Community Healthlink Policy and Procedure Manual		
Section: 7 Clients Rights and Responsibilities	**Policy Number:** 7-15-01	**Effective Date:** 4/22/2014
Title: Seclusion and Restraint		**Review Date:** 08/25/2015
Scope: Staff in programs providing direct care services		**Originated:** 9/7/99
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PURPOSE:

To provide guidelines and documentation procedures for all staff who implement seclusion or restraints. Community Healthlink utilizes the Crisis Prevention Institute (CPI) training program.

DEFINITIONS:

Seclusion: The separation of an individual from normal program participation in an involuntary manner. The person served is in seclusion if freedom to leave the segregated room or area is denied. Voluntary time-out is not considered seclusion.

Mechanical Restraint: Mechanical restraint includes any device or physical object used to confine or otherwise limit an individual's freedom of movement, such as a device used to prevent an individual from hurting him or herself or others. Devices or objects necessary for orthopedic, surgical or similar medical treatment purposed are not considered restraints if they are not used to limit an individual's voluntary movements.

Physical Restraint: The use of physical, mechanical, or other means to temporarily subdue an individual or otherwise limit a person's freedom of movement.

Substantial Risk: Substantial risk is defined as the serious imminent threat of bodily harm, where there is the present ability to effect such harm.

RESPONSIBILITY:

Responsible parties include all personnel who provide direct services to clients served by Community Healthlink.

This policy was developed with the Community Healthlink's Human Rights Subcommittee of the Clinical Policy and Operations Team and approved by CHL's Executive Management Team. It serves as a guide for all personnel.

POLICY:

Restraint or seclusion of a person served by Community Healthlink is allowed only in programs or services that permit restraints or seclusion by policy approved by the Clinical Policy and Operations Committee and only when consistent with approved policy.

The use of mechanical or chemical restraints of a person served by Community Healthlink is prohibited.

Physical restraint and/or seclusion of a person served by Community Healthlink is permitted only if the person served is a danger to her/himself or others and only to prevent injury to the person served and/or others. Physical restraint or seclusion lasting for more than 20 minutes must be approved by the Program Director or designee or on-call clinician. Physical restraint or seclusion will be implemented only by staff with current certification to use restraint or seclusion.

Agency Behavior Management Statement

Each licensee is required to maintain a written statement defining the rules, policies and procedures for behavior management. The statement must define and explain the use of behavior management procedures used in the facility, including, where applicable, the form of restraint used in an emergency, the behavioral interventions used as alternatives to restraint, and controls on abuse of such restraints. *See* 102 CMR 3.07(7)(a) 3. EEC regulations impose limits on specific restraint holds and the circumstances under which physical restraint may be applied, and require resident participation in the establishment of such rules, policies and procedures, when feasible and appropriate. *See* 102 CMR 3.07(7)(j) and 3.07(7)(c). Program staff must be trained in how to follow these regulations and this accompanying policy as well as their program's approved policies at all times.

Licensees are required to direct behavior management toward the goal of maximizing the growth and development of the residents and of protecting the group and individuals within it. *See* 102 CMR 3.07(7)(h). Physical restraint is the most severe and restrictive form of behavior management that a staff person can use from among a range of available behavior management measures. Best practice indicates that the use of measures less stringent than physical restraint can resolve many situations very effectively, and EEC regulations require that less intrusive measures be employed first, whenever possible. Staff judgment and the use of appropriate behavior management responses depend largely upon the soundness of a licensee's policies and the quality and comprehensiveness of the agency's staff training.

Components of Behavior Management Policy

A program's behavior management policy must include the following components and must adhere to the guidelines and limitations noted below:

1. **Appropriate responses to misbehavior**, including a complete list of both positive and negative responses/consequences used by the program.

2. **A description of the circumstances under which restraint may be used and of appropriate interventions prior to restraint, citing specific examples of**

behaviors that would immediately precede a restraint. This includes a description of the agency's methods for de-escalation of the resident's behaviors and its procedures for preventing the need for a physical restraint. EEC regulations provide that restraint may *only* be used when a resident is demonstrating by his/her actions that he/she is dangerous to him/herself (called "demonstrable danger"), and the danger has been or is unlikely to be averted by alternatives to restraint. Staff judgment about the seriousness of the danger in each individual situation is a crucial part of understanding whether or not restraint is warranted. No set of examples, however exhaustive, can substitute for the careful judgment of a staff person properly trained in de-escalation and prevention of physical restraint.

