



Behavior Management, Seclusion, Restraints and De-Escalation

A hostile or physical situation from an individual client, between clients, staff and clients or any combination of the situations mentioned, can immediately affect the safety to all individuals involved in or around the situation, and it can create a potentially dangerous crisis. The greatest responsibility in human services is to protect the safety and well-being of all individuals. The use of behavior restraints, physical or mechanical, chemical restrains, and seclusion, should be the last safety resort. De-escalation should be used first and foremost. Written policy detailing explicit criteria must exist to which and when these methods should be utilized in crisis situations.

“When there is a need to utilize seclusion or restraints, facilities will treat patients with the utmost dignity and respect and protect them from humiliation. Facilities must have written policies that include last resort indications for the use of seclusion or restraints, and specific monitoring parameters during the period of seclusion or restraint, such as the frequent monitoring of neurological condition, vital signs and placement of restraint.”

Numbers Nationwide

“In October 1998, The Hartford Courant published a five-part investigative series that revealed an alarming number of deaths resulting from the inappropriate use of physical restraints in psychiatric treatment facilities across the United States. A 50-state survey conducted by the newspaper documented at least 142 deaths in the past decade connected to the use of physical restraints or to the practice of seclusion. The report also suggested that the actual number of deaths is many times higher because many incidents go unreported. According to a separate statistical estimate commissioned by The Courant and conducted by the Harvard Center for Risk Analysis, between 50 and 150 restraint- or seclusion-related deaths occur every year across the country.

In 1999, the Hartford Courant published a series of articles that revealed hundreds of Restraint-related deaths of children and adults throughout the country primarily in residential settings, triggering increased legislation and regulation on the federal level. The evidence showed that most of these tragedies were unnecessary and preventable. “

“Restraint and seclusion have no therapeutic value and should be used only for emergency safety by order of a physician with competency in psychiatry or a licensed independent mental health professional (LIP). A physician trained in psychiatry or a LIP should see the patient within one hour after restraints are initiated.. Restraints should be continued only for periods of up to one hour at a time, and a face-to-face examination of the patient by the physician or LIP must occur prior to each time a restraint order is renewed.

Alternatives to the use of restraint and seclusion should be used. De-escalation techniques and debriefings should be used after each restraint and seclusion incident.”

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Behavior Management, Seclusion, Restraints and De-Escalation

Definition

“Behavioral restraint” means “mechanical restraint” or “physical restraint” as used as an intervention when a person presents an immediate danger to self or to others.”

Types of Restraints

“Containment” means a brief physical restraint of a person for the purpose of effectively gaining quick control of a person who is aggressive or agitated or who is a danger to self or others.’

“Mechanical restraint” means the use of a mechanical device, material, or equipment attached or adjacent to the person’s body which cannot be easily removed and that restricts freedom of movement of all or part of a person’s body or restricts normal access and that is used as a behavioral restraint.’

“Physical restraint” means the use of a manual hold to restrict freedom of movement of all or part of a person’s body, or to restrict normal access to the person’s body, and that is used as a behavioral restraint. “Physical restraint” is any staff-to-person physical contact in which the person unwillingly participates.’

“Seclusion” means the involuntary confinement of a person alone in a room or an area from which the person is physically prevented from leaving. “Seclusion” does not include a “timeout.”.

“Chemical restraints” means drugs/medication used as restraints. These medications are used in addition to or in replacement of the patient’s regular drug regimen to control extreme behavioral during an emergency. “

Federal Law and Regulations Regarding Patient Rights

“In 1999, the Health Care Financing Administration (HCFA, now known as the Centers for Medicare and Medicaid Services, CMS) created new regulations regarding Patient’s Rights. Included in these rules are requirements regarding restraint and seclusion that must be met by all hospitals that participate in Medicare and Medicaid. The requirements affect both adult and child inpatient psychiatric units.”

It is your responsibility to assure that you are in compliance with Federal, State and Institutional regulations and laws pertaining to restraints of any sort.

