

State of Alabama
Department of Mental Health and Mental Retardation

NUMBER: 510-75

SUBJECT: MR Services – Program Supports

TITLE: Use of Restrictive Procedures

EFFECTIVE: 11/14/08

REVIEWED:

CHANGED:

RESPONSIBLE OFFICE: Mental Retardation Division

APPROVED:

I. POLICY:

Individuals served by the Division of Mental Retardation of the Alabama Department of Mental Health have the right to be free of unnecessary restrictions and to have access to behavioral intervention that is supported by sound scientific evidence.

Behavioral interventions utilize the principles of positive behavioral supports. When positive, proactive approaches fail to prevent inappropriate/challenging behavior that jeopardizes the safety of recipients and staff, staff will utilize the least restrictive effective method for controlling the behavior.

II. DEFINITIONS:

1. **Self-Injurious Behavior (SIB):** Behavior that places the recipient in imminent danger of harming him/herself.
2. **Physical Aggression (PA)** Behavior that poses an imminent danger of harming others.
3. **Physical Restraint:** Any manual/physical method or mechanical device, material, or equipment attached or adjacent to the person's body that he/she cannot remove and which restricts the free movement or normal access to one's body as a means of controlling his/her physical activities in order to protect him/her or others from injury.
 - a. **Manual Restraint:** The use of an approved hold (as specified and taught in the facility's Crisis Prevention and Intervention course) to restrict an individual's movements for their protection from harm or to prevent harm to others.

- b. **Mechanical Restraint:** The application of a device, material, or equipment to any portion of the body to restrict a recipient's movement.
4. **Chemical Restraint:** The immediate administration of a medication that is not part of a recipient's regular drug regimen, or if part of the regular drug regimen, is administered at a time or dose other than prescribed.
5. **Other Restrictive Behavior Interventions/Procedures:** There are other procedures that employ restrictive techniques addressed in the Division of Mental Retardation Behavioral Services Procedural Guidelines. The additional procedures are not restraints, but require justification, review and approval, and monitoring that is based upon the level of restrictiveness assigned in the guidelines.
7. **Emergency Use of Restraint:** Any of the above procedures utilized outside the context of an approved Behavior Support Plan. Each procedure requires the specified approvals indicated in the Procedures section of this policy. Emergency Procedures require the use of the least restrictive procedures for the briefest period of time necessary to prevent injury to recipients or others due to behaviors that reasonably could not have been anticipated.
8. **Programmatic Use of Restraint:** Any Manual or Mechanical Restraint procedure that is included in a formal Behavior Support Plan. Each procedure requires the specified approvals as indicated in the Procedures section of this policy. Programmatic use of Chemical Restraint is prohibited.

IV. STANDARDS:

1. Positive approaches such as rewarding appropriate behavior are always a first choice of intervention with recipients. When positive approaches fail to prevent inappropriate behavior, interventions should be used that require the least amount of restriction in order to control the behavior. Examples, in order of relative degree of restrictiveness, include, but are not limited to the following:
 - A. Talk with the recipient (if possible) and try and identify and resolve the problem. (Are they hungry, thirsty, too hot or cold, sick, etc?)
 - B. Redirect inappropriate behaviors that are not dangerous, when possible, to behaviors/activities that are appropriate. Attend to the person when engaged in appropriate behavior and do not call undue attention to behaviors that is non-dangerous inappropriate behavior.
 - C. Verbally interrupt the behavior with a verbal prompt to stop.
 - D. Redirect the recipient to an appropriate activity.