3. **Demonstrable Danger.** Staff must be trained to identify demonstrable danger and must, in each instance, be able to justify their decision to use restraint. Examples of demonstrable danger may include, but are not limited to, the following: a resident who is assaultive, self-injurious, threatening injury with a weapon, attempting to or putting his/her hand through a window or a wall, attempting to use large or broken furniture to injure himself or others, or inciting a riot where other interventions have been tried and found ineffective and a serious disturbance is imminent. Examples of behaviors which, by themselves, do not reach the threshold of demonstrable danger include, but are not limited to, the following: yelling, swearing, making verbal threats, clenching a fist, asking about consequences, destroying property, banging or pounding with a fist (without injury), or refusing to comply with a rule or staff directive.

4. **A description of the use of physical escort, if applicable.** The description must include examples of behaviors that would immediately precede an escort and a specific description of how a resident would be escorted, including how many staff participate in the escort, what parts of the child's body are controlled during the escort, the location to which the child will be escorted, and any limitations on escort, (such as prohibitions on escorting a child on stairs, in a crowded room, in public, etc.) An escort may not include dragging a resident or carrying a resisting resident, unless the child is of an age and size generally considered appropriate for carrying. Carrying a young child to safety in an appropriate manner would include a situation where the child was too young to completely understand the danger or where he/she could not walk fast enough to get away from danger, but would have walked with some guidance/assistance from staff. In these situations, the escorts would be appropriate. However, a pre-adolescent or adolescent resident who is resisting an escort should first be offered the opportunity to walk on his/her own. Removing other residents from the area must also be considered as an alternative and should be done if possible. If an acting-out resident continues to refuse an

escort (and the room cannot be cleared of others) and his or her actions demonstrate that he /she is dangerous to himself or others, the resident may require a physical restraint instead of an escort. (*See* 102 CMR 3.02(2), "Physical Escort" and "Physical Restraint," which make clear that an escort includes only touching or holding the hand, wrist, arm, shoulder, or back to induce a resident to walk to a safe location. Holding a resident or carrying a resident who is older than the age at which carrying is normally appropriate is considered a restraint.) Under these circumstances, the program must develop and teach safe and appropriate carrying techniques to staff and must clarify that these carrying techniques constitute a physical restraint.

5. **A complete description of the method of physical takedown for restraints other than standing restraint.** The program's restraint description must specify that staff are to initially attempt the least restrictive position available within their program's approved method, unless immediate safety concerns dictate otherwise. Typically, when circumstances require restraint, staff can initiate a standing restraint and only progress to more restrictive positions, such as a sitting or floor restraint, if the standing hold is not sufficient to provide safety for the resident or others. Program policy must specify the conditions under which staff would be justified in deciding to implement a more restrictive hold. The description must also identify how many staff are to be involved in a takedown, the steps of the takedown (such as whether children are moved to preliminary positions prior to lying or sitting on the floor) and whether the child is taken to a sitting, prone or supine position. The guidelines must make clear that staff may not manipulate a resident's head or neck to move the resident from a standing to a seated or floor position. The guidelines must also expressly prohibit methods of moving a resident from a standing to a horizontal position that allow the resident's chest or back to strike the floor before the knees, arms or buttocks, because these actions may damage the resident's breathing apparatus. The licensee must always seek to employ the least restrictive behavior management tool capable of maintaining the safety of the individual and the group.

6. **The name of the method of physical restraint employed, and a complete description of each type of hold used**, including the number of staff involved, how the staff are deployed during the hold, the specific parts of the body which staff are assigned to restrain, the placement of the child's head and limbs during the hold, and the placement of all staff involved in the hold. Headlocks, choke holds, full or half nelsons, or pressure points to cause pain **are not** to be used under any circumstances. *See* 102 CMR 3.07(7)(j) 7. Holds that cover any portion of the face or use any cloth or object on the face are not permitted. Similarly, a hold that

puts a resident in the "hog-tied" position is also prohibited. Prone restraints should never take place on soft surfaces such as mattresses, which could impair breathing. Holds that include any direct force or pressure on the chest or diaphragm that may restrict breathing are prohibited. The hold commonly described as a "prone basket," in which the resident is lying face down with his/her arms or hands underneath any part of the chest, may restrict breathing and is therefore prohibited. A straddle position may not be used for any resident with a history of sexual abuse, whether such history has been conveyed verbally or in writing. Holds that require the resident's hands to be held behind the back must be justified by the behavior of the resident at the time of the restraint and the physical threat presented by the population the program serves. For example, juveniles with a history of violent behavior, who are either detained by the court or committed to the Department of Youth Services may require such a hold.

