ALIGNMENT

nonviolent crisis intervention
a CPI specialized offering

The *Nonviolent Crisis Intervention*® Training Program and the Joint Commission Standards on Restraint and Seclusion

cpi

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The *Nonviolent Crisis Intervention*® Training Program and the Joint Commission Standards on Restraint and Seclusion

Alignment

Joint Commission Standard	Joint Commission Element of Performance	How CPI Works With the Element of Performance
Standard PC.03.05.01: The [organization] uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.	1. The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others. 2. The hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation. 3. The hospital uses restraint or seclusion only when less restrictive interventions are ineffective. 4. The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others. 5. The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.	CPI recommends that physical intervention be used only as a last resort when a patient has become a danger to self or others, and that the least restrictive intervention be used at all possible times. CPI does not recommend or endorse time limits on physical interventions. Instead, CPI advises that staff continually assess for signs that the patient is no longer dangerous to self or others and discontinue the physical intervention as soon as possible.
Standard PC.03.05.03: The [organization] uses restraint or seclusion safely.	1. The hospital implements restraint or seclusion using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation. 2. The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care.	The *Nonviolent Physical Crisis Intervention*SM techniques are designed for safety and allow a Therapeutic Rapport to be re-established with the individual who has lost control. Key elements of *Nonviolent Physical Crisis Intervention*SM responses include: ▪ No element of pain is involved. ▪ The intent is to calm the individual. ▪ The intent is to keep the individual off the floor, thus reducing risks of restraint-related positional asphyxia and other injuries. ▪ Team interventions are used when necessary. ▪ Used only as a last resort when someone presents a danger. ▪ Used to protect—not to punish. CPI teaches that inherent in any form of physical intervention is some level of risk of physical or emotional harm. When staff are aware of the possible risks associated with restraint, CPI believes they are more likely to more strenuously seek intervention strategies that avoid using restraint. CPI also recommends that Certified Instructors incorporate into training population-specific examples. In this way, staff are educated regarding the care plan(s) of those in care. Further, CPI suggests that an organization evaluate each individual patient for any medical or psychological conditions that may contraindicate the use of restraint. If possible, CPI recommends that this information be included directly in an individual's care plan to ensure the best possible care for that person.

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Standard PC.03.05.05: The [organization] initiates restraint or seclusion based on an individual order.	1. A physician or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation. 2. The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion. 3. The attending physician is consulted as soon as possible, in accordance with hospital policy, if he or she did not order the restraint or seclusion. 4. Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following limits: – 4 hours for adults 18 years of age or older – 2 hours for children and adolescents 9 to 17 years of age – 1 hour for children under 9 years of age Orders may be renewed according to the time limits for a maximum of 24 consecutive hours. 5. Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation. 6. Orders for restraint used to protect the physical safety of the nonviolent or non–self-destructive patient are renewed in accordance with hospital policy.	All interventions are designed to protect the *Care, Welfare, Safety, and Security*℠ of the service users and providers. CPI strongly suggests that organizations review information regarding any pertinent local, state, or federal policy. With that in mind, CPI will always suggest that staff consult and work with a patient's direct care provider to ensure that all interventions used are medically appropriate. CPI does not advocate use of timed physical interventions, but rather continual assessment for opportunities to discontinue a physical intervention or—at the very least—an opportunity to utilize a less restrictive intervention.
Standard PC.03.05.07: The [organization] monitors patients who are restrained or secluded.	1. Physicians or other licensed independent practitioners or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. (See also PC.03.05.17, EP 3.)	The *Nonviolent Crisis Intervention*® training program teaches participants to monitor the physical and psychological needs of the person being restrained. CPI recommends that an additional staff member who is trained in proper restraint use—but not directly involved in the restraint—continuously monitor the person's physical and psychological status, including but not limited to vital signs, circulation, and comfort.

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Standard PC.03.05.09: The [organization] has written policies and procedures that guide the use of restraint or seclusion.	1. The hospital's policies and procedures regarding restraint or seclusion include the following: – Physician and other authorized licensed independent practitioner training requirements – Staff training requirements – The determination of who has authority to order restraint and seclusion – The determination of who has authority to discontinue the use of restraint or seclusion – The determination of who can initiate the use of restraint or seclusion – The circumstances under which restraint or seclusion is discontinued – The requirement that restraint or seclusion is discontinued as soon as is safely possible – A definition of restraint in accordance with 42 CFR 482.13(e)(1)(i)(A–C) – A definition of seclusion in accordance with 42 CFR 482.13(e)(1)(ii) – A definition or description of what constitutes the use of medications as a restraint in accordance with 42 CFR 482.13(e)(1)(i)(B) – A determination of who can assess and monitor patients in restraint or seclusion – Time frames for assessing and monitoring patients in restraint or seclusion 2. Physicians and other licensed independent practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint and seclusion.	The *Nonviolent Crisis Intervention*® training program is built upon the information taught in the CPI *Crisis Development Model*℠. This model establishes a framework for assessing crisis situations and it is discussed here when staff shall utilize physical intervention(s). CPI supports that only trained staff members be allowed to intervene in a crisis, specifically when an intervention has moved to a physical level. Further, CPI strongly suggests that an organization have written policies and procedures regarding who has authority to physically intervene, how that decision is made, and when the physical intervention will be discontinued, as well as which techniques staff are authorized to utilize. CPI recommends that an organization review its policies on a regular and ongoing basis to ensure that policies are in accordance with not only best practice standards and guidelines but also legislative regulations. CPI also recommends that its Certified Instructors incorporate this information directly within their training of the *Nonviolent Crisis Intervention*® program so as to keep all staff informed of these rules/regulations.