“Most programs require extensive initial training, as well as recurrent updates on a regular basis. As a result, implementation of these procedures can be extensive to maintain. In most medical, psychiatric and law enforcement applications, strict guidelines govern the use of physical restraints. Often these include accreditation requirements such as the Joint Commission on Accreditation of Healthcare Organizations or other groups such as the National Association of Psychiatric Treatment center for children.”

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Behavior Management, Seclusion, Restraints and De-Escalation

Seclusion and Restraint

“HCFA (Health Care Financing Administration) regulations require that a licensed independent practitioner have face-to-face contact with the patient within one hour of the initial order for seclusion or restraint. Additionally the patient’s treating physician must be consulted as soon as possible if the treating physician is not the practitioner who ordered the seclusion or restraint.

JCAHO (Joint Commission on Accreditation of Healthcare Organizations) standards allow qualified, registered nurses or other qualified, trained staff to initiate the use of seclusion or restraint. An order for the seclusion or restraint must be obtained from a licensed independent practitioner as soon as possible but no longer than one hour after the initiation of the seclusion or restraint. In Medicare/Medicaid funded programs a physician or licensed independent practitioner must conduct a face-to-face evaluation of the patient within one hour of the initiation of a restraint or seclusion as required by the HCFA interim final rule for Patients Rights, August 1, 1999. In other facilities the initial evaluation of patients in seclusion and restraint is 2 hours for a patient age 17 and under and 4 hours for ages 18 and over. If the patient is no longer in seclusion or restraints when the original order expires the licensed independent practitioner must conduct an in-person evaluation of the patient within 24 hours of the initiation of the seclusion or restraint. Verbal and written orders are limited to one hour for children under age 9 and 2 hours for individual’s ages 9-17. The order for continuation of a restraint or seclusion can be made by a qualified registered nurse or other qualified trained individual who has been authorized by the organization to perform this function. However, a licensed independent practitioner must perform an in-person reevaluation at least every 4 hours for individuals 17 years and younger.

JCAHO standards for restraint and seclusion do not apply: when a staff person physically redirects or holds a child, without the child’s permission, for 30 minutes or less; when the individual is restricted for 30 minutes or less from leaving an unlocked room (time-out) or when an individual is restricted to an unlocked room or area.

The HCFA regulations and JCAHO standards were current at the time of the publication of this parameter. However, this is an area of regulatory oversight that has been in rapid evolution and practitioners should stay informed of the new regulations and standards as they are announced. Each unit should have its own de-escalation program that helps patients manage angry outbursts [CG]. Anger management and stress reduction techniques are important components of prevention in psychiatric facilities and should be a component of a psycho-education program for children and adolescents. If less restrictive options have failed or cannot be safely applied, seclusion and restraint procedures may be required. “

Policies and Procedures on Seclusion and Restraints

Well written policies and procedures within your program should clearly define activities and protocol from admission, involuntary admission, assessments, client transfer, Therapeutic intervention for acting out individuals and de-escalation methods, seclusion and restraints along with monitoring

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Behavior Management, Seclusion, Restraints and De-Escalation

responsibilities and care giving duties.

The program should define the roles of individual staff members and in-service training. Non violent procedures should be emphasized. Seclusion and restraints should only be used in emergency situations when a client is at imminent risk of harming themselves or others, only to be utilized until the client resumes control and/or all other less restrictive interventions have been exhausted.

Roles of the staff are described in the written procedure. The registered nurse will be notified ASAP. The registered nurse will notify the physician or licensed independent practitioner within an hour of initiation. The Physician will provide guidance and order interventions as necessary and will see the patient within one hour. The registered nurse will notify the family of the intention of seclusion or restraints. Records will be documented using a chart format. It will include the reason for restriction, the type used, the time starting and ending of the restriction and regular observations of the client while restricted. An incident report will be completed in the event of an injury.

