



## MONTANA STATE HOSPITAL POLICY AND PROCEDURE

### REVIEW OF SECLUSION and RESTRAINT INCIDENTS

**Effective Date:** March 25, 2019

**Policy:** QI-04

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- I. PURPOSE:** To provide a post-incident review process for all restraint and seclusion interventions separate from the review conducted by patient treatment teams, and to obtain interdisciplinary advice and guidance on the use of these interventions at Montana State Hospital (MSH).
  
- II. POLICY:** MSH is committed to providing treatment in the least restrictive setting in the least intrusive manner allowable to ensure the safety of the patient, other patients, and staff members. The Hospital is also committed to using restraint and seclusion procedures only when necessary as a last resort to help manage behaviors that present a high and imminent risk of harm to others or to the person for whom the procedure is applied.

Restraint and seclusion procedures are containment measures that may be necessary at times to provide protection to people at risk for harm, but they are not treatment interventions, nor an appropriate “consequence” for modifying undesirable behavior.

The use of restraint and seclusion procedures is considered an unusual and high-risk event requiring a great deal of oversight and review. The purpose of oversight and review procedures is to ensure the safety of all persons and the application of these procedures in a manner consistent with laws, regulations, and standards of care for people with psychiatric disorders.

MSH will have an organized, interdisciplinary, leadership driven Weekly Event Review Committee to review and monitor seclusion and restraint usage, provide an educational resource for hospital staff, and review and make recommendations on policy and procedures for Seclusion and Restraint.

A post-incident review of all procedures except physical holds will be conducted following each incident and will involve staff on the treatment unit, and clinical management staff. The focus of the review process will be to evaluate the incident for conformance with applicable standards and to learn from the event and make changes in treatment regimens in order to reduce the risk of similar occurrences in the future.

The evaluation process of reviewing seclusion and restraint use is considered a quality improvement activity. All forms and reports generated by this process are considered quality improvement tools.

**III. DEFINITIONS:**

- A. **Seclusion:** Involuntary confinement of a patient alone in a room or an area from which the person is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive individuals.
- B. **Restraint:** The use of any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces free movement of the patient's arms, legs, body or head. Only those methods approved by MSH administration will be used to physically restrain a patient. **Chemical Restraint** is not approved for use at MSH.
- C. **Chemical Restraint:** A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and **is not a standard treatment or dosage for the patient's medical or psychiatric condition.**
- D. **Emergency Transport Restraints:** Wrist and ankle restraints or the transport blanket may be used for brief periods to safely transport a patient in an emergency situation. Examples of this use include use of wrist and/or ankle restraints to transport a patient on unauthorized leave safely back to their treatment unit or use of the transport blanket to transport a violent or self-destructive patient to a safe location within a treatment unit. Use of emergency transport restraints require an order by a Physician/Licensed Independent Practitioner and face to face evaluation by a Physician/Licensed Independent Practitioner or trained RN or PA within one hour, along with documentation and review required just as with all other restraint procedures.
- E. **Security Restraint:** A soft (leather, fabric weave, Velcro or locking type) but reliable restraint used to restrict an individual's movement as applied under this policy. Security Restraints are utilized by the Forensic Treatment Unit as described in MSH policy FP-03 Security Restraints for Patient on a Forensic Commitment and are not reviewed by the Weekly Event Review Committee.
- F. **Patient Fall:** A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, the ground or other surface
- G. **Weekly Event Review Committee:** A multidisciplinary committee which has the responsibility to review incidents where seclusion and or restraints are used to manage behavior. The committee evaluates the appropriateness of the use of seclusion and or restraints and adherence to MSH policies TX-16, Use of Seclusion and Restraints and TX-31, Use of Restraints for Non-violent Non-Self-Destructive Behaviors. The committee also reviews patient falls and patient and staff injuries due to violence.