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Standard PC.03.05.11: The [organization] evaluates and reevaluates the patient who is restrained or secluded.	1. A physician or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. 2. When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse or trained physician assistant, he or she consults with the attending physician or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy. 3. The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others, includes the following: – An evaluation of the patient's immediate situation – The patient's reaction to the intervention – The patient's medical and behavioral condition – The need to continue or terminate the restraint or seclusion	CPI recommends that everyone who was involved in the crisis be involved in a debriefing process. The *Nonviolent Crisis Intervention*® training program's unit on Postvention provides a structure for reviewing incidents with the person who was in crisis, staff members, and any witnesses. The CPI *COPING Model*℠ assists in identifying events leading up to the incident and/or patterns of behaviors and provides the individual with the opportunity to assist the staff in identifying alternative behaviors and/or interventions that could be utilized to prevent recurrence.
Standard PC.03.05.13: The [organization] continually monitors patients who are simultaneously restrained and secluded.	1. The patient who is simultaneously restrained and secluded is continually monitored by trained staff either in-person or through the use of both video and audio equipment that is in close proximity to the patient.	CPI supports this principle: CPI strongly advocates not for time limits but rather for continuous—"ongoing, without interruption"—assessment for opportunities to discontinue the physical intervention, or, at the very least, to look for an opportunity to engage in a less restrictive intervention.

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Standard PC.03.05.15: The [organization] documents the use of restraint or seclusion.	1. Documentation of restraint and seclusion in the medical record includes the following: – Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior – A description of the patient's behavior and the intervention used – Any alternatives or other less restrictive interventions attempted – The patient's condition or symptom(s) that warranted the use of the restraint or seclusion – The patient's response to the intervention(s) used, including the rationale for continued use of the intervention – Individual patient assessments and reassessments – The intervals for monitoring – Revisions to the plan of care – The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion – Injuries to the patient – Death associated with the use of restraint or seclusion – The identity of the physician or other licensed independent practitioner who ordered the restraint or seclusion – Orders for restraint or seclusion – Notification of the use of restraint or seclusion to the attending physician – Consultations	The CPI *COPING Model*℠ provides a framework for staff to debrief with an individual after a crisis. Within this framework, staff are taught to review and document observed behaviors of the individual prior to and during a crisis, alternatives and other less restrictive interventions attempted, the individual's condition which warranted the use of restraint and/or other interventions, the individual's responses to those interventions, review and alteration to the individual's plan, and notification of other interested parties. Further, CPI is willing to assist organizations in collecting and organizing data through our Research and Development department.

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Standard PC.03.05.17: The [organization] trains staff to safely implement the use of restraint or seclusion.	1. The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals: – At orientation – Before participating in the use of restraint and seclusion – On a periodic basis thereafter 2. Based on the population served, staff education, training, and demonstrated knowledge focus on the following: – Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion – Use of nonphysical intervention skills – Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition – Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia) – Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary – Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion – Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification (See also PC.03.05.07, EP 1) 3. Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion. 4. The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.	CPI recognizes and supports that training is an ongoing process, not a one-time event. CPI recommends that staff either be retrained in the *Nonviolent Crisis Intervention*® training program—or that staff attend a formal refresher training—every 6–12 months. Further, CPI supports the implementation of regular drills, rehearsals, and practice sessions for staff; these are to include additional practice, and they are to apply both verbal and physical intervention skills to unique situations that may arise. CPI suggests that these sessions be recorded to help Certified Instructors keep track and assess which staff need additional training, as well as to assess staffs' competency in applying the skills learned in the *Nonviolent Crisis Intervention*® program.

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Standard PC.03.05.19: The [organization] reports deaths associated with the use of restraint and seclusion.	1. The hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS): – Each death that occurs while a patient is in restraint or seclusion – Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion – Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death 2. The deaths addressed in PC.03.05.19, EP 1 are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.	In the *Nonviolent Crisis Intervention*® training program as well as in the Instructor Manual is an addendum, "Understanding the Risks of Restraints." This information can assist in educating staff regarding the dangers associated with using restraints, and it reinforces the reasoning behind discontinuing a restraint as soon as a patient is no longer a danger to self or others. CPI strongly recommends that, in the event of a death, proper authorities be notified immediately and that the death be thoroughly investigated in accordance with any federal, state, and local legislation/ regulation.