POLICY: Use of Restraint

PURPOSE: The purpose of this policy is to describe the appropriate use of restraint in State Supported Living Centers and the ICF-IID component of Rio Grande State Center (“state centers”).

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State Supported Living Centers

APPLIES TO: State center employees, volunteers and contractors

DISTRIBUTION: The state center must ensure the policy, all exhibits, and forms are distributed to applicable staff, contractors, and agents and to any individual or legally authorized representative (LAR) requesting a copy.

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FORMS:
- SSLC 001A Crisis Intervention Restraint Checklist
- SSLC 001B Medical/Dental Restraint Checklist
- SSLC 001C Protective Mechanical Restraint For Self-Injurious Behavior Checklist
- SSLC 001D Crisis Intervention Face-to-Face Assessment and Debriefing
- SSLC 001E Administration of Chemical Restraint Consult and Review Form

REFERENCES:
- Settlement Agreement, Sections C and J and Appendix A
- Texas Health & Safety Code, Chapter 322 and Chapter 592, Subchapter E
- 42 Code of Federal Regulations (CFR) §483.450
- 40 TAC §3.101 (Definitions)
- 40 TAC Chapter 3, Subchapter F (Restraints)
- 40 Texas Administrative Code (TAC) §9.229 and §90.42(e)(4)
I. State Center Expectations and Responsibilities

Each state center ensures these requirements are met:

1. Each state center must operationalize and implement this statewide policy addressing the use of restraint.

2. The least restrictive, effective restraint may only be used after a graduated range of less restrictive measures have been exhausted, as safety permits, or considered in a clinically justifiable manner.

3. Staff may not use a restraint on an individual unless it is an approved restraint necessary to protect the individual or others from imminent physical harm: in a behavioral crisis; in order to conduct a medical or dental procedure; for the purpose of preventing an individual from inhibiting or undoing medical or dental treatment, including from dangerous involuntarily self-injurious behavior (SIB); or due to voluntary or intentional SIB for which intensive, one-to-one supervision and treatment have not sufficiently reduced the risk of self-injury.

4. Restraints are applied with the minimum amount of force or pressure that is necessary to prevent harm to the individual and others, and staff take all necessary steps to avoid causing any physical discomfort, harm, or pain to the individual in using a restraint.

5. A restraint is terminated as soon as the individual’s behavior is no longer a danger to himself or herself in a behavioral crisis, the behavior is no longer preventing the safe and effective implementation of a medical or dental procedure, the restraint is no longer needed to prevent the individual from inhibiting or undoing medical or dental treatment, or the behavior is no longer dangerously self-injurious.

6. Staff administer restraints in the safest, most humane, and most respectful manner possible, while safeguarding the individual’s personal dignity, privacy, and well-being.

7. In providing medical or dental services, the practitioner is sensitive to the individual’s understanding and possible anxiety in reaction to the assessment, procedure, or treatment. The services are provided in a manner that is comforting, calming, and responsive to the individual to reduce the need for any use of restraint.

8. An authorization by a primary care physician (PCP) or a psychiatrist to use or extend a crisis intervention physical or mechanical restraint is for the shortest period of time to prevent imminent physical injury and must not exceed 12 consecutive hours.

9. The interdisciplinary team (IDT) must ensure that a PCP or psychiatrist reviews and updates, at least annually and as necessary in response to changes in condition and at IDT meetings, any conditions, factors, or limitations on specific physical techniques, drugs, or mechanical devices that must be considered in any application of restraint. Staff must be made aware of these changes.
10. If an individual in restraint experiences signs or symptoms of restraint-related injuries or distress or a medical emergency, staff must respond immediately, releasing the restraint and ensuring that the signs, symptoms, or the medical emergency are promptly and appropriately addressed as described in the state center’s policies and procedures.

11. If an emergency evacuation or an evacuation drill occurs while an individual is in restraint, staff must respond as described in the state center’s policies and procedures to ensure the individual’s safety.

12. Staff must allow an individual who has been released from restraint time to recover and return to regular activities, including the opportunity to relax and exercise restrained limbs, to drink fluids, to toilet, to complete a snack or meal, and to receive prescribed medications.

13. Staff must provide continuous one-to-one supervision to individuals while in a restraint. Individuals receiving medical restraints must receive supervision as ordered by the PCP or dentist in accordance with state center procedures. The director may approve an alternate level of supervision based on the IDT’s clinical justification and recommendation.

