion and on a periodic basis thereafter.

EP 2. For organizations that use restraint or seclusion: Any staff involved in the use of restraint or seclusion receive education and training and demonstrate knowledge focused on the following:

- Strategies to identify behaviors of staff and individuals served, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion
- Recognizing how factors such as age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual served reacts to physical contact
- Use of nonphysical intervention skills
- Methods for choosing the least restrictive intervention based on an assessment of the behavioral or medical status or the condition of the individual served
- Safe application and use of all types of restraint or seclusion used in the organization, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
- Identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
- Monitoring the physical and psychological well-being of the individual served who is restrained or secluded, including but not limited to respiratory and circulatory status, skin integrity, vital signs, elimination, hygiene, and nutritional and hydration needs.
- Use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification
- Recognizing when to contact a medically trained licensed practitioner or emergency medical services to evaluate and/or treat the physical status of an individual in restraint or seclusion

EP 3. For organizations that use restraint or seclusion: Staff providing training in restraint or seclusion have education, training, and experience in the techniques used to address behaviors of individuals served that necessitate the use of restraint or seclusion.

EP 4. For organizations that use restraint or seclusion: The organization documents in staff records that restraint and seclusion training and demonstration of competence were completed.

Rationale for CTS.05.05.03 and CTS.05.05.05

Providing adequate staffing and in appropriate roles increases safety related to restraint and seclusion. Organizations that assign staff based on staff competencies, the physical design of the environment, and the needs of the individuals served have shown a decreased need for restraint and seclusion. Staff training and education is also necessary to reduce restraint and seclusion and to safely use it, when necessary. Implementation of staff education and training programs reduces conflicts, aggressive incidents, and the use of restraint and seclusion. In addition to improved outcomes for individuals served, staff training protects staff by preventing and managing aggression, conflict, and other unwanted situations.

References:*

- Magnowski, S. R., & Cleveland, S. (2019). The Impact of milieu nurse–client shift assignments on monthly restraint rates on an inpatient child/adolescent psychiatric unit. *Journal of the American Psychiatric Nurses Association*, 26(1), 86–91. https://doi.org/10.1177/1078390319834358
- Slaatto, A., Mellblom, A. V., Kleppe, L. C., Baugerud, G. A., & Kjøbli, J. (2021). Conflict prevention, de-escalation and restraint in children/youth inpatient and residential facilities: A systematic mapping review. *Children and Youth Services Review*, 127, 106069. https://doi.org/10.1016/j.childyouth.2021.106069

*Not a complete literature review.

Requirement

Standard CTS.05.05.07: For organizations that use restraint or seclusion: The organization takes action to reduce the need for restraint and seclusion.

EP 1. For organizations that use restraint or seclusion: To minimize the use and impact of restraint or seclusion, the organization performs an initial assessment on an individual served who is at risk of endangering themselves, staff, or others and identifies the following, with the help of the individual served and their family, as appropriate:

- Techniques and/or tools that would help the individual served control their aggressive behavior
- Signs of escalation in the individual served, to prevent reaching the point of imminent risk
- Interventions that preserve the dignity of the individual served if placed in restraint or seclusion
- Preexisting medical conditions or any physical, intellectual, developmental, or cognitive disabilities and limitations that would place the individual served at greater risk during restraint or seclusion
- History of sexual or physical abuse or other trauma that would place the individual served at greater psychological risk during restraint or seclusion

EP 2. For organizations that use restraint or seclusion: Whenever possible, the organization uses nonphysical techniques based on information from the initial assessment in managing behaviors of individuals served.
Note 1: Such techniques may include implementing a crisis response plan, redirecting the focus of the individual, employing verbal de-escalation and positive behavioral support, or using sensory modulation.
Note 2: It is important to consider the needs of the individual served. For example, an individual with intellectual, developmental, or cognitive disabilities may require specialized de-escalation plans that consider differing language and communication needs.

EP 3. For organizations that use restraint or seclusion: The organization only uses restraint or seclusion when less restrictive or nonphysical interventions are ineffective or not feasible and when there is an imminent risk of an individual served physically harming self, staff, or others.

EP 4. For organizations that use restraint or seclusion: The organization considers information learned from the initial assessment and chooses the least restrictive type of physical intervention.

EP 5. For organizations that use restraint or seclusion: The organization does not use restraint or seclusion as a means of coercion, discipline, convenience, or retaliation by staff.

Rationale

Restraint and seclusion should only be used as a last resort to manage dangerous and harmful behaviors. An assessment of an individual's behavioral, social, and medical history; their preferences; and the effectiveness or ineffectiveness of past exposure to de-escalation methods is key in preventing restraint and seclusion and improving outcomes when restraint or seclusion must be used. Including developmental and cognitively appropriate interventions, based on the individual's assessment in treatment planning, also reduces the use of restraints and seclusion and improves outcomes when they are used.