- E. Escort the recipient to another area. This involves asking the person if they would like to go to another location (to their bedroom for example) and does not involve any physical management to get them there.
 - F. Remove other individuals from the area
 - G. Response Interruption (Physically holding the recipient's hands by their side for 5 seconds or less).
 - H. Transport using an approved hold (two-man come-along) for the purpose of moving an uncooperative recipient to another location for their protection or the protection of others.
 - I. Manual Restraint as previously defined
 - J. Mechanical Restraint as previously defined.
 - K. Chemical Restraint as previously defined.
2. Non-programmatic techniques, such as verbal abuse, psychological abuse (i.e. threats, intimidation), corporal punishment, seclusion, electric shock, water misting etc. are prohibited.
 3. As a general rule, the least restrictive means necessary will be used to control inappropriate behavior. More restrictive procedures will only be used when less restrictive procedures have failed unless a formal Behavior Support Plan has been developed and includes adequate justification why a more restrictive procedure is necessary.
 4. Physical restraint, either in an emergency or as part of a written, approved Behavior Support Plan, shall be employed only to protect an individual from injury to self or to prevent injury to others. Physical restraints should be considered only for behaviors considered dangerous or potentially dangerous. These include self-injurious behavior, physical aggression to others, and elopement to dangerous areas (e.g.; busy highway, etc).
 5. Restraints are not used as punishment, for the convenience of staff, a lack of staff, or as a substitute for programmatic supports.
 6. Restraint procedures are designed and used so as not to cause physical injury to an individual and to minimize physical and psychological discomfort.
 - A. When the use of restraints is deemed necessary, the restraint that poses the least amount of restriction should be attempted first. For example, manual

restraints would normally be used before a mechanical restraint. A mechanical restraint would be used before a chemical restraint. Any deviation from this practice will need to be justified by the Qualified Mental Retardation Professional (QMRP) or Physician authorizing the restraint or be included in an approved Behavior Support Plan. The justification for any deviation must include why the deviation was necessary to ensure the safety of the recipient and/or staff.

- B. Mechanical restraint devices are inspected prior to each use to ensure that they remain in good repair and are free from tears or protrusions that may cause injury.
 - C. Only devices identical to those specified in the written order for emergency restraint or in the Behavior Support Plan are used to restrain the individual.
7. Only a physician can authorize the use of a chemical restraint. Manual and mechanical restraints require the authorization of a QMRP. Manual restraint may be applied utilizing an approved technique while the QMRP is being contacted to ensure the safety of the recipient and/or others. Use of mechanical restraint requires approval by a QMRP regardless of whether it is being implemented in an emergency situation or it is part of a Behavior Support Plan.
 8. In order to be authorized to use/implement manual and mechanical restraints, all staff must complete competency based in-service on the use and application of restraints. Documentation of the training must be completed and maintained.
 9. The use of the manual and mechanical restraint must be discontinued within five (5) minutes of the recipient being calm as defined and specified in the release criteria as indicated on the Behavior Support Plan and/or restraint order form. Criteria for "calm" for the individual who is being restrained must be clearly defined and available to the staff who will use the restraint procedure. It is the responsibility of the QMRP who authorizes the restraint to document the criteria for release to ensure the restraint is discontinued "as quickly as possible".
 10. If there is a recurrence of the behavior after the restraint has been discontinued for more than five (5) minutes, and less restrictive measures have again failed, the QMRP must be contacted for a new Restraint Order.
 11. The use of restraints must be reported to and reviewed by the Behavior Review Committee, Advocacy Advisory Committee, and the Continuous Quality Improvement Committee.
 12. If the behavior requiring the use of restraints resulted in bodily harm by the individual, the Interdisciplinary Team must meet within three (3) days of the use of restraints. The Responsible QMRP and Psychologist will review the circumstances of such use to include: activities occurring just before the use of restraints, staff/recipient