**IV. RESPONSIBILITIES:**

- A. ***Hospital Administrator:*** Ensures a committee and process exists within the hospital organization to review, monitor and report on seclusion and restraint usage.
- B. ***Director of Treatment Services:***
1. Ensuring a clinical philosophy which promotes treatment in the least restrictive manner while reducing seclusion and restraint.
  2. Providing feedback to the treatment providers regarding the findings of the committee and the use of seclusion and restraint.
  3. Promoting alternative, less restrictive, interventions with the treatment teams.
  4. Participating on the Weekly Event Review Committee.
- C. ***Licensed Nursing Staff:*** Ensure all episodes of seclusion and restraint are documented on the Nursing Report.
- D. ***Program Managers:***
1. Ensuring a copy of the Seclusion and Restraint Intervention Order/Progress Note is sent to the Director of Quality Improvement.
  2. Leading the event review process.
  3. Overseeing the application of what has been learned through review processes to practice on patient treatment units.
  4. Participating on the Weekly Event Review Committee.
- E. ***Nurse Managers:***
1. Reviewing each Seclusion and Restraint Intervention Order/Progress Note and incident report forms for accuracy.
  2. Actively participating in event review procedures.
  3. Leading the event review process in the absence of the Program Manager.
  4. Participating on the Weekly Event Review Committee.
  5. Providing feedback, training to unit staff.
- F. ***Director of Quality Improvement:***
1. Ensuring data from these reports are entered into a computer database and aggregated for regular reporting purposes.
  2. Chairing the Weekly Event Review Committee.
  3. Coordination of staff education regarding the use of seclusion and restraint.
- G. ***Medical Director:***
1. Ensuring a clinical philosophy which promotes treatment in the least restrictive manner while reducing seclusion and restraint.
  2. Providing feedback to the practitioners regarding the findings of the committee and the use of seclusion and restraint.
  3. Promoting alternative, less restrictive, interventions with the treatment teams.
  4. Participation on the Weekly Event Review Committee.

H. *Director of Nursing:*

1. Ensuring a clinical philosophy which promotes treatment in the least restrictive manner while reducing seclusion and restraint.
2. Providing feedback to the practitioners regarding the findings of the committee and the use of seclusion and restraint.
3. Promoting alternative, less restrictive, interventions with the treatment teams.
4. Participating on the Weekly Event Review Committee.

I. *Committee Members:*

1. Attending and participating in Committee meetings.
2. Supporting the delivery of quality care by providing:
  - a. Review of seclusion and restraint incidents according to this policy.
  - b. Active participation in Committee education efforts.
  - c. Supporting the delivery of quality care by:
    - i. Reviewing seclusion and restraint incidents according to this policy.
    - ii. Accepting the role of the Weekly Event Review Committee as an educational resource: The Committee provides an effective and functioning educational resource, which the Hospital may utilize to assure initial (orientation) and ongoing staff training.
    - iii. Providing Hospital Policy Review: The Committee offers consultation and recommendations for updating and developing seclusion and restraint policy.
    - iv. Disseminating information and data about standards, evidence-based and promising practices, and use of restraint and seclusion procedures at MSH and other psychiatric hospitals to clinical staff throughout the organization.

V. **PROCEDURE:**

A. Seclusion and Restraint Report:

1. All uses of seclusion and restraint will be reported daily to the Hospital Management Team via the Nursing Report.
2. A copy of the Seclusion and Restraint MD Order/Progress Note will be completed and sent to the Director of Quality Improvement at the end of each intervention or, in case of extended interventions, every twenty-four hours.
3. Data from these reports will be entered into a computer database. Aggregate data from these reports will be made available to the hospital's administrative and clinical staff on a quarterly and on as needed basis.