Risk management elements include consistent hiring practice, written policies and procedures, orientation and training, along with appropriate staffing numbers within your organization. Staffing ratios should be no less than 1:6 in residential, group home, or transitional living programs with proper overnight staffing and regular documented rounds. Case loads should be less than 12-15 and low turnover should be your goal. All aspects of care, treatment, and services should be developed. De-escalation teams should be established based on clinical and individual assessment, teams trained on the individual plans, methods explained to consumer and parent(s)/guardian noting benefits and drawbacks; and all aspects of the plan and communications documented.

Supervisors should strive to be player-coaches with regular meetings individually. Regular group meetings should be established and documented to provide active clinical communication oversight to the program. This should include intra and inter staff communication program protocols. Service communication about consumers should occur daily and the program should be discussed with consumers at least weekly. Supervisors should be on-site at least 75% of the time.

Written policies on behavioral management, restraints, seclusion, verbal de-escalation, and restraint holds to protect consumers, or others, should be clearly documented and communicated. Written policies should also cover last resort indications for the use of seclusion or restraints, and specific monitoring parameters during the period of seclusion or restraint, such as the frequent monitoring of neurological condition, vital signs and placement of restraint. All staff should be properly trained and appropriate retraining should be practiced and mandated.

Emergency contingency and crisis management plans should be developed, practiced and mandated throughout your organization with possible individual behavior plans and safeguards considered as part of your program.

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Behavior Management, Seclusion, Restraints and De-Escalation

Elements of Behavior Management Crisis Policies:

1. Develop a crisis management team to over see your program.
2. Define what is or is not a restraint, seclusion, therapeutic holds, de-escalation, the authorization protocol, establish time limits, supervision and after care criteria
3. Develop a management philosophy that identifies restraints and seclusion as a last resort
4. Specific monitoring parameters during the period of seclusion or restraint, such as the frequent monitoring of neurological condition, vital signs and placement of restraint should be clearly established and followed.
5. Develop policy and procedures relating to the transfer of restraint, seclusion, therapeutic holds, de-escalation
6. Review and implement rehabilitation and training programs for the clients
7. Within the first 24 hours of client admission, a face to face assessment with the client by authorized personnel (directors, professional medical staff, caseworker/social worker) assigned to the client should be completed and a review all medical records, medication and past nonviolent and de-escalation history
8. Develop treatment plan, rehabilitation and training programs for the clients
9. Develop physician protocol, by order, for the use of the intervention of restraints, seclusion, therapeutic holds or de-escalation by a physician competent in psychiatry or from a licensed independent mental health professional (LIP).
10. Assess the communications in your organization and team for language and hearing problems
11. Have a plan in place to screen and adapt de-escalation and intervention techniques for the hearing impaired and cultural diverse (i.e., visual contact at all time etc).
12. Have a plan to screen medical problems and past trauma history
13. Have a plan for notification of family and reporting protocol
14. Meet staffing requirements and assess regularly
15. Audit training records, supervise staff and document activities
16. Institute cohesive policies, procedures and training that encourage adaptive client behavior and nonviolent staff intervention within your organization.
17. Train staff on crisis nonviolent intervention and authorized de-escalation controls
18. Train staff how to monitor individuals in restraints or seclusion
19. Train clients on anger management and other self control techniques
20. Train staff on first aid and CPR
21. Train staff on self protection techniques during all orientation and in-service training
22. Use the least restrictive safety interventions
23. A physician trained in psychiatry or a LIP should see the patient within one hour after restraints are initiated.
24. Establish face to face incident assessments after periods of de-escalation, restraint or seclusion have been completed
25. Notify the crisis team that facilitates policy/procedures and follow regulatory notification requirement related to restraint and seclusion.

