TITLE: Restraint/Seclusion Policy

PURPOSE: Regulations and SRS Policy are not specific regarding proper procedures for protecting people's rights when Restraints (Mechanical, Physical, or Chemical) or Seclusion (isolation from others) are used as behavior intervention strategies. The Disability Planning Organization of Kansas, Inc. (DPOK) recognizes the willingness of providers in this CDDO area to be proactive in the areas of safeguards for individuals in services.

Individuals served shall have the right to be free from the unreasonable, unsafe, or unwarranted use of restraint or seclusion for the purposes of discipline, punishment or staff convenience. Service providers are expected to use positive behavioral support methods. If restraint or seclusion is used as safety intervention, it should be method of last resort. Restraint and seclusion are not treatment interventions. It is inappropriate to use these methods instead of providing adequate levels of staff. If such methods are used for the purpose of behavior intervention strategy, that use must follow the prescribed process.

The Restraint/Seclusion procedures shall give formal guidance for the provision of any service using funds administered by DPOK. However, the procedures serve only as a blueprint for advocacy by case managers or service providers working with families who are seeking to restrain or seclude children or adults in the home, and in working with non-DD community/education services seeking to restrain or seclude.

Definitions:
Mechanical Restraint – means the use of any device or object to limit a person's movement except that a protective or stabilizing device ordered by a person appropriately licensed to issue the order for the device or required by law shall not be considered to be a mechanical restraint. A mechanical restraint shall not mean any devise used by a law enforcement officer, campus police officer, or school security officer carrying out law enforcement duties.

Physical Restraint – means the use of bodily force to substantially limit a person's movement, except that consensual, solicited, or unintentional contact, or contact to provide comfort, assistance, or instruction shall not be construed to be physical restraint. Inappropriate Physical Restraint can include but not be limited to: tape, blankets, tiedowns, body carrier.

Chemical Restraint – means the administration of medication for the purpose of behavioral restraint.

Time Out – means a behavior management technique utilized with children that involves removing a child from sources of reinforcement following an inappropriate behavior for a limited period of time (as defined does not require these procedures when carried out by a family teaching a child). However, regarding adults, Time Out and Seclusion shall be considered the same for the purposes of these procedural requirements.

Seclusion Room – means a room or other confined area in which a person is placed in isolation from other persons for a limited time as a behavior intervention strategy and which the individual is prevented from leaving.

Imminent Risk of Harm – means an immediate and impending threat of causing substantial physical injury to self or others.

* Principles and procedures are excerpted from The Child Health Act of 2000 and proposals from the Kansas Disability Rights Center and Kansas Dept of Education

PROCEDURE:

1. The use of restraint or seclusion is prohibited except for an
   1.1. Emergency AND
   1.2. For the safety of the individual and others around them (imminent risk of harm)
2. If by recorded history or recent event it is determined that an individual is likely to have recurring behavioral episodes that put themselves or others around them at risk of harm, the person's support team shall conduct:
   2.1. Functional Assessment of the behavior, (example in the Kansas DD Targeted Case Management Handbook)
   2.2. Risk Assessment (example in the Kansas DD Targeted Case Management Handbook)
   2.3. Clear data based demonstration of other less restrictive behavior intervention strategies that have been implemented and proven ineffective
3. If the decision is made to use restraint or seclusion it must be defined in the individual's person centered plan.
   3.1. Where the seclusion can occur or specifically how the restraint may occur,
   3.2. The maximum length of any period of restraint or seclusion
   3.3. The number of times during a single day restraint/seclusion used
   3.4. Other team defined conditions
   3.5. Specify data to be collected to determine whether the strategy is effective, including number of times used within a fixed period of time.
   3.6. Establish a date of review within 60 days of implementation to determine the effectiveness of the intervention, including
      3.6.1.1. Case Manager
      3.6.1.2. CDDO Representative
      3.6.1.3. Guardian (if applicable)
      3.6.1.4. HCP/CSS area representative
      3.6.1.5. Appropriate service provider(s)
   3.7. A team meeting may be convened at any time to review and possibly make changes in the use of intervention with as little as 3 day notice.
   3.8. Restraints and seclusion plans cannot be written if the individual is known to have any medical condition that a licensed health care provider has indicated in written statement precluding the action.
   3.9. Restraint plan shall not be required for medication prescribed by a health care professional for the purpose of aiding comfort in preparation for a specific medical procedure.
   3.10. Restraint or Seclusion Plan must be reviewed and approved by licensed provider's Behavior Management Committee

3.11. In the event of self-directed supports, targeted case management provider's Behavior Management Committee must review and approve the coordination of such a plan by the case manager.