B. Membership:

1. Committee membership is comprised of the following members of the management team:
  - a. Hospital Administrator,
  - b. Director of Clinical Services,
  - c. Medical Director,

- d. Director of Nursing,
  - e. Director of Quality Improvement,
  - f. Program Managers,
  - g. Nurse Managers,
  - h. Additional staff may be asked by the chairperson to consult with this Committee on a case-by-case basis.
- C. Leadership of the Weekly Event Review Committee:
1. The Director of Quality Improvement shall chair the committee or designate the chair.
- D. Meeting Frequency:
1. The Committee will ordinarily meet weekly.
- E. Minutes:
1. Minutes will be recorded for all committee meetings with copies going to committee membership for dissemination of information to clinical staff.
- F. Review of Seclusion, Restraint and Incidents:
1. The committee will review uses of seclusion and restraint by examining the Seclusion and Restraint Order/Progress Notes filed with the Director of Quality Improvement, the event review and by reviewing the patient's chart.
  2. The attached Quality Improvement Seclusion and Restraint Audit Tool and the Quality Improvement Non-Violent Non-Self-Destructive Audit Tool will be utilized when conducting reviews
  3. If a pattern of opportunities to improve is noticed, the Committee may request and monitor a plan for improvement.
  4. The committee will note whether each incident of seclusion or restraint was implemented appropriately and in accordance with the provisions of the Hospital's Seclusion and Restraint Policy and Use of Restraints for Non-Violent Non-Self-Destructive Behaviors Policy.
  5. If any use of seclusion or restraint is judged to be inappropriate or out of compliance with policy or statutory requirements, the Committee will:
    - a. Recommend a plan of correction to the appropriate supervisory staff and/or Medical Director (when appropriate) so supervisory staff can take corrective action.
    - b. Consider the need to initiate an Abuse and Neglect Investigation per MSH policy TX-17.
  6. The Committee is responsible for tracking these incidents to resolution.
  7. Information regarding the use and review of seclusion and restraint interventions will be provided to the hospital's Quality Improvement Committee on a quarterly basis.
  8. Patient falls will be evaluated based on the criteria set forth in the Post Fall Assessment Quality Assurance Review Audit Tool.

- G. Reporting:
1. The Director of Quality Improvement will ensure a process to maintain a database and prepare and distribute reports regarding these occurrences at periodic intervals but not less than quarterly. This information is analyzed and reported on a quarterly basis to the Senior Leadership Team, hospital-wide Quality Improvement Committee, and to the medical staff.
  2. The Quality Improvement Committee will:
    - a. Review aggregate (total hospital and data by treatment unit) seclusion, and restraint data on a quarterly basis, as well as other reports generated by the Weekly Event Review Committee.
    - b. Will identify performance improvement goals for use and reduction of Seclusion and Restraint.
- VI. **REFERENCES:** Related Policies: Seclusion and Restraint; Use of Restraints for Non-Violent Non-Self-Destructive Behaviors Policy; Standards/Statutes: § 53-21-146 M.C.A., and CMS Standards.
- VII. **COLLABORATED WITH:** Hospital Administrator, Weekly Event Review Committee, Medical Director, Director of Quality Improvement, Director of Clinical Services, and Director of Nursing.
- VIII. **RESCISSIONS:** QI-04, *Seclusion and Restraint Committee* dated December 9, 2015; QI-04, *Seclusion and Restraint Committee* dated February 11, 2011; QI-04, *Seclusion and Restraint Committee* dated August 17, 2007; QI-04, *Seclusion and Restraint Committee* dated November 17, 2004; QI-04, *Seclusion and Restraint Committee* dated February 14, 2000; HOPP 13-03R. 11191 “Review of Time Out, Behavior Control, Seclusion, and Restraint Interventions” dated November 1991.
- IX. **DISTRIBUTION:** All hospital policy manuals.
- X. **ANNUAL REVIEW AND AUTHORIZATION:** This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.
- XI. **FOLLOW-UP RESPONSIBILITY:** Director of Quality Improvement.
- XII. **ATTACHMENTS:** For internal use only.
  - A. Restraint/Seclusion Procedure Review.
  - B. QI Non-violent Non-Self-Destructive Order Audit Tool.

Signatures:

Kyle Fouts  
Interim Hospital Administrator

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Director of Quality Improvement