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Behavior Management, Seclusion, Restraints and De-Escalation

Elements of a Nonviolent Intervention & De-escalation Program

1. Develop a crisis management team and crisis team leader for each client.
2. Within the first 24 hours of client admission, and thereafter during regular assessment and daily activities, authorized directors, medical staff, case/social worker and staff assigned to the client should review all medical records, stats, medication and clients past history.
3. Ensure staff training records are up to date and that the staff team is competent
4. Staff should assess the communications skills of the client and evaluate any language and hearing problems
5. Emphasis proactive listening by staff and focus on the client's body language, facial expressions and etc.
6. Interviews should be conducted with the client to help determine and identify triggers for stress, agitation issues and personal management crisis strategies.
7. Nonviolent, de-escalation protocol and back up plan should be developed per client by the professional staff and a copy of that plan should be properly stored on each level of the building in which access is granted. This should be ongoing intermittently.
8. The nonviolent and de-escalation plans should be verbally discussed with the client and parent/guardian. This protocol should be discussed and documented weekly by the team.
9. Train staff on crisis nonviolent intervention, de-escalation controls and back up plan. Self protection during training should be highlighted.
10. Once the order is given, use the least restrictive safety interventions as prescribed in the plan
11. During a escalation, follow protocol as deemed necessary by the documented methods along with the supervision activities within your program
12. Follow policy and procedures relating to the transfer of restraint, seclusion, therapeutic holds, and de-escalation
13. Specific monitoring parameters during the period of seclusion or restraint, such as the frequent monitoring of neurological condition, vital signs and placement of restraint should be clearly followed.
14. During the intervention, monitor the physical signs of the client; check skin color, danger signs, breathing, hand and arm movements and any unusual signs that may be of concern
15. Once client is under control, constant monitoring followed by post crisis evaluations should be completed and documented as required by Federal, State and Institutional regulations and laws.
16. The physician competent in psychiatry or from a licensed independent mental health professional (LIP the intervention of restraints, seclusion, therapeutic holds) should complete a face to face assessment within 24 hours of the intervention.
17. The nonviolent and de-escalation activities should be verbally discussed with the client and parent/guardian.
18. The crisis management team and crisis team leader for clients involved in the intervention should be notified and the incidents, assessment and treatment plan should be evaluated and discussed
19. The crisis management team should facilitate policy/procedures as deemed necessary and follow regulatory notification requirements related to the restraint and seclusion.
20. Follow all reporting guidelines

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Behavior Management, Seclusion, Restraints and De-Escalation

De-escalation and restraint measures not allowed in facilities

1. A physical restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or respiratory capacity, including techniques in which a staff member places pressure on a person's back or places his or her body weight against the person's torso or back.
2. A pillow, blanket, or other item covering the person's face as part of a physical or mechanical restraint or containment process.
3. A facility may not use physical or mechanical restraint or containment on a person who has a known medical or physical condition, and where there is reason to believe that the use would endanger the person's life or seriously exacerbate the person's medical condition.
4. A facility may not use prone mechanical restraint on a person at risk for positional asphyxiation as a result of one of the following risk factors (obesity, pregnancy, agitated delirium or excited delirium syndromes, cocaine, methamphetamine, or alcohol intoxication), exposure to pepper spray, preexisting heart disease, enlarged heart or other cardiovascular disorders and respiratory conditions, including emphysema, bronchitis, or asthma) that are known to the provider unless written authorization has been provided by a physician, made to accommodate a person's stated preference for the prone position or because the physician judges other clinical risks to take precedence. The written authorization may not be a standing order, and shall be evaluated on a case-by-case basis by the physician.
5. A facility shall avoid the deliberate use of prone containment techniques whenever possible, utilizing the best practices in early intervention techniques, such as de-escalation. If prone containment techniques are used in an emergency situation, a staff member shall observe the person for any signs of physical duress throughout the use of prone containment. Whenever possible, the staff member monitoring the person shall not be involved in restraining the person. subdivision (a) may not place a person in a facedown position with the person's hands held or restrained behind the person's back.
6. A facility described may not use physical restraint or containment as an extended procedure.
7. A facility shall keep under constant, face-to-face human observation a person who is in seclusion and in any type of behavioral restraint at the same time. Observation by means of video camera may be utilized only in facilities that are already permitted to use video monitoring under federal regulations specific to that facility.
8. A facility described shall afford to persons who are restrained the least restrictive alternative and the maximum freedom of movement, while ensuring the physical safety of the person and others, and shall use the least number of restraint points.
9. A person in a facility has the right to be free from the use of seclusion and behavioral restraints of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff. This right includes, but is not limited to, the right to be free from the use of a drug used in order to control behavior or to restrict the person's freedom of movement, if that drug is not a standard treatment for the person's medical or psychiatric condition.