References:*

- O'Donoghue, E. M., Pogge, D. L., & Harvey, P. D. (2020). The impact of intellectual disability and autism spectrum disorder on restraint and seclusion in pre-adolescent psychiatric inpatients. *Journal of Mental Health Research in Intellectual Disabilities*, 13(2), 86–109. https://doi.org/10.1080/19315864.2020.1750742

*Not a complete literature review.

Requirement

Standard CTS.05.05.09: For organizations that use restraint or seclusion: The organization assesses and monitors the individual in restraint or seclusion.

EP 1. For organizations that use restraint or seclusion: Staff assess the individual served at initiation of restraint or seclusion and at regular intervals, defined by the organization and provide necessary interventions. These assessments and interventions include the following, as relevant to the type of restraint or seclusion:

- Assessing for signs of any injury associated with applying restraint or seclusion
- Addressing nutrition and hydration status
- Checking circulation and completing range of motion in the extremities
- Checking vital signs
- Addressing hygiene and elimination needs
- Assessing physical and psychological status and comfort
- Addressing readiness for discontinuation of restraint or seclusion

EP 2. For organizations that use restraint or seclusion: An assigned staff member who is competent and trained monitors the individual in restraint or seclusion through continuous in-person observation.
Note: An individual in seclusion without restraints may be continuously monitored using simultaneous video and audio equipment, if consistent with the individual's condition or wishes.

Rationale

Monitoring is essential to safety of the individual served who is in restraint or seclusion. It is important that staff are trained and able to report and address any adverse physical or psychological reactions. Monitoring also provides staff with the information they need to decide when the restraint or seclusion can be discontinued.

Reference*

- American Psychiatric Nurses Association. (2022, February). *Standards of practice: Seclusion and restraint*. https://omsapaprod.wpenginepowered.com/wp-content/uploads/2023/03/APNA-Standards-of-Practice-Seclusion-and-Restraint-2.2022.pdf

*Not a complete literature review.

Requirement

Standard CTS.05.05.11: For organizations that use restraint or seclusion: The organization initiates restraint or seclusion based on an individual order.

EP 1. For organizations that use restraint or seclusion: A physician or licensed practitioner, who is authorized to order restraint or seclusion by organization policy in accordance with state law, orders the use or continuation of restraint and seclusion.
Note: Because the use of restraint and seclusion is limited to emergencies (in which a physician or other licensed practitioner may not be immediately available), the organization may authorize qualified, trained staff members to initiate restraint or seclusion before an order is obtained from a physician or other licensed practitioner.

EP 2. For organizations that use restraint or seclusion: As soon as possible after the initiation of restraint or seclusion, in accordance with organization policy, qualified staff notify and obtain an order (verbal or written) from a physician or other licensed practitioner authorized to order restraint or seclusion by organization policy in accordance with state law, if the practitioner did not order the restraint or seclusion.

EP 3. For organizations that use restraint or seclusion: Written and verbal orders for restraint and seclusion are limited to the following:

- Four hours for adults ages 18 and older
- Two hours for children and youth ages 9 to 17
- One hour for children under age 9

Note 1: If time limits differ in applicable law and regulation, the organization uses the more stringent requirement.
Note 2: If restraint or seclusion use needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from the physician or other licensed practitioner.

EP 4. For organizations that use restraint or seclusion: Orders for restraint or seclusion are not written as a standing order or for use on an as-needed basis (that is, PRN).

Standard CTS.05.05.13: For organizations that use restraint or seclusion: The organization evaluates and reevaluates the individual in restraint or seclusion.

EP 1. For organizations that use restraint or seclusion: Prior to the expiration of each order and before renewing the order, a physician or other licensed practitioner authorized by organization policy in accordance with state law evaluates the individual in restraint or seclusion in person for the following:

- The individual's immediate situation
- The individual's reaction to the intervention
- The individual's condition
- The need to continue or terminate the restraint or seclusion

Note 1: A trained designee, in accordance with law and regulation and organization policy, may conduct the in-person evaluation prior to the expiration of each order.
Note 2: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.

EP 2. For organizations that use restraint or seclusion: When the in-person evaluation (performed prior to the expiration of each order) is performed by a trained designee, they consult with the physician or other licensed practitioner responsible for the care of the individual served as soon as possible after the evaluation, within the time frame determined by organization policy.

