

MEMORANDUM
 State of Minnesota
 Department of Public Welfare
 Medical Services Division
 Centennial Office Building
 Fifth Floor
 St. Paul, Minnesota
 55101

DATE: March 9, 1971

TO: All Medical Services Divisions Institutions
 ATTENTION: Medical Director
 ATTENTION: Administrator

FROM: David J. Vail, M. D., Director
 Medical Services Division

SUBJECT: Revised Policy on Restraint and Seclusion

I. Philosophy

One can begin the philosophy of restraint with the understanding that not all restraint can be eliminated. Self-control is a form of restraint, as are laws and regulations. Our goal might be a milieu that encourages self-control, and a society that guarantees that laws and rules will be fair to both the individual and society. The first institution to achieve this goal would truly be a forerunner in the MH-MR field.

Until we reach this goal, involuntarily imposed restrictions will be used. The enclosed are an attempt to upgrade our standards of use of restraint.

Let me begin by stating that I have developed these standards based on a theory of "Peer review" as the only effective way of safeguarding the rights of the patient/resident. Review must be performed at the treatment level, and the team assigned to the patient is the logical unit to do this. Incidents of restraint or seclusion should be reviewed, not with an eye for fixing blame for unpleasant incidents, but with the goal of teaching ward personnel how to intervene effectively in situations that might otherwise lead to the use of restraint or seclusion.

These standards are not meant to instructions to the institutions, but are written as guidelines to describe minimum standards. I suggest each institution draw up its own policy regarding the use of restraint and seclusion as submit a copy to central office for approval. I further suggest that a committee be formed, or one already formed be used to review restraint and seclusion within the institution according to these guidelines. Review from central office would also conform to the hospital's own policy.

II. Present Policy

The following is in effect RIGHTS OF MHCE 253A.17 PATIENTS. SUBDIVISION I

Restraints shall not be applied to a patient unless the head of the hospital or a member of the medical staff determines that they are necessary for the safety of the patient or others. Each use of a

restraint and reason, therefore, shall be made part of the clinical record of each patient under the signature of the head of the hospital or a member of the medical staff.

The following is proposed as a "High Priority" change to MHCA 253A.17, Subdivision 9:

Every person hospitalized in a state hospital under this act shall be entitled to receive proper care and treatment according to the best available and most advanced contemporary professional standards, and to this end the head of the hospital shall devise, or cause to be devised for each person so hospitalized.

- 1) a case plan which shall define precisely and set forth the case problem to be overcome,
- 2) precise goals for the solution or easement of the said problem,
- 3) specific measures to solve or ease the said problem and,
- 4) progress in each case shall be reviewed at not less than quarterly intervals to determine outcomes related to the goals and to review and modify the case plan as necessary.

The changes proposed above are meant to guarantee the patient's right to treatment. It is not my intent to say that restraint or seclusion should be a major consideration in developing a treatment plan, but neither should they be overlooked in the discussion of specific measures to solve or ease the said problem (#3). It might be argued that restraint is not a form of treatment and, therefore, should not be a part of a proposed care plan. Indiscriminate use of restraint or seclusion can adversely affect a treatment plan, however, and therefore, its use should be determined before the fact and not after. In any case, each incident of restraint or seclusion (as determined by the individual institution) should be reviewed by the treatment team in the light of section 4) of the proposed changes.

It was the consensus of the committee studying restrain/seclusion that the 1960 policy should be retained. Effort has been made to update the policy in keeping with current concepts. The change has not really been of theory, but one of emphasis.

III. Definitions

- A. General. A broad definition of restraint is any measure which deprives or tends to deprive the individual of freedom of movement. This definition would then include ENCLOSURE IN A PRIVATE ROOM (SECLUSION), A LOCKED WARD OR PORTION OF A WARD. In order to get a full picture of the use of restraint, more specific definitions are required.
- B. Restriction. The mildest form of controlling patient's/resident's behavior by temporarily limiting his general freedom of movement to a relatively large area such as a dayroom, ward, or building, or excluding the patient/resident from a specific area such as the canteen, auditorium, etc.