The program's written behavior management statement must include controls on the abuse of restraints. *See* 102 CMR 3.07(7)(a)3. Such controls must address what steps staff may and may not take when an escort or restraint goes awry; for example, if staff are unable to complete the escort or restraint in the manner in which they have been trained. Each program must develop appropriate guidelines detailing how staff may intervene, according to the principle of using the least restrictive means necessary to keep the resident and others safe.

7. **Guidelines for monitoring the resident and for release of the restraint**. Programs must describe how staff will monitor physical restraint and modify or discontinue the restraint, when appropriate, in response to the resident's distress. Staff must be trained not to treat the resident's ability to speak as evidence of absence of distress. **The often-used statement "if she/he can talk, he/she can breathe" is <u>false</u>.** In general, monitoring may be accomplished by visual, tactile, and/or verbal means. A method of monitoring which combines more than one sensory channel provides greater safety than relying on one sense alone. Monitoring the resident during a standing hold may include the use of one or more of these sensory channels. For verbal residents, staff must be trained to assess both the content and quality of a resident's verbal responses. **Staff must be able to look at the resident's face during any sitting or floor position restraint** in order to visually observe the resident's condition and breathing. Visual monitoring may be performed by the staff directly participating in the restraint, provided that the program's approved restraint procedure allows for involved staff to see the resident's face at all times. If the staff who are directly involved in the restraint are unable to observe the resident's face, then other staff not directly involved in the restraint must visually monitor the resident. Finally, guidelines must include as a

goal that each physical intervention be discontinued as soon as possible, because the length of the restraint is directly related to the rate of injury in many children. Restraints lasting longer than 20 minutes should be rare. Under unusual circumstances in which a longer restraint is required, restraint guidelines must indicate who is responsible for approving any restraint that lasts longer than 20 minutes, and the circumstances under which such continuation would be approved. During a restraint of more than 20 minutes duration, staff must be trained to continually seek input of other staff, clinicians and administrators regarding an assessment of whether or not the restraint should be continued. In addition, staff must be trained to consider relieving and replacing one another during a restraint, both as a means of offering the resident an alternative person to work with to reach de-escalation and end the restraint, and as a means of relieving their own fatigue.

Guidelines and procedures for release from the restraint must be described. Staff must always evaluate a resident's response in the context of emotional, behavioral and physical distress. A resident must be released immediately if he/she exhibits any sign of significant physical distress, or at the first indication that it is safe to release the resident. *See* 102 CMR 3.07 (7)(j)10 and 11. In general, during the course of a safe restraint, breathing patterns should change from faster to slower and then become more regular. A breathing pattern that changes after initially slowing is a sign of significant distress and requires immediate release. A statement by the resident that he/she is having difficulty breathing, labored breathing, rapid breathing, "grunting" sounds, sudden silence or any indication of vomiting are some, but not all, of the signs of significant distress. **These signs must be taken seriously and require immediate release and an assessment of the need for further medical attention.**

Residents may express some mild discomfort in their extremities during a restraint, and staff must always respond by initiating a partial release or adjusting their hold. Staff must always be aware that a physical restraint is a physiological intervention as well as a behavioral one, and must take steps to ensure that the resident is safe throughout the use of the procedure.

8. **Processing and Follow-up**. A complete description of the program's procedures for processing a restraint with a resident and the follow-up and quality assurance procedures used with staff must be submitted.

9. **Documentation procedures**. EEC regulations require that all restraints be documented in a physical restraint incident report. *See* 102 CMR 3.04(3)(h) and (i) and 3.07(7)(j)14. Licensees must submit a copy of the program's restraint incident

report form and any other restraint documentation forms and procedures used by the program. Furthermore, licensees are required to offer each resident who has been restrained the opportunity to comment in writing on the restraint as soon as possible, within 24 hours of its occurrence. *See* 102 CMR 3.04(4)(i). Such comments shall be attached to the restraint incident report.