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Behavior Management, Seclusion, Restraints and De-Escalation

Written policy and treatment plans should be fully developed, reviewed and initiated by order of a physician with competency in psychiatry or a licensed independent mental health professional (LIP).

When a client becomes intimidating or physically aggressive, it is essential to intervene as a team. Once the need is determined, the crisis response team should be notified and staff assistance called. Emergency phone numbers for in-house communications should be used and code words should be developed. In the event that the crisis response team has been called and more staff is needed, staff assistance may be activated using separate phone numbers and code words. Non violent crisis Intervention techniques should be used as directed by the team leader. The team leader must determine the need for additional staff, responsibilities of each member and options or limits to the client.

Verbal de-escalation techniques should be initiated. The nonviolent, acting out client should be isolated from other patients. This may include asking the client to move to another area. Control position should be established by the staff. The team leader, registered nurses or licensed independent mental health professional (LIP) must be notified ASAP. As only specified by the physician during the treatment planning, the team leader, registered nurses or licensed independent mental health professional (LIP) can authorize the written orders. The team leader or registered nurses should immediately notify the physician within an hour of initiation. The physician will provide guidance and order interventions as necessary and will see the patient within one hour. The registered nurse will notify the family of the intention of seclusion or restraints. Records will be documented using a chart format. It will include the reason for restriction, the restriction used, the start and end time of the restriction and regular observations of the client while restricted. If the patient is in seclusion or in restraints more than one hour and within the guidelines of the age and time limited described in the treatment plan, an additional face to face meeting should be done. Restraints should be continued only for periods of up to one hour at a time, and a face-to-face examination of the patient by the physician or LIP must occur prior to each time a restraint order is renewed. If the patient is released and another intervention is reinstated, then another face to face by the physician or licensed independent mental health professional should be done at the next one hour mark. One-on-one supervision is provided per contact with assessments done by staff in accordance to the written orders. A log is kept. An incident report will be completed in the event of an injury and a log will be kept of all activities.

Protocol should be established to prepare the client for seclusion such as removing dangerous article like jewelry, glasses, dentures, contacts, shoes, hair ribbons, smoking materials etc. Depending on the restraint and/or seclusion, policy and training should be established for supervision, medial checks

Any trained four or five person carry initiated by written order, by authorized trained team staff members, for those who are physically aggressive toward others, should be applied in a safe manner in such a way that no harm is provided to the client and that at least one finger width exist between the restraints and the client's extremities. Circulation will be assessed according to the written order and documented on flow chart. A seclusion/restraint flow chart will be started and assigned to the 1:1 staff member. One on

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Behavior Management, Seclusion, Restraints and De-Escalation

one supervision should be given at all times. This staff member will be responsible for continuous client observation and recording client behavior in accordance to the written order. Fluids should be offered in accordance to written orders. Toilet facilities will be offered in accordance to written orders. Meals should be offered at regular meal times. Staff will assist with feeding.

Restraint should be released one at a time on a rotating basis according to the written order starting with a leg, opposite arm, leg, arm and waist if applicable. Post debriefing will be done by the Team leader, physician or licensed independent mental health professional (LIP). Quality management controls exist to monitor activities. A seclusion and restraint team will meet monthly to evaluate to evaluate trends and make recommendations for changes in policy and future monitors. One on one supervision should be given at all times. Cameras should be present in room. The sprinkler heads should be recessed. Time out procedures are present in the policy and procedures.