4. When restraint or seclusion is used, according to plan OR emergency
    4.1. As soon as possible after use the immediate staff or witnessing staff will document the use of the seclusion or restraint,
        4.1.1. Including all information noted 3.1, 3.2, 3.3, 3.4, & 3.5 above.
        4.1.2. Description of the antecedents that immediately preceded the use
        4.1.3. The specific behavior being addressed
        4.1.4. The alternative methods used to de-escalate the situation prior to use
        4.1.5. How the restraint ended, injuries, medical care provided, etc.
        4.1.6. Suggestions for strategies to be used in the future to avoid use
        4.1.7. Signature of person initiating the action
        4.1.8. Signature of witness to the intervention
    4.2. Notify Targeted Case Manager
    4.3. Notify Guardian, if applicable
    4.4. Provider shall facilitate efforts to define alternative methods of behavior management to keep the situation from escalating to emergency status following any such episode.
5. During the period of restraint or seclusion designated personnel must have the ability to see and hear the individual at all times.
6. No more than one individual at a time may be placed within one seclusion space.
7. Seclusion Rooms shall be
    7.1. At least 36 square feet
    7.2. Equipped with heating, cooling, ventilation and lighting comparable to remainder of building
    7.3. Free of objects that pose a danger
    7.4. Equipped with a door that locks only if the lock automatically disengages when a person on the exterior of the door moves away.
8. Physical/Mechanical restraint should be proportionate to the severity of the individual's behavior, size and physical strength/capabilities.
9. Personnel implementing restraint or seclusion must be properly trained, including
    9.1. Methods of getting the individual into seclusion room
    9.2. Methods for placing the individual in the restraint or room
    9.3. Supervision the individual while in restraint.
    9.4. Training should include at a minimum:
        9.4.1. Proper use of positive behavior supports and techniques and strategies designed to minimize and prevent the need for usage of restraint and seclusion
        9.4.2. Understanding of rules governing seclusion and restraint
        9.4.3. Safe administration of seclusion and restraint practices
        9.4.4. Physical safety during emergencies
        9.4.5. Identify the effects of physical restraint on the person restrained, monitoring physical signs of distress and obtaining medical assistance
        9.4.6. Simulated experience of administering and receiving physical restraint and its effects on the person restrained
        9.4.7. Instruction on documenting and report requirements
10. Provider shall provide to DPOK Quarterly Summary Report of each use of restraint or seclusion

11. DPOK will make available information to providers seeking to implement effective positive behavior support plans
12. Provider plans may include
    12.1. Organization wide approach to preventing and responding to problem behavior that is proactive and instructional, rather that reactive and punitive
    12.2. Individual and organizational strategies
    12.3. A system of continual data collection
    12.4. Utilization of data-based decision-making
    12.5. Application of research-validated positive behavior interventions.

NOTE: At no time shall aversive behavioral interventions such as application of noxious, painful, intrusive stimuli or activities intended to induce pain such as electric skin shock, ice applications, hitting, slapping, pinching, kicking, hurling, strangling, shoving, deep muscle squeezes or other similar stimuli; any form of noxious, painful or intrusive spray, inhalant or tastes; withholding sleep, shelter, bedding, bathroom facilities or clothing; contingent food programs that include withholding meals or limiting essential nutrition or hydration or intentionally altering staple food or drink in order to make it distasteful; movement limitation used as a punishment such as helmets, immobilized wheelchairs, removal from wheelchair. The term aversive does not include such interventions as voice control, limited to loud, firm commands; time-limited ignoring of a specific behavior; token fines as part of a formal token economy system; brief physical prompts to interrupt or prevent a specific behavior; interventions medically necessary for the treatment or protection of the individual; or other similar interventions.

Policy No.	82.20
Affiliate Mtg Review Date:	12/1/2006
Council Review Date:	12/4/2006
HCP/CSS Submittal Date:	3/1/2005
Staff/Mgr Approval Date:	1/8/2007
Bd. Policy Approval Date:	1/25/2007
Public Meeting	2/26/2007
Effective Date:	3/1/2007