Collaborative Safety Strategies
New Employee Training Program

Restraint and Seclusion PARTICIPANT HANDOUT

Developed by

Office of the Commissioner
Division of Safety Services
Safety Education and Training Unit
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in collaboration with the
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This Collaborative Safety Strategies (CSS) Participant Restraint and Seclusion Handbook is for educational purposes and is designed for use in conjunction with the CSS training program conducted by a certified DMHAS, Division of Safety Services, Safety Education and Training Unit CSS Instructor. The content reflects best safety practices for the prevention and management of dangerous behavior however, they should not be considered inclusive or exclusive of all the methods of service provision reasonably directed to obtaining the same results. New knowledge, procedures, technologies, clinical or research data, and clinical service experiences may provide sound reasons for alternative approaches even though they are not described here. The ultimate judgment regarding the use of any specific actions or procedures taken to prevent or manage dangerous behavior must be made considering the specific individual circumstances presented at the time.

State of Connecticut, Department of Mental Health and Addiction Services
Division of Safety Services, Safety Education and Training Unit
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Restraint and Seclusion Application for Newly Employed Inpatient Direct Care Staff (CSS-N/RSAT)

Upon completion, you will learn be able to:

- Prevent restraint and seclusion related injury or death by clinically assessing the patients mental and physical status *during* the use of restraints or seclusion use.
- Demonstrate the safe application, use of and discontinued use of mechanical restraints or seclusion according to DMHAS Policy and manufacturer's instructions to prevent use related physical injury or death.
- Demonstrate the ability to lift and carry a patient from the floor to a restraint bed.
- Use Seclusion according to DMHAS Policy B
- Recognize when patients have met behavioral criteria to discontinue their use.

Successful full completion is demonstrated by :

- Achieving a score of at least 80% on the **written Post-Tests** and by,
- 100% active class participation
- Accurately demonstrating the ability to apply and remove 4 point leather restraints and for CVH and SW/GB staff, the Net restraint.
- Completing the Participant Evaluation

Introduction

Remember that, "DMHAS believes that people have the right to be free the use of restraint or seclusion except to ensure the immediate physical safety of the patient, a staff member, or others."

Mechanical restraints are used on our inpatient units at CMHC, CVH , CRMHC and SW/GBCMHC. Seclusion is used at CVH, SW/GB and only on the 4th floor at CMHC. There is also a seclusion room at CRMHC, but it is rarely used.

Restraints are defined as "Any method, 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." Over the past two days, you've learned a variety of strategies to prevent violence and should it occur, how to use physical restraints to contain it. During this module, when we use the term restraint, we are referring to 4 point mechanical restraints.

Seclusion is defined as **"**The **involuntary** confinement of a patient alone in a room or an area from which s/he is physically prevented from leaving".

Generally, **seclusion** is used when containment of the dangerous behavior is required, but when the freedom of movement while in the seclusion room is safe. Individuals should not be in seclusion, for example, if they are actively suicidal or self injurious or are unable to contain their physical aggression in seclusion.

It's important to know that DMHAS seclusion and restraint rates consistently remain below the national average. Still, the use of mechanical restraints and seclusion are our most high risk interventions that can result in injury or death.

Preventing R/S related injury or death: Intensive Care for the Patient in R/S

The risks of injury and death increase with the use of mechanical restraints and seclusion. The interventions you've taken to this point were directed at physically containing the violence. But, that isn't the end of the crisis – it's only the point at which the violence is contained. In fact, the interventions that you have to use until the patient is behaviorally safe (out of R/S) are much like an intensive care unit in a medical hospital.

That means that immediately prior to, during application and use, you must provide a high level of care to reduce the risk of injury or death:

- Monitor the patient closely per individualized assessment and R/S Policy – constant observation is typical. *Whiting has video monitoring on WU6.*

  While monitoring, you must minimally perform the A-F assessment. Remember, that the elderly pose risks associated with poor skin integrity and that their bones tend to be weaker, thus are at greater risks for breaks.

Patients who are in restraints are typically on Constant Observation (CO), which means that a staff member is present at all times. Patients in seclusion, may have the door open with a staff member present (CO) or they may have the door locked, with staff checking at least every 15 minutes. Decisions about how closely to monitor are made based on the assessment findings.

- Continuously reassess physical, medical, emotional and behavioral condition (minimally):
  - Signs of injury associated with R/S use
  - Nutrition and hydration
  - Circulation and ROM
  - Vital Signs
  - Hygiene and elimination
  - Physical and psychological status and comfort
  - Patient specific concerns

  Use your facility specific flow sheets and policy's for other monitoring requirements.

- Communicate concerns immediately to licensed medical staff. Take all complaints of pain, discomfort seriously – and have it immediately medically evaluated. Never assume that the complaint is not serious e.g., attention seeking. Make sure they are fully evaluated by a licensed doctor or nurse.
- Debrief with the patient about what just happened. Provide reassurance to the patient and inform them of the specific behavioral criteria for discontinuing R/S. Then work with the patient to discontinue R/S to meet criteria. Your assessment will determine how to help the pt meet the criteria. For example, in an extremely agitated or psychotic patient, some quiet time or music or other calming activity at first – will probably be helpful. Find out from the patient, what would help them calm down and regain behavioral self control.

Criteria for Release from R/S

The main criteria for release from R/S is that the person no longer poses an immediate risk of violence –again, think about the scale – the risks of remaining in either R/S now would outweigh the risks of release from R or S. Typically, you will observe that:

1. Cognitively, there is a decrease in their focus, hostility and suspicion related to what triggered the behavior.
2. They will be less aroused - irritability and intensity of emotions should be decreased.
3. Behaviorally, impulsivity, verbal aggression, physical aggression, physical tension should be decreased.