14. If an individual is in restraint at the time of shift change, staff must communicate and coordinate between shifts to provide continuity of care. Staff going off-duty must do a person-to-person transfer of the responsibilities for the continuation of and the monitoring of the restraint procedures to the shift coming on-duty and review the status of the individual, including information about any medication given during restraint.

15. One or more persons trained as a restraint monitor must be on duty at all times to respond to the initiation of crisis intervention restraint procedures, immediately if possible, but in no case in more than 15 minutes. If data suggests a high number of restraints, additional restraint monitors may be required.

16. A licensed nurse must assess an individual who has been restrained for injuries or other negative health effects, determine if the individual’s vital signs are stable, and document the individual’s mental status as soon as possible but within 30 minutes after the initiation of restraint. A licensed nurse must continue assessment at 30 minute intervals or less as needed. Staff must continuously monitor the individual until the licensed nurse arrives.

17. If a medical or dental restraint is used before or during intervention for routine medical or dental care, a medical restraint plan must be developed prior to use of the medical restraint to describe the rationale for use of the medical restraint and to provide specific individualized instructions on how to safely implement the medical restraint.

18. A state center must obtain the required prior written consent or authorization for a crisis intervention plan, a medical or dental restraint plan, or a protective mechanical restraint plan for SIB, in accordance with applicable Texas law, federal law, and the SSLC Division’s statewide policy on Assuring and Protecting Rights and Consent and Authorization for Treatment and Services, #045. The required prior written consent may be obtained at the individual support plan (ISP) meeting. These plans must be reviewed by the Behavior
Support Committee (BSC) and the state center director, and reviewed and approved by the Human Rights Committee (HRC) before implementation in compliance with the statewide operational policy on Assuring and Protecting Rights and Consent and Authorization for Treatment and Services #045.

19. A state center may adopt policies that allow less use of restraint than allowed by this statewide operational policy.

II. Approved Restraints

Staff must only use the following approved physical, mechanical, or chemical restraints either as crisis interventions or as medical or dental restraints in compliance with the requirements in this statewide policy, other applicable statewide policies, state laws, federal laws, and the State’s Settlement Agreement with the U.S. Department of Justice (Settlement Agreement).

A. Physical Restraints Used as Crisis Interventions or as Medical or Dental Restraints

Staff must use only approved physical restraints as trained in Prevention and Management of Aggressive Behavior (PMAB) or in an approved restraint plan that meets the individual’s needs.

B. Mechanical Restraints Used as Crisis Interventions or as Medical or Dental Restraints

1. Only commercially available mechanical restraint devices designed for the safe and relatively comfortable use of restraint may be used as either authorized mechanical restraints without approved restraint plans or mechanical restraints described in approved restraint plans. The IDT and state center’s director must approve in writing any modifications to a mechanical restraint to accommodate the individual’s need (e.g., obesity, physical impairment, history of physical abuse).

2. Staff must inspect a mechanical device to ensure that the device is in good repair and without tears or protrusions that may cause injury. Staff must have a damaged mechanical device repaired or replaced before it can be used to restrain an individual.

C. Drugs Prescribed and Administered as Crisis Intervention Chemical Restraints

1. A PCP or psychiatrist may order a drug as a crisis intervention chemical restraint for behavior management if immediate use of the medication is essential to prevent or mitigate the danger of the individual's harmful behavior, and lesser restrictive alternatives have not reduced the risk of imminent physical harm. This order must not be a standing order or on an as needed (PRN) basis.

2. Prior to the order, the behavioral health service provider and licensed nurse must consult and document on SSLC 001E Administration of Chemical Restraint Consult and Review Form that the following conditions have been met:
   a. The individual is experiencing a behavioral crisis;
   b. A graduated range of less restrictive alternatives have been attempted, as safety permits, but has not reduced the risk of imminent physical harm;
c. A psychiatrist or PCP has determined that early administration of the individual’s regularly prescribed psychotropic medication instead of a chemical restraint is not a reasonable option;
d. A request for chemical restraint has been made to the psychiatrist or PCP by the nurse, and the psychiatrist or PCP verbally orders the medication prior to its administration and follows with a written order;
e. The psychiatrist’s or PCP’s order for chemical restraint requires that the individual be evaluated by a licensed nurse every 15 minutes for two hours or more following the medication administration and that one-to-one supervision be provided until the individual is determined by a nurse to be medically stable; and
f. The individual’s level of supervision remains at one-to-one until the individual is determined by a nurse to be medically stable.