10. **A complete description of the training that will be provided for staff prior to their participation in restraint**. The training must identify and describe the needs and common behaviors of the client population, the basic physiology of children and adolescents, the importance that structure and daily programming play in guiding children's behavior, the range of behavior management responses that the agency will permit, and the critical importance of establishing an appropriate relationship with each resident. The training must prioritize the use of prevention strategies, non-confrontational approaches, and alternatives to physical restraint. Emphasis **must** be placed on de-escalation techniques that can be employed to defuse potentially difficult situations and other techniques (such as time-outs, consequences, redirection, etc.) that address the child's or adolescent's behavioral issues in the least restrictive manner possible. The use of physical restraint must be placed in the appropriate context: to be used only as a last resort when a child demonstrates by his/her actions that he/she is dangerous to him/herself, and that danger cannot be addressed through any other means. Actions that demonstrate that a child is dangerous **must** be defined within the training to ensure that staff persons clearly understand the circumstances and parameters **under which** they are permitted to use physical restraint. The description of the training must include the training curriculum content,[1] the qualifications of the trainer, the method of training, and the number of hours involved in the training. The training plan must also specify the requirements for refresher training.

11. **A description of the procedures for regular review, the name of the restraint coordinator and the names and positions of staff that serve on a restraint safety committee**. In order to ensure that physical restraint in residential programs receives effective oversight, EEC regulations require that the licensee identify a restraint coordinator. *See* 102 CMR 3.07(7)(a)5. The restraint coordinator will be responsible for the following: oversight and documentation of restraint training; ensuring that restraint is employed only when necessary and is carried out according to the training provided; and the collection and review of restraint data and staff and resident safety information. *See* 102 CMR 3.02(2). Furthermore, programs are required to establish a restraint safety committee, which must include the restraint coordinator as well as child care and clinical staff, to review all restraint data on a regular basis. *See* 102 CMR 3.07(7)(a)7. The purpose of such a

review is to determine the appropriateness of the use of the restraint(s), to determine patterns of responses, if any exist, and/or to identify issues that may need to be addressed by further training.

Program-specific Training Approval and Certification

The requirements for restraint training are based upon the provisions of 102 CMR 3.04(7), Orientation and Training, and 102 CMR 3.07(7), Behavior Management. Staff training must be consistent with EEC regulatory requirements. Each licensee must submit a copy of its restraint training curricula and plans, including the specific schedule (hours) of the proposed trainings to EEC for approval. EEC reviews each program's restraint training individually and then decides whether or not to approve the training. For this reason, EEC will not approve or certify any mass-marketed restraint curricula or any pre-packaged training. Some licensees provide different restraint training to staff depending upon the program in which they work; for example, some agencies have an "adolescent division," a "child division," a "juvenile justice division." Under these circumstances, the licensee must request separate EEC approval for each program's restraint training. In addition, when a staff person is granted certification as a restraint trainer, that certification is never transferable between agencies or between programs within one agency if the training differs between programs.

PROCEDURES:

Staff in programs that permit the use of restraint and seclusion will maintain current certification in the use of these behavioral interventions.

Data Collection:

Data will be collected on every restraint or seclusion incident.

ALL physical restraints will be documented on the Restraint Form. On the restraint form, the staff member filling out the form is responsible for describing the antecedents to the physical interventions as well as the length of the intervention itself. The following criteria must be followed in order to correctly fill out a restraint form:

1. All restraint forms must be completed in black ink.
2. The restraint form is classified as a new order by checking the appropriate line at the top of the form.
3. All information must be filled out on the client involved, (ie, legal name-no nicknames, date of birth, date of admission).
4. The correct times of the physical restraint should be noted.
5. The emergency situation is classified by checking the appropriate box under the "reason for restraint" heading.

6. The antecedents to the restraint are documented in appropriate section. The information in this box should be objective as possible, and written in the third person, never mentioning the names of other clients. Also listed should be the interventions tried before utilizing physical intervention in the section beneath, including such things as crisis counseling or offering a PRN (if applicable).
7. The restraint form is signed by the appropriate person. For restraints under 20 minutes, the shift supervisor should sign the form. For restraints longer than 20 minutes, the on-call administrator or in-house administrator authorizing the restraint should sign.
8. Upon completion, the restraint forms are given to Program Director or designee. The Program Director will send a copy of all restraints forms to the person in charge or Human Rights Officer, Program Coordinator/Manager, and the Human Rights Committee, and the Compliance Officer, who in turn will need to review these forms.

A **Client Comment Form** will be completed. The following criteria must be followed in order to correctly fill out a client comment form:

1. Each restraint form will have a corresponding client comment form with matching dates and times.
2. After a client is safe, she/he will be given the opportunity to sign the restraint form. She/he will be handed the restraint form so they can read it and make comments if so desired. If she/he does not wish to comment, staff will ask that she/he check where appropriate. Staff will ask the she/he sign and date/time the form on the line at the bottom.
3. Staff will sign/date/time as a witness under the heading “Clinician’s Signature.” If a client does not wish to comment, then staff must comment (saying “does not wish to comment”).