- interaction at the time restraints were required, positive reinforcers available and the less restrictive procedures that were attempted. The review should also include the number of times and types of restrictive procedures used. The Responsible QMRP must maintain a system to identify individuals who have required the use of restraints, and the date restraints were used.
13. If the use of emergency restraint procedures is required three (3) or more times within a six (6) month period, the Interdisciplinary Team must meet. The meeting must include a functional behavior assessment and a revision of the Individual Program Plan. The team must meet within three (3) working days of the third use of an emergency restraint procedure.
 14. During an emergency such as a fire or a tornado warning, if the individual has a toileting accident, vomits or has a seizure, the use of the emergency procedure must be discontinued. An approved alternative technique for the management of the behavior can be utilized if the recipient continues to endanger themselves or others and until a QMRP or Physician can be contacted for further instructions.
 15. If any emergency procedure must be used beyond the authorized time limit, the area supervisor/designee must contact the QMRP who authorized the procedure for the approval of an extension. Documentation of the extension must be made in the Interdisciplinary (ID) Notes as well as on the restraint order.
 16. Use of mechanical restraints in a Behavior Support Plan requires adherence to the stringent approval process outlined in the Behavior Services Procedural Guidelines.
 17. All restraint usage, manual, mechanical (both emergency and programmatic), and chemical must be documented on a Restraint Order form.
 18. Signed physician's orders for restraints used for medical purposes (medical restraints) are not considered behavioral physical restraints. For example, if a person has had a medical procedure performed on his or her hand and a physician orders mittens to prevent removal of the stitches and to promote healing, this would not be considered a restraint as addressed by this policy. On the other hand, if mittens are ordered to prevent a person from picking the skin on their hands, the mittens would be considered a restraint because it is related specifically to the maladaptive behavior of skin picking.

V. PROCEDURES:

Emergency Manual Restraint:

1. In the absence of a Behavior Support Plan, when it appears necessary to protect an individual from injury to self or to prevent an individual from injuring others, and other less restrictive alternatives have failed to calm the individual, staff should request assistance from the area supervisor, who may give temporary authorization to

implement an approved manual restraint prior to notification of a QMRP. The supervisor will then notify a QMRP that a manual restraint has been implemented, supplying information regarding the behavior that prompted the necessity for the restraint. A description of the less restrictive measures attempted should be provided to the QMRP as well.

2. Emergency manual restraint is not to be approved for longer than 30 minutes. All individuals should be released as soon as they are calm.
3. All emergency manual restraints, regardless of the length of the restraint, will be documented on the facility's approved Restraint Order form. The completed restraint form will be submitted according to the facility's policy regarding the reporting of restraint use.

Emergency Mechanical Restraint:

1. In the absence of a Behavior Support Plan, if a recipient exhibits behavior that places him or herself or others at risk of injury and less restrictive alternatives have failed to calm the individual, the area supervisor will contact a QMRP. The supervisor will describe the behavioral situation and the less restrictive alternatives that have been attempted. A request for authorization to use mechanical restraint will then be made. The supervisor will also contact the Campus Coordinator.
2. Emergency mechanical restraint will not be applied by any staff until verbal or written authorization to do so is obtained from a QMRP.
3. When contacted, the QMRP will:
 - A. Recommend other alternative techniques to be used, or
 - B. Give permission to apply mechanical restraints, observe the individual to ensure restraints are properly applied, and sign the Restraint Order. If the QMRP is not on the grounds, they will sign the Restraint Order within one (1) hour of authorization.
4. If the QMRP authorizes the use of mechanical restraints, the area supervisor will complete the Restraint Order, documenting the behavioral situation and less restrictive alternatives attempted. Instructions from the QMRP will also be documented on the form, to include criteria for release from restraints.
5. When the authorization for mechanical restraints is received, the recipient will be placed in restraints. The area supervisor will notify the Switchboard Operator of the restraint. The Switchboard Operator will document the information on the Restrictive Procedure Log.