If they have had medications or used other methods to become calm, you should see fewer or decreased diagnostic symptoms e.g., psychosis.

When you are able to talk with a patient who is in R/S to meet criteria for discontinuing, the focus of the conversation is on the specific criteria. This is not the time for more in-depth, insight gaining discussions. That can and should occur after R/S discontinued.

Remember that waiting too long to use R/S can have negative outcomes, so can releasing too early. Make sure that the criteria are met. There's always a risk or reoccurring dangerous behavior, but if the criteria is met and there's a plan in place, the risks should decrease.

The ultimate decision to release a patient from R/S must always be made in the consideration of individual circumstances presented by the patient and surrounding circumstances. This information is provided to help focus on the specific clinical data that is needed to make the recommendation to the clinically licensed person responsible for ordering the discontinuation of R/S.

After Care of the Person who has been released from R/S

Using the intensive care medical model, after a patient has been released from R or S, they should still be monitored closely. You should be viewing the person as a short term continued risk and put a non-emergency plan in place that reduces the likelihood that they will re-escalate.

The patient should be aware of the plan – and whenever possible, should participate in developing it. It should address all the elements of the non-emergency plan that we discussed earlier e.g., interventions, activity, structure, etc.

Four Point Mechanical Restraints

Once it's been determined that restraints or seclusion is safe to use:

1. Search the patient for possession of unsafe smoking articles (matches, lighters) according to facility policy.
2. Always follow mechanical restraint manufacturer's instructions
3. Select the proper type and restraint size.
4. Always position the patient in the supine (face up position) to prevent aspiration.
5. During application –, special care must be taken to ensure that pain is not induced and breathing is not restricted in any way. Make sure to never place:
   - Any pressure, using your body, on the patient's chest or abdomen
   - any material over the patient's face
   - the person in the face down – prone position

1. Lay the **Attached Leg Cuff** restraint flat on the bed with the straps hanging off the side. Loop the straps around the anchoring point (movable part of frame) and pull through the roller buckle and keeper in quick release position. Use the same procedure for the strap on the other side.
2. Place the arm limbs onto the **Separate Cuffs** and wrap the cuff around the patient's wrist leaving enough room to insert **1** finger, bringing the Ubar through the closest vertical slot and then the leather tongue through the Ubar (tongue facing down).
3. Loop the long **connecting bed strap** to the movable part of the bed frame at a comfortable level of limb with buckle in quick release position. Ensure that the strap is wrapped around the frame at least once before passing the end of the strap through the buckle (or lock).
4. Place the ankle limbs onto the **Attached Leg Cuff**. Wrap the cuff around the patient's ankle leaving enough room to insert 1 finger, bringing the Ubar through the closest vertical slot and then the leather tongue through the Ubar.
5. A staff member double checks all the attached points and insert 1 finger into cuffs to ensure that they are fit correctly.
6. Team leader gives cue for team to release securing patient to the bed. 1-2- Release!
7. The head of the bed is elevated.

NET RESTRAINT FOR GB and CVH Staff ONLY

NOTE: All limbs are to be secured/held until the release is given by Team Leader.

1. The head of the bed is elevated, insert wedge pillow for beds with non-adjustable frames.
2. Spread the Restraint Net with the neck and shoulder openings toward the head of the bed. See photo.
3. Attach one side of the Restraint Net (the side farthest from the doorway) to the movable part of the bed frame by securing each of the five (5) cross straps using the D-ring fasteners. Wrap the end of the strap around a movable part of the bed frame, then pass the strap through the D -ring and pull the strap tight.
4. Gather the restraint net and straps to one side so the patient can be easily positioned underneath
5. Place the patient on the bed, face up, using the side where the net has not yet been secured to the bed.
   - Insert the patient's arms through the arm holes and rest the arms on the bed parallel to the patient's body. Be sure the center strap is running down the length and center of the patient's body to maintain proper alignment.
   - Place the patient's legs in the bottom restraints. These are double security fasteners. Secure the ankles or calves by wrapping the fuzzy loop strap around the limb and "sandwiching" it between the two hook straps.
   - You should be able to slide one finger between each of the patient's limbs and the hook and loop cuffs.
6. Attach the remaining five cross-straps to the other side of the bed using the method described in step 2.
7. Attach the end-strap to the bed frame at the foot of the bed using the D-ring*. Be sure this strap is snug, to prevent the Net from riding up around the neck if the patient tries to slide down.
8. To secure patient's arms, position each arm on the two vertical restraint straps (see Fig. 1). These are double security fasteners. Secure the upper arms by wrapping the fuzzy pile strap around the arm and sandwich between the hook straps. The red straps will fit smaller arms and the blue straps will fit larger arms. The wrists are secured by following the same steps, these hook straps are not color coded.
9. Team leader or designee will perform a final check of all the cuffs and straps to ensure that they are properly secured and applied. Do NOT leave excess slack in the straps. This may allow the patient to partially escape or become entangled under the loose strap.
10. Inform the patient that you are going to check breathing and chest pressure. Place the flat palm of your hand through the side of the net to the center of the sternum where the cross straps meet to ensure that it fits between the device and the patient's body (too loose, pt can get out – to tight, circulation and/or breathing can be impaired) .

***Excess strap may be tied using the Posey Quick-Release Tie - If a Posey Quick-Release Tie is used, be sure the strap releases through the D-ring with one quick pull. DONOT tie a knot in case the patient must be released in an emergency. Make sure Posey Quick-Release Tie and/or D-ring is out of the patient's reach and that the straps do not loosen if the restraint is pulled or jerked.*