Behavioral Restraint and Seclusion

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Opening Conversation

How many of you have witnessed a restraint or seclusion incident?
- What did you think?
    - Was it necessary?
    - Why?
- How did things end?
- How did you feel?

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Foundational Principles

- Restraint and seclusion use is almost always entirely avoidable.
- Restraint and seclusion are ***safety measures of last resort*** for behavior that poses an imminent risk of harm to someone.
- Restraint and seclusion do not keep people safe; May cause death even when done "safely" and correctly.
- Restraint and seclusion do not positively change behavior; May increase negative behavior and decrease positive behavior.

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Charles Curie Quote

“Seclusion and restraint with its inherent physical force, chemical or physical bodily immobilization and isolation do not alleviate human suffering. It does not change behavior.” Charles Curie, Former SAMSHA Administrator

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The Joint Commission

Use of restraint and seclusion: The use of restraint and seclusion poses an inherent risk to the physical safety and psychological well-being of the individual served and staff.

Therefore, restraint and seclusion are used only in an emergency when there is an imminent risk of an individual served physically harming herself or himself or others, including staff. Nonphysical interventions are the first choice, unless safety demands an immediate physical response.

Reducing the use of restraint and seclusion. Because restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of the rights of an individual served, and even death, organizations continually explore ways to prevent, reduce, and strive to eliminate restraint and seclusion through effective performance improvement initiatives.

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Restraint vs. Seclusion

Restraint

Any manual, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely

Types of ***Behavioral*** Restraint:

- Physical = manual holds or ‘takedowns”
- Mechanical = use of a device, material or equipment
- Chemical = medication

Not:

- Briefly holding to calm or comfort
- Brief assistance to redirect or prompt-
- Devices used from transportation or security or postural support or protective equipment

Seclusion

Involuntary confinement alone in a room or an area from which the resident is physically prevented from leaving

Doesn’t matter if door is locked or even closed

Not:

- Voluntary time out
- Restriction to area consistent with unit rules or an individual’s treatment plan

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What is “chemical restraint”?

Medication used as a **restriction** to manage an individual’s behavior or restrict freedom of movement and is not a standard treatment or dosage for the patient’s condition;

Generally unplanned and in emergency or crisis.

- Not medication routinely prescribed to treat individual’s psychiatric condition to improve functioning.
- Not necessarily all PRNs but often PRNs are used.
- Often used in combination with other forms of restraint or seclusion.

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Where to look for what is allowed?

Federal Law
- Hospitals
- Residential Facilities for Adolescents
- ICFs for Individuals with DD

State Law and Regulations
- Title 22 by facility type
- Health & Safety Code §1180

Joint Commission Standards
- Voluntary accreditation of health facilities

Facility Policies

What they cover?
- What types of restraint or seclusion is allowed
- Who can order it
- Duration of orders
- Level of observation when in restraint or seclusion
- Frequency of monitoring or assessment
- Staff training (some)
- Debriefing (some)

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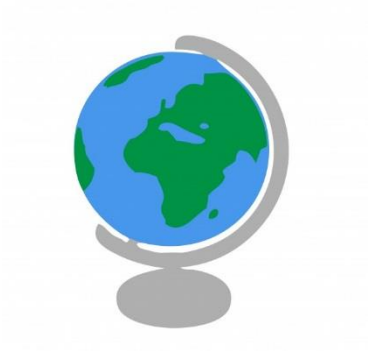
Universal Standards

All patients have the right to be free from physical or mental abuse, and corporal punishment.
All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.
Organizations should strive to completely eliminate the use of behavioral restraint or seclusion.



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What does that mean?

1. Safety measure of last resort:
    - When other less restrictive alternatives have failed or are determined ineffective to protect someone from harm.
    - It must be discontinued at earliest possible time

2. Only when behavior poses imminent risk of serious physical harm to a person
    - Least restrictive intervention possible
    - Fewest points
        - Use of seclusion vs. restraint
        - + use of chemical restraint
    - For the least amount of time necessary
    - Release as soon as no longer poses imminent risk….

3. Never for coercion, discipline, convenience or retaliation by staff
    - Is staff using it after an aggressive act is over?
    - Does the individual still pose an *imminent* risk of serious harm?