De-escalation Tips

1. Always identify yourself
2. Talk and think calm
3. Ask the patient how they are doing and what is going on
4. Ask patient if they are hurt and assess for medical problems
5. Ask patient if they are having difficulty or what happened before they got upset
6. Remember why the patient is in the hospital
7. Find a staff member that has a good rapport, have that person talk to the patient, let the patient know you are there to listen
8. Offer medication if appropriate
9. If a patient screams or swears, reply with a calm nod, don't react
10. Help patients remember and use coping mechanisms they have identified in therapy
11. Use team or third party approach if patient is wearing down one staff member. Have someone else step in (10 minutes of talking may avoid restraints)
12. Reassure patients and maintain professional boundaries (express your concern for their safety and that you are there to help)
13. Allow quiet time for patients to respond, silent pauses are important
14. Ask the patient if they would be willing to talk to you (repeat requests persistently and kindly)
15. Respect needs to communicate in different ways (language/cultural differences) as well as fear, embarrassment, or shame that they may be experiencing
16. Empower the patient and encourage them in every step towards calming themselves that they take
17. Make it okay to try to talk over the upsetting situation even though it may be difficult and painful
18. Acknowledge the significance of the situation for the patient
19. Ask the patient how else you can help
20. Ask the patient for permission to share important conversation with other caretakers for ongoing discussion

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Behavior Management, Seclusion, Restraints and De-Escalation

Federal Law and Regulations Regarding Children's' Rights

"The Child Health Act, Public Law 106-310 was established in October, 2000. This law established national standards that restrict the use of restraint and seclusion in all psychiatric facilities that receive Federal funds and in "non-medical community-based facilities of children and youth." To implement this law, two sets of regulations must be developed. One set, the 2001 HCFA Interim Final Rules on "Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services to Individuals under Age 21" are completed. This rule only applies to clients in residential facilities that are funded under Medicaid's "Psychiatric Services under 21" benefit. The second set of regulations that would affect other group homes and residential facilities has not yet been promulgated."

"For children's non-medical community programs: Restraints and involuntary seclusion (R/S) may be used with children in community programs only in emergencies and to ensure immediate physical safety for the child or others. Mechanical restraints are prohibited. Seclusion is allowed only when a staff member continuously monitors a child face-to-face. Time-outs, however, are not considered seclusion, and physical escorts are not considered physical restraints. "

CWLA (Children's Welfare League) Practice and Policy Recommendations to Protect Children in Care:

- Restraints and seclusion must only be used in emergency situations to ensure the physical safety of the child and all others and should never be used for purposes of discipline, retaliation and convenience.
- The use of chemical restraints and mechanical restraints should be prohibited. Locked isolation must only be used when a staff member is continuously visually monitoring the resident and when strong licensing and/or accreditation and internal controls are in place.
- There should be federally mandated reporting of all injuries and deaths, within 24 hours, to a state licensing or regulatory authority. All use of seclusion and restraints must be reported to the state licensing and regulatory authority in accordance with federally required, state-developed regulations.
- All staff must receive appropriate initial and ongoing training in behavior management, de-escalation, and the use of seclusion and restraints, including less intrusive interventions and emphasis on the medical, legal and other implications of the use of restraints.
- Any legislation must support the development of national guidelines and standards on the quality, quantity, orientation and training, as well as the certification or licensure of those staff responsible for the implementation of behavioral intervention concepts and techniques.
- Proposed remedies must include a plan to address the workforce crisis confronting children's service organizations throughout the country in the recruitment and retention of qualified direct care practitioners. The goal of establishing a licensing, certification, and credentialing standard for direct care workers is of primary importance.

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Behavior Management, Seclusion, Restraints and De-Escalation

States should be required in their licensing, contracting, and regulation to include reporting and analysis of restraints on a regular basis, to set minimum expectations about staff development, and to make expectations consistent between public and privately operated facilities that serve the same children and youths as a condition of their receipt of federal monies for children and youth services.”