6. The accountable staff will remain in the immediate area with the person who is restrained and will physically check the individual at least every fifteen (15) minutes to ensure he/she is not in distress; the restraints are tied or applied appropriately and are allowing adequate circulation, etc. The result of the check will be documented on the Restraint Order form.
7. The area supervisor will check the individual's status every thirty (30) minutes to ensure all standards of this policy are met. The area supervisor will initial the Restraint Order at the time nearest the time the check was made.
8. For at least ten (10) minutes prior to the end of every hour in restraint, accountable staff will attempt to release the individual to offer an opportunity for range of motion, bathroom breaks, bathing if needed, fluids, meals, etc. If the individual is not calm, they will be placed back in restraints. The accountable staff will document actions on the Restraint Order.
9. Any time the accountable staff perceives a danger to the health and wellbeing of the individual in restraints, the nurse will be contacted to assess his/her status. The nurse will document findings and actions taken in the ID Notes.
10. After two hours in mechanical restraints (in extremely rare cases), if the criteria for release from restraints has not been met, the individual will be assessed by the area supervisor and the nurse to determine if the restraint should be discontinued. If the restraint cannot be safely discontinued, the QMRP will be contacted for further action. If no alternative action is possible and the QMRP agrees, the nurse should contact the physician for the consideration of a chemical restraint.
11. The use of the mechanical restraint must be discontinued within five (5) minutes of the recipient being calm as defined and specified in the release criteria, or when the authorized restraint period expires, whichever comes first.
12. The area supervisor will notify the Switchboard Operator of the release. The Switchboard Operator will document the release on the Restrictive Procedure Log.
13. The nurse will check the well-being of the recipient once released from mechanical restraint and will document his/her findings in the Interdisciplinary Notes.
14. If the behavior recurs after the release of any type of restraint, staff should use the least restrictive means necessary to control the behavior. If less restrictive measures fail, the QMRP should be contacted and all the procedural steps above should be repeated.
15. The completed Restraint Order will be submitted according to the facility's policy regarding the reporting of restraint use.

Chemical Restraint:

1. Chemical restraint may only be ordered by a physician.
2. If an individual's Behavior Support Plan has been implemented, but behavior continues to escalate, staff should contact a QMRP for further instructions. The QMRP should evaluate the situation and determine whether other alternatives considered less restrictive are available and implement those if appropriate.
3. If alternative interventions have been exhausted, the QMRP may consider a request for chemical restraint.
4. If chemical restraint is deemed advisable, the nurse will be contacted and the nurse will contact the physician/psychiatrist, making certain that current medical conditions/procedures, etc for that individual are brought to the physician's attention.
5. The physician may give a verbal or written order for a medication. Orders for chemical restraint may not exceed 12 hours. No depot medications (e.g.; haloperidol decanoate) may be administered as an emergency medication. No PRN or standing orders for psychotropic medication may be utilized.
6. The nurse will attempt to notify the guardian or responsible relative to apprise them of the situation. If the guardian is unavailable, the facility director will be advised.
7. If a physician orders a chemical restraint, the nurse will prepare and administer the medication and document and initial the physician's order if received verbally, and document and initial the Medication Administration Record.
8. The nurse will complete the Restraint Order and document any special instructions from the physician. The completed restraint form will be submitted according to the facility's policy regarding the reporting of restraint use.
9. If the physician does not order a chemical restraint, the physician will contact the QMRP to discuss the situation and the available alternatives.
10. A team meeting will be held within 10 working days after the chemical restraint has been administered to evaluate the need for modifications of the individual's plan pursuant to an analysis of the situation/events leading to the emergency. The completed restraint form will be submitted according to the facility's policy regarding the reporting of restraint use.

Programmatic Use of Manual Restraint:

1. When an individual meets the criteria for the planned use of manual restraint as written into an approved Behavior Support Plan, the manual restraint will be implemented specifically as written in the BSP.
2. The area supervisor will notify the QMRP the individual has been placed in manual restraint. The area supervisor will complete the Restraint Order.
3. The QMRP will sign the Restraint Order within one (1) hour of notification.
4. The area supervisor will monitor to ensure the manual restraint is implemented in accordance with the Behavior Support Plan and this policy.
5. Documentation and routing of the programmatic manual restraint will be the same as previously described for emergency use of the restraint.

Programmatic Use of Mechanical Restraint:

1. When an individual meets the criteria for the planned use of mechanical restraint as written into an approved Behavior Support Plan, the area supervisor will notify the QMRP of the need to implement the mechanical restraint as written in the BSP.
2. The QMRP will proceed to the location of the restraint in order to observe and document the procedure in order to ensure that the procedure *was* implemented in accordance with the Behavior Support Plan and this policy.
3. Documentation and routing of the programmatic mechanical restraint will be the same as previously described for emergency use of the restraint.

VI. REFERENCES:

1. DMH/MR Policy (20-62, 20-68)
2. ICF/MR Title XIX, 1995 (W193, W267, W274-W279, W281, W283W285, W295-W309, W310 W317)
3. Behavioral Services Procedural Guidelines (effective October 1, 2006)