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Other requirements:

4. Use (or extended use) generally requires approval of specially trained staff

5. Must be [constantly] observed and periodically assessed/checked

6. Only used by staff trained in restraint/seclusion

7. All patients must be assessed on admission:
    - Advance directive on de-escalation & use of restraint or seclusion
    - Personal triggers
    - Preexisting medical conditions
    - History of trauma
8. Debriefing required following each incident

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NEVER:

1. Obstruct airway or impair breathing
   Pressure on back or body weight against back or torso
2. Anything covering mouth
3. Restrain a person with known medical or physical risk if believe it would endanger life or exacerbate medical condition
4. Prone with hands restrained behind back
5. Containment as extended procedure
    - If prone, must observe for distress
6. Prone **mechanical** restraint with those at risk for positional asphyxiation, unless written authorization by MD
7. [Never seclusion with individuals who is imminently self-injurious]

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Hospital Standards

1. Only by order of MD or licensed independent practitioner:
    1. In an emergency, at RN's discretion but need to get order ASAP from MD
    2. No PRN orders or standing orders
    3. MD must co-sign order within 24 hours

2. MD or specially trained RN or PA must see patient face to face within 1 hour
    1. Ideally NOT by RN who ordered restraint/seclusion
    2. Must consult with MD ASAP after face-to-face
3. Order only lasts 4 hours (for adults)
4. Order can only be renewed up to 24 hours & then must been assessed 1:1 by MD or LIP before writing new order

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More on Hospital Standards

Simultaneously restraint and seclusion ONLY if continually monitored either:

1. Face to face or
2. By trained staff using both video & audio equipment in close proximity to patient

6. Monitoring by MD or LIP at interval determined by hospital
7. Documentation requirements:
    1. Description of behavior & interventions used
    2. Alternatives & less restrictive interventions attempted
    3. Patient's condition
    4. Patient's response including rationale for continued use

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Joint Commission

1. MD/LIP in-person eval every 8 hrs for adults

2. Must check patients every 15 minutes
3. Observation:

Must be continuous in person observation.

    1. Seclusion ONLY: after 1st hour, ok to monitor with simultaneous video & audio equip
4. Staff must be trained & demonstrate competency
    1. Viewpoints of patients who experience R/S must be incorporated in staff training &, if possible, participate/contribute to staff training & education
5. Upper level management notification at intervals with extended restraint/seclusion use
    1. Debriefing required
6. Data collection required

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Limitations in Adult Residential Facilities

- No mechanical restraint
- No chemical restraint
- Manual restraint for no more than 15 minutes at a time
    - Each additional 15 minute increment must be approved by certified administrator not involved in restraint event
- No seclusion of regional center consumers
- Direct visual contact at all times when in seclusion
    - Not be video and/or audio equipment or electronic transmission.

Title 22 Section 85302 et seq

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Reviewing restraint or seclusion incident

1. Did they follow the law & facility procedures?
    - Did they get orders as required?
        - Within timelines
        - Assessment within 1 hour
    - Did they record patient observations?
    - Did they use the least amount of intervention necessary?
    - Did the restraint/seclusion end as soon as dangerous behavior ceased?
    - Were staff involved currently trained?

2. Was it necessary?
    - What was the risk posed?
    - Was the behavior *really* imminently dangerous?
    - Could something less restrictive be used that would ameliorate the risk?

3. What lead up to the restraint use? Look back in time, and then back further….
    - Precursors, triggers, antecedents
    - What did staff do (or not do) as things developed?

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Other things to ask or think about?

4. Did the individual have an advanced directive or crisis plan?
    - Was it followed?
    - Is the plan working?

If keep having restraint events, then plan isn't working or staff aren't following it….

    - How to it avoid the next time?
    - Need a plan?
    - What didn't work?
    - What needs to change?

5. Was anyone injured?

- How can the risk be prevented?

6. What are environmental contributing factors?
    - What was happening in milieu at the time?
    - How did staff intervene?
7. What is the staff & facility culture?
    - Trauma informed?
    - Command and control?
8. Look at data
    - Individual patterns
    - Patterns on unit (time of day, day of week, which staff)
    - Across populations, units, facility,