PROGRAM COMMTTTEE

January 28, 1969

Present: Mr. Errickson, chairman,; Mr. Krafve, Mrs. Blomquist, Mr. Madow, Mr. Berg, Chaplain Streufert, Mrs. Myers, Mrs. Wangsness, Mrs. Anderson, Mr. Knack, Mrs. Finstuen, Mrs. Stabbert, Mr. McHugo, Mr. Nelson, Mr. Hormel

Absent: Dr. Johnson, Mrs. Nethery, Mrs. Gates, Mrs. Goodwin

Guest : Mr. Dave Lenway, Ward Charge on South Maple

Mrs. Wangsness and Mr. Lenway presented their Team and Ward Evaluation of Maple South with each committee member receiving a copy of the outline. The committee felt that the outline was a good one and program directors said most of it could be utilized in their own units, but we do need a way of measuring and a basic scale to follow and evaluate from one month to another. Mr. Errickson proposed that a committee be appointed to write up a form, developing a ward evaluation scale. This committee consists of Mr. Errickson, chairman; Mr. Berg, Mr. Underhill, Mr. Lenway, and Mrs. Jacobsonc

Restraints and Seclusion: Mrs. Blomquist attended the state Humane Practices meet that was held in St. Paul last Monday. Central office asked that each institution a restraint committee to submit information to their Sub-Committee in regards to restraints and seclusion in their respective institution. Faribault State Hospital already has such a working committee. When this information is submitted to the Sub-Committee, they will prepare guidelines and we then hope that Dr. Vail will send a order out that is more realistic than that which we have had. Questions they would answered include:

1. How long does the patient stay in restraint and seclusion?
2. How does the patient get there?
3. Was it a benefit to him?
4. How does it affect the other patients on the ward?
5. What occurs while there?

Mrs. Blomquist has asked that three more technicians be added to her committee. Mrs. Myers suggested that a feed-back be given to the units on the restraint totals.

Mr. Madow would like to discuss behavior rating scale data collection with the Program Directors. This topic will be brought up at the February 11 meeting.

Agenda for February 4*

1. Mr. Welsandt—our working resident
2. Mrs. Blomquist---Review Restraint and Seclusion

Recorder
Lillian Biehl

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While it is recognized that there may he times or circumstances when it appears advisable to use seclusion or restraint, there is always the need to question and analyze these procedures in order to be sure that they are really in the best interest of the patient — or others with whom the patient may come in contact — and that they are in keeping with the treatment and rehabilitation program goals of the institution. Also included in the discussion of seclusion and restraint, gome consideration should be given to the area of chemical restraint.

Seclusion and restraint might be thought of in terms of their relationship to:

1) Care and treatment
2) Kumars? practices
3) Programming
4) Specific concerns relating to the use of seclusion and restraint.

The following outline may serve as a basis for discussion, evaluation and recommendations.

Care and Treatment

Is restraint and seclusion used in the best interest of the patient, or is it more frequently used as a staff convenience?

How does restraint and exclusion affect patients — does it modify behavior and if so, for better or worse?

Is it used on a prescription basis, or to meet individual situations as they arise?

Who makes the determination to place a patient in seclusion or restraint?

What happens to the patient who is put in seclusion — how is his time in seclusion spent?

What staff is available to the patient in seclusion — in what frequency or availability, and for what purpose?

II - Humane Practice

1) Is the use of seclusion and restraint viewed as punitive by patients?
2) How is the patient put into seclusion or restraint?
3) For how long a period of time is the patient kept in seclusion or restraints?
4} How are patient's needs met while in seclusion?
5) How isolated is the patient? (Is there a window in the door, or is he completely removed visually from anything outside of the seclusion room?)
6) How is the process of isolation viewed by other patients?
7) Does seclusion and restraint solve problems, or merely keep patients under control?
8) To what extent are patients who are in seclusion and restraints discussed by staff in order to try to arrive at a better or different solution to the problem on the basis of individual needs?

III. Programming

1) Does restraint and seclusion reflect the development or absence of program – or is there no relationship?

2) Is there any program for patients in seclusion or restraints?

3) Should there be and if so, what kind of program and how should it be administered?

4) Is the use of restraint and seclusion an indication that there is a need for more programming to keep patients occupied so the need for seclusion and restraints may be minimized?

IV Specific Concerns Relating to the Use of Seclusion and Restraint.

1) When should restraint or seclusion be used?

2) For what kinds of behavior?

3) Under what conditions?

4) By whom and how should decisions be made?

5) To whet extent are patients involved in explanations, either before or after being put in seclusion ' or restraint?

6) To what extent does staff spend time seeking alternatives to seclusion and restraints?