EP 3. For organizations that use restraint or seclusion: Unless state law is more restrictive, at least every 24 hours, a physician or other authorized licensed practitioner responsible for the individual served sees and evaluates the individual before writing a new order for restraint or seclusion in accordance with organization policy and law and regulation.

EP 4. For organizations that use restraint or seclusion: At the time of the in-person evaluation of the individual in restraint or seclusion or when consulting with the designee who performed the evaluation, the physician or licensed practitioner does the following:

- Works with the individual served and staff to identify ways to help the individual regain control
- Revises the individual's plan for care, treatment, or services as needed
- If necessary, provides a new written or verbal order for restraint or seclusion

Rationale for CTS.05.05.11 and CTS.05.05.13

Established clinical practice that includes medically high-risk interventions requires oversight by a licensed practitioner. Restraint and seclusion can cause medical complications and even death. Like other high-risk interventions such as prescription medications and invasive procedures, the use of restraint and seclusion requires oversight by a licensed practitioner when ordering and renewing orders.

Because of the risks involved, it is important to evaluate and reevaluate individuals in restraint or seclusion. Those designated to initiate restraint and evaluate individuals in restraint or seclusion must be trained in accordance with standard CTS.05.05.05.

Reference*

- Nunno, M.A., McCabe, L.A., Izzo, C.V., Smith, E.G., Sellers, D.E., & Holden, M.J. (2021). A 26-year study of restraint fatalities among children and adolescents in the United States: A failure of organization structures and processes. Child & Youth Care Forum, 51, 661–680. https://doi.org/10.1007/s10566-021-09646-w

*Not a complete literature review.

Requirement

Standard CTS.05.05.15 For organizations that use restraint or seclusion: Restraint and seclusion use are discontinued when the individual served meets the behavior criteria for discontinuation.

EP 1. For organizations that use restraint or seclusion: As early as feasible in the restraint or seclusion process, the individual served is made aware of the rationale for restraint or seclusion and the behavior criteria for its discontinuation. Restraint or seclusion is then discontinued as soon as the individual served meets the behavior criteria.

EP 2. For organizations that use restraint or seclusion: Staff help individuals in restraint or seclusion to meet the behavior criteria for discontinuing restraint or seclusion.

Rationale

Due to safety risks associated with restraint and seclusion, it is not only important to use them as a last resort to protect individuals and staff from imminent danger, but also to closely monitor the individual in seclusion or restraint so that these interventions can be discontinued as early as is safely possible.

Reference*

- American Psychiatric Nurses Association. (2022). *Standards of practice: Seclusion and restraint*. https://omsapaprod.wpenginepowered.com/wp-content/uploads/2023/03/APNA-Standards-of-Practice-Seclusion-and-Restraint-2.2022.pdf

*Not a complete literature review.

Requirement

Standard CTS.05.05.17 For organizations that use restraint or seclusion: The individual served and staff participate in a debriefing about the restraint or seclusion episode.

EP 1. For organizations that use restraint or seclusion: For each episode of restraint or seclusion, the individual served and, if appropriate, the individual's family participate in a debriefing with available staff members who were involved in the episode as soon as possible, but no longer than 24 hours after the episode.

EP 2. For organizations that use restraint or seclusion: The debriefing about each episode of restraint or seclusion is used to do the following:

- Identify what led to the incident and what could have been handled differently
- Ascertain that the physical well-being, psychological comfort, and right to privacy of the individual served were addressed
- Counsel the individual served for any trauma that may have resulted from the incident
- Assess the impact of the restraint or seclusion episode on their behavioral functioning
- When indicated, modify the individual's plan for care, treatment, or services

Rationale

Debriefing is used to analyze what took place before, during, and after a restraint or seclusion event. It helps identify how actions can be improved through policy changes or through changes in individualized treatment plans. In addition, it serves as an opportunity for staff and individuals involved to debrief the event and potentially mitigate traumatizing effects it has caused. Post-intervention debriefing sessions also decrease restraint and seclusion rates.

Reference

- Boulton, K. A., Raghupathy, V., Guastella, A. J., & Bowden, M. R. (2022). Reducing seclusion use in an Australian child and adolescent psychiatric inpatient unit. *Journal of Affective Disorders*, *305*, 1–7. https://doi.org/10.1016/j.jad.2022.02.066
- National Association of State Mental Health Program Directors. (2006, November). *Six core strategies for reducing seclusion and restraint use.* https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf

*Not a complete literature review.

Requirement

Standard CTS.05.05.19 For organizations that use restraint or seclusion: The organization documents the use of restraint or seclusion.