Behavior Management, Seclusion, Restraints, and De-escalation within Schools

“Controversy surrounds the use of seclusion and physical restraint in school-based programs, and use of these interventions carries a high degree of risk for being misunderstood. Both should be used only as a last resort in cases of danger to the student and/or others. The immediate goals of seclusion and physical restraint are to defuse the dangerous situation, protect the student and others from injury, and regain a safe, controlled, productive learning environment.”

“Seclusion (also called “seclusion timeout” or “isolated timeout”) as used in this document means: Removing a student from the general activity and isolating him/her in a separate supervised area/room for a set period of time or until the student has regained control. It does not include such things as:

- In-school suspension;
- Detention;
- Student requested break;
- The student is instructed to return to his/her desk and/or sit on the sidelines.

Seclusion Guidelines

1. Use the least restrictive intervention appropriate – seclusion should be a last resort.
2. Make sure “time in” is reinforcing.
3. Include the use of “seclusion” in the student’s IEP/BIP.
4. Teach the student what he/she is to do when seclusion is going to be used; foreshadow what will happen before, during, and after seclusion.
5. Set criteria for ending the seclusion period.
6. Maintain constant adult supervision.
7. The “name” of the room is less important than how the space is used.
8. Develop written procedures or policies.
9. Keep a log or incident report.
10. Use the data to evaluate the use of seclusion.
11. General school building codes apply; fire codes impact the use of locks.

Physical Restraint (also called “manual restraint”) as used in this document means:

Holding a student in order to restrain his/her movement; use of physical force, without the use of any device or materials, to restrict the free movement of all or a portion of a student’s body. It does not include:

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Behavior Management, Seclusion, Restraints and De-Escalation

- Briefly holding a student in order to calm or comfort the student;
- Holding a student's hand or arm to escort the student safely from one area to another when the student is complying with the request to move;
- Intervening in a fight;
- Using protective or stabilizing devices, including adaptive equipment prescribed by a health care professional; using a weighted glove or wide arm cuff to hold one of the student's arms, allowing him/her to refrain from stereotypy and work with the free arm/hand.

Physical Restraint

1. Use only in an emergency; e.g., immediate danger to the student and/or others.
2. Have First Aid and CPR available.
3. Foreshadow for the student what will happen during restraint. Teach the student what he/she is to do during and after restraint is used.
4. Include the use of "restraint" in the student's IEP/BIP.
5. Use only for the period of time necessary.
6. Move other students when possible rather than moving or transporting the student in crisis.
7. Develop written procedures or policies.
8. Ensure that staff has information and training.
9. Keep a log or incident report.
10. Use the data to evaluate the use of restraint.

The use of mechanical or chemical restraint is not appropriate for use in schools without medical authorization and oversight."



Behavior Management, Seclusion, Restraints and De-Escalation

- Develop policies and procedures, the authorization protocol, establish time limits, supervision and after care criteria
- Assess the communications in your organization and team for language and hearing problems
- Have a plan in place for to screen and adapt de-escalation and intervention techniques for the hearing impaired and cultural language, (i.e., Visual contact at all time etc).
- Have a plan to screen medical problems and past trauma history
- Meet staffing requirements and assess regularly
- Train staff on crisis nonviolent intervention, authorized de-escalation controls, self protection techniques during orientation and in-service training, first aid, and CPR.
- Train staff how to monitor individuals prior to, during and after physical restraints or seclusion
- Audit training records, supervise staff and document activities
- Inform the student what is expected when seclusion is going to be used.
- Maintain constant visual supervision with student during seclusion
- Use the least restrictive safety interventions
- Parents should be informed about the use of physical hold restraints as soon as possible
- Complete and maintain a incident report of all interventions
- Notify the crisis team to help facilitate policy/procedures as deemed necessary and follow regulatory notification requirement related to the restrain and seclusion.