I don't feel this category of restrain needs to be reported; however, the Humane Practices Committee should observe that this category doesn't become a "catch all" for more restrictive types of restraint.

Restriction to a locked ward should be reviewed at least quarterly as required by the proposed change MHCA.

- C. Seclusion. A means of controlling the behavior of a patient/resident by temporarily removing him from social contact, such as confining him to a relatively small isolated room. The salient feature of seclusion is that the patient/resident is involuntarily removed from social contact. The fact that the door is locked or not locked is not of concern.
- D. Restraint. The severest method of controlling the behavior of patients/residents is temporarily limiting freedom of body or limb movement. This is physical restriction of movement. The following is a partial list of descriptive forms of restraint.
- 1) Muffs
 - 2) Mittens
 - 3) Cuff and bed—cuffs used to secure hands or feet to the bed itself includes wristlets and anklets
 - 4) Cuff and belt—cuffs locked to a belt designed for this purpose
 - 5) Safety brace—posey belts, folded bed sheets, flannel ties, chair boards, bed ties, side rails and crib sides.
 - 6) Tying jackets—alias sleeveless camisoles, vests, boleros (a more restrictive version of 5)
 - 7) Crib enclosures—includes netting and cribs which tend to make an enclosed space of the crib itself.
 - 8) Arm boards—alias "yucca" boards. To prevent bending of arms for purposes of self-abuse. Does not include arm boards for I.V.'s

IV. Reasons for restrain or seclusion

Section 3 of the memorandum on Restraint and Seclusion, 1960, listed four reasons for restraint. A follow-up memo on November 25, 1960 amended this to five. It should be noted that these five reasons are not an authority

to use restraint or seclusion. The MHCA states that restraints shall not be applied except for the safety of the patient or others. The reasons are to facilitate review and reporting.

- A. Aggression – out: includes damage to other patients or personnel and serious or extensive damage to property.
- B. Aggression – in: includes self-abuse, as in self-biting, head-banging, or other activities causing actual injury to the body. Does not include masturbation, unless this is actually injuring body tissues, as through excoriation. Includes suicidal intent.
- C. Medical: Inability to cooperate with urgent medical procedures, e.g., pulling out I.V.'s or stomach tubes, etc. Includes discoordination (a general term referring to ataxia, danger of injury from falling out of bed, etc.)
- D. Behavior Modification: Seclusion or restraint used as an integral part of a behavior modification program. It is important that this be a planned program that has been accepted by the Behavior Modification Review Committee.
- E. Limit Setting: Refers only to seclusion. To meet unusual conditions of tension or anxiety requiring separation from the group for therapeutic reasons, or clear danger of imminent elopement. Seclusion used for this reason should be as a part of a pre-planned treatment plan.
- F. Other. It is not enough to state that “restraints shall not be applied to a patient unless...they are necessary for the safety of the patient or others”, and therefore, the only authentic categories are the above. We all know that patients are restrained and secluded for reasons other than those stated. This category is for those people who are honest and concerned enough to report these incidents as they occur. It is only when these incidents are reported that they can be corrected.

V. Relief – same

VI. Ordering – same

VII. Reporting

Reporting should be accomplished in a way that guarantees all incidents of restraint or seclusion are reviewed by someone at the local level. The format for reporting should be determined by local policy, but the following information is recommended as minimal:

- a) A brief statement of how restraint/seclusion is to be used as a part of the patient's/resident's treatment plan. What are the expected results of restrain/seclusion if used?
- b) What was the patient's/resident's behavior prior to restraint or seclusion that resulted in the use of restraint or seclusion?

- c) What intervention was attempted prior to use of restraint/seclusion? What was the result of this intervention?
- d) What was the rationale for selecting restraint/seclusion?
- e) Describe period of restraint/seclusion. What was patient/resident told about reason for restraint/seclusion? What was patient/staff interaction during and after episode?
- f) What is staff members evaluation of this episode? Was it effective? What other intervention might have been tried? How could attempted intervention have been more effective?
- g) Should space be available for review at the local level to also answer questions in (f) above?