EP 1. For organizations that use restraint or seclusion: Documentation of restraint and seclusion in the case/clinical record includes the following:

- Any in-person medical and behavioral evaluation for restraint or seclusion

- A description of the individual's behavior and the intervention used, including less restrictive interventions attempted
- The individual's condition or symptom(s) that warranted the use of the restraint or seclusion, including concerns about the safety of the individual or staff, and the rationale for the type of intervention used
- The individual's response to the intervention(s) used, including the rationale for continued use of the intervention
- Each of the individual's assessments and reassessments performed by staff
- Continuous monitoring of the individual served
- Revisions to the plan for care, treatment, or services
- Death or injury associated with the use of restraint or seclusion
- Names of the staff members who participated in the restraint and seclusion episode, including those who were directly involved and those who monitored the well-being of the individual served
- Notification of the use of restraint or seclusion to the physician or other licensed practitioner
- Orders for restraint or seclusion
- If the family of the individual served was notified, in accordance with law and regulation, of the use of restraint and/or seclusion (for a child or youth, this includes their parent(s) or guardian) - Behavior criteria for discontinuing restraint and/or seclusion
- That the individual served was informed of the behavior criteria they needed to meet for restraint and/or seclusion to be discontinued
- Assistance provided to the individual served to help them meet the behavior criteria for discontinuing the use of restraint and/or seclusion
- Debriefing the individual served with staff following an episode of restraint and/or seclusion

Rationale

Documentation is a key practice in any clinical treatment, but is especially important when a high-risk intervention like restraint or seclusion is used. Information about the episode, including what lead up to it, monitoring that occurred, and debriefing, must be included.

Reference*

- American Psychiatric Nurses Association. (2022). *Standards of practice: Seclusion and restraint*. https://omsapaprod.wpenginepowered.com/wp-content/uploads/2023/03/APNA-Standards-of-Practice-Seclusion-and-Restraint-2.2022.pdf

*Not a complete literature review.

Requirement

Standard CTS.05.05.21 For organizations that use restraint or seclusion: The organization collects data on the use of restraint and seclusion.

EP 1. For organizations that use restraint or seclusion: The organization's leaders determine the frequency with which data on the use of restraint and seclusion are analyzed. When an opportunity for improvement is identified, the organization implements a performance improvement plan to address the opportunity. Note: When determining the frequency of analysis, the organization takes into consideration the number of cases where restraint or seclusion are used. At a minimum, the data is analyzed annually.
See also PI.01.01.01 EP 20, PI.04.01.01 EP 2.

EP 2. For organizations that use restraint or seclusion: Data on all restraint and seclusion episodes are collected from and classified for all settings/locations by the following:

- Shift
- Staff who initiated the process
- The length of each episode
- Day of the week each episode was initiated
- The type of restraint used
- Number of episodes per individual served

- Whether injuries were sustained by the individual served or staff
- Age of the individual served
- Gender of the individual served
- Race, ethnicity, and preferred language of the individual served

Rationale

Collecting data to improve outcomes for individuals served and inform practice is a key component for quality and safety in healthcare. Leadership involvement is an important part to any organizational change, and is essential to a multipronged approach to implement performance improvement projects and ultimately improve safety of individuals served. Taking action on identifying any opportunities for improvement is shown to improve outcomes. In addition, classifying data in different ways can identify areas to target for performance improvement, including health disparities.

Reference*

- Boulton, K. A., Raghupathy, V., Guastella, A. J., & Bowden, M. R. (2022). Reducing seclusion use in an Australian child and adolescent psychiatric inpatient unit. *Journal of Affective Disorders*, *305*, 1–7. https://doi.org/10.1016/j.jad.2022.02.066
- Singal, S., Howell, D., Hanna, L., Tang, S.X., Van Meter, An., Saito, E., Kane, J.M., & Michaels, T.I. (2023). Race-Based Disparities in the Frequency and Duration of Restraint Use in a Psychiatric Inpatient Setting. *Psychiatric Services*, 75(4), 308-315. https://doi.org/10.1176/appi.ps.20230057

*Not a complete literature review.

New BHC "Restraint" glossary definition:

A restraint is any method (chemical or physical) of restricting the freedom of movement of an individual served to manage their behavior. This includes any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of an individual to move their arms, legs, body, or head freely. It also includes any drug or medication when it is used as a restriction to manage the individual's behavior or to restrict their freedom of movement and is not a standard treatment or dosage for their condition.
Examples of interventions that would not meet the definition of restraint include the following:

- Briefly holding an individual without undue force in order to calm or comfort them
- Physically assisting someone to complete a task
- Escorting or guiding someone away from an area or situation
- Separating individuals in order to break up a fight
- Physical interventions that do not use undue force to prevent imminent danger (stopping an individual from running into traffic, tripping, or falling)