Crisis De-escalation Management Resources

“Today, most training in physical restraints is done by a handful of agencies that specialize in this type of training, usually along with other strategies for conflict de-escalation and problem solving. These include: Nonviolent Crisis Intervention; Therapeutic Options; Therapeutic Crisis intervention; The Mandt System and Professional Assault Response Training” (Safe & Responsive Schools, Effective Responses, Physical Restraints.)

The American Psychiatric Association (APA), American Psychiatric Nurses Association (APNA), National Association of Psychiatric Health Systems (NAPHS), and the American Hospital Association (AHA) Section for Psychiatric and Substance Abuse Services have joined together to create a compendium of strategies that direct care providers and administrators may want to consider as they continuously evaluate and update their facilities’ comprehensive policies and practices. The document was developed with extensive input from behavioral healthcare providers throughout the country – front-line staff members, clinical leaders, behavioral health administrators, and system executives who have been working with patients and families to reduce the use of restraint/seclusion and to improve care within their facilities.

1. [News Release](#)
2. [Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health](#) (42-page pdf document)

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LOSS CONTROL TECHNICAL BULLETIN

Bulletin
5200

8/06
Page 14 of 14

Behavior Management, Seclusion, Restraints and De-Escalation

3. [Appendix](#) (including useful forms, assessment tools, and checklists)
4. [Statement](#) of Charles G. Curie, Administrator, Substance Abuse and Mental Health Services Administration
5. [Ideas](#) for using and distributing these resources
6. [Promotional flyer](#) for posting or distributing to your staff
7. Give us your [comments](#) and ideas

<http://www.naphs.org/rscampaign/index.html>

Nonviolent Crisis Intervention
Crisis Prevention Institute, Inc. (CPI)
3315-K North 1245h Street,
Brookfield, WI 53005 Phone - 800-558-8976
<http://www.crisisprevention.com>

The Mandt System,
David Mandt & Associates
PO Box 831790
Richardson, TX 75083-1790
Phone - 972-495-0755 Fax - 972-530-2292
<http://www.mandtsystem.com/> or e-mail
comment@mandtsystem.com

Professional Assault Response Training (PART)
6105 Glenhurse Way
Citrus Heights, CA 95621-1720
Phone - 916-723-3802

Therapeutic Crisis Intervention (TCI)
Residential Child Care Project
Family Life Development Center -College of Human Ecology
Cornell University, Ithaca, NY 14853
Phone 607-254-5210; fax 607-255-4837

Therapeutic Options, Inc.
100 Delaplane Avenue
Newark, Delaware 19711
Phone - 302- 753-7115
<http://www.therops.com/>

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LOSS CONTROL TECHNICAL BULLETIN

Bulletin
5200

8/06
Page 15 of 14

Behavior Management, Seclusion, Restraints and De-Escalation

Resources

Magellan Position Statement on the Use of Seclusion and Restraints

https://www.magellanprovider.com/providing_care/clinical_guidelines/seclusion_restraints.asp?leftmenu=5&sub=child5_7

<http://www.toddertime.com/>

<http://www.toddertime.com/interest/restraint.html>

<http://www.toddertime.com/advocacy/hospitals/code/HS-restraint-laws.html>

<http://www.toddertime.com/advocacy/hospitals/code/definitions-SRM.html>

(Cribari,1996) and American Academy of Pediatrics (AAP Committee on Pediatric Emergency Medicine, 1997) "(Safe & Responsive Schools, Effective Responses, Physical Restraints.)

<http://www.unl.edu/srs/pdfs/physrest.pdf>

Joint Commission on Accreditation of Healthcare Organizations

www.jcaho.org

Health Care Financing Administration

www.hcfa.gov

Children's Welfare League

<http://www.cwla.org/advocacy/secres991026.html>

Guidelines for the Appropriate Use of Seclusion and Physical Restraint in Special Education Programs

<http://dpi.wi.gov/sped/doc/secrestrgd.doc>

National Association of Psychiatric Health Systems

<http://www.naphs.org/rscampaign/index.html>

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