Reporting at the local level should be done in a way that guarantees the patient's/resident's rights, while allowing staff education and development. Reporting should be complete enough to allow review with an eye toward determining if use of restraint/seclusion was indicated and effective. If not indicated, what other intervention might have been used; and more importantly, what intervention should be used the next time similar circumstance occurs?

Reporting to central office should be done in a manner that facilitates the gathering of data useful to the institutions. STATISTICS REPORTED TO CENTRAL OFFICE SHOULD NOT BE USED TO POLICE OR CHASTISE THE INSTITUTION. I recommend that institutions continue their reporting to central office, as they have been doing. As soon as the institution develops its plan for restraint/seclusion, the local research committee should contact the research section to review the reporting system to central office. Attention should be given to the type of feedback that would be helpful to the institutions.

Reporting, according to this section of the standards does not take the place of proper charting on the patient's chart. The requirement for charting remains, and is the responsibility of the medical director, through the records librarian, and/or the Director of Nursing.

VIII. Review

The inclusion of this section is the largest change to these standards. The review of each incident of restraint and seclusion and its application to the individual's treatment plan, should be considered minimal professional standards.

Review should be accomplished on two levels within the institution; the treatment team as the first level, and an institution-wide committee as the second level. The treatment team should review incidents involving patients within their care. The institutional team should spot-check selected incidents reviewed by treatment teams. It is recommended that representatives from administration, the medical director, and Humane Practices be part of the Central Review committee. Other members should be assigned as indicated by the institutions plan.

Since review may be undertaken for different reasons, in different areas within the institution, Central Review may be accomplished by certain individuals according to the reason given for the use of restraint or seclusion (Section IV).

Aggression-out: incidents requiring restraint/seclusion for this reason should be reviewed by the treatment team assigned to the individual patient or resident. Recommendations of the team should be made a part of the review. Samples of the team's review should be spot-checked by an institutional review team.

Aggression-in: Same as above

Medical (includes discoordination): restraint under this category should be the responsibility of the medical director. The medical director should determine policy for ordering restraint under this category and should determine review practices according to his standards. Reporting should be to him, or his representative. The medical director may wish to provide feedback to the Central Review Committee about restraint in this area.

Behavior Modification: it is expected that all Behavior Modification treatment plans involving restraint or seclusion will be reviewed by the Behavior Modification Review Committee prior to their implementation. In this case, review should be the same as Aggression-In or Out. There is a concern, however, that restraint or seclusion might be used under the guise of Behavior Modification when no plan was approved the Behavior Modification Review Committee. In these instances, any incident of seclusion or restraint must be reported to the Behavior Modification Committee.

Limit Setting: same as Aggression Out or In.

Other: all incidents or restraint/seclusion reported for reasons other than those above must be reviewed by the head of the hospital. A random sample, if not all of these cases, should be reviewed by the Central Review Committee.

In addition to the review mentioned above, the Central Review Committee should also review the institution's restraint/seclusion plan to determine its effectiveness.

The remainder of the 1960 memorandum as amended on November 25, 1960, will remain in effect.

I would like to raise some questions that might be worth asking when drawing up your local plan for restraint/seclusion.

1. Hospitals should consider establishing Crisis Intervention Teams in order to cut down on the use of restraint/seclusion.
2. Is it acceptable to use restraint or seclusion to detain a patient or resident for a treatment he doesn't want (EST, Behavior Modification, etc.)? From leaving the institution?
3. What about persons restricted to locked wards? How often should their treatment be reviewed?

4. Should there be an absolute maximum that a person should be restrained or secluded at one time, such as 16 hours per day? 30 days on a locked ward?
5. How does a person receive treatment when in seclusion or on a locked ward?
6. What determines an incident of seclusion or restraint? The period of time involved might vary between an acute episode, and a chronic condition?
7. Is it possible to involve the patient or resident before he or she is restrained (or secluded)? What appeal rights (if any) does the patient have before the fact?

CC: Mental Health Medical Policy Committee
DPW Cabinet
MSD Staff

DJV:mhv