D. Pretreatment Medical (including Dental) Sedations Used as Chemical/Medical Restraints
   See Section IV for more details on the pretreatment sedation (PTS).

III. Prohibitions
A. Prone restraint and supine restraint are prohibited.

B. Staff is prohibited from using restraint:
   1. For punishment, disciplinary purposes, retaliation, or retribution;
   2. For convenience of staff or others;
   3. As part of a positive behavior support plan (PBSP); or
   4. As a substitute for treatment or habilitation.

C. No restraint may be used if it:
   1. Secures the individual to a stationary object while he or she is in a standing position;
   2. Obstructs the individual's airway, including the placement of anything in, on, or over his or her mouth or nose;
   3. Impairs the individual's breathing by putting pressure on his or her torso;
   4. Interferes with the individual's ability to communicate;
   5. Extends muscle groups away from each other;
   6. Uses hyperextension of joints;
   7. Uses pressure points or pain; or
   8. Is prohibited by the individual's medical orders or ISP or is medically contraindicated.

D. An order for the use of restraint as a standing order or on an as needed (pro ne rata) basis is prohibited.

E. The following mechanical restraint devices are prohibited and must never be applied:
   1. Metal wrist or ankle cuffs;
   2. Rubber bands, ropes, and cords, unless part of an approved device;
   3. Long ties and leashes, including halter leashes;
   4. Restraining sheets, padlocks, papoose/restraint boards, or restraint chairs;
   5 Camisoles, transport jackets, or strait jackets;
6. Barred enclosures with tops, including crib-style beds with mesh tops; and
7. A mechanical restraint that is damaged or in disrepair.

IV. Conditions of Application

A. IDT Activities

1. The IDT ensures that any conditions, factors, or limitations on specific physical
techniques, drugs, or mechanical devices that must be considered in the use of restraint
are documented (See Policy #006.3 At Risk Individuals; Annual Integrated Risk Rating
Form (IRRF) Behavioral Health Risk Factors, SSLC 006B)). The conditions, factors, or
limitations include:
   a. Physical, behavioral, psychiatric, or medical conditions that constitute a risk; and
   b. Any considerations in the use of restraint due to the individual's communication level,
cognitive functioning level, height, weight, emotional condition (including whether
the individual has a history of having been physically or sexually abused), and age.

2. An ISP addendum (ISPA) meeting is required as soon as possible, but not later than one
business day after the use of a crisis intervention restraint when there is no crisis
intervention plan in place. The IDT reviews the initial restraint and any restraints that
might have taken place while the meeting was being scheduled. The meeting discussion
must include a review of the circumstances involved in the use of the restraint, decisions
on the development of a crisis intervention plan, and other possible actions.

3. When more than three crisis intervention restraints occur in a 30-day rolling period (see
Settlement Agreement, Section C.7.) the IDT must complete an ISPA meeting as soon as
possible, but not later than 10 business days after the fourth restraint occurred during the
30-day rolling period. Additional ISPAs are not necessary if the criterion (more than
three restraints in a 30-day rolling period) is met again prior to the ISPA occurring.

4. The IDT discusses at least the following, determining which areas are influencing the
restraints and what action(s), if any, are needed:
   a. Review the individual’s relevant adaptive skills and biological, medical, and
psychosocial factors that may influence the current levels of crisis intervention
restraint.
   b. Review environmental conditions that may have impacted the crisis interventions
restraints.
   c. Review the relevance of the most current structural and functional assessment (if one
exists) in terms of identifying the strengths of the individual and the function of
behaviors leading to the crisis intervention restraint and whether the assessment
remains accurate, needs revision, or a new assessment needs to be completed.
   d. Review the relevance of the most current PBSP (if one exists) in terms of the
circumstances and behaviors that lead to restraint and the development of prevention
strategies and interventions based on the structural and functional assessment. The
conclusion of the review must indicate whether the current PBSP is adequate, needs
revision, or a new PBSP needs to be developed.
   e. Revise or develop additional programs, if applicable, to reduce the use of crisis
intervention restraint, such as desensitization activities to minimize the need for
restraints or skill acquisition plans to develop more effective behaviors to communicate and reduce the dangerous behaviors that lead to crisis intervention restraints.

f. Review the information available on treatment integrity and whether relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior.

g. Determine the action(s) to be taken (e.g. crisis intervention plan, PBSP, SAPs), if any, to reduce the restraints and the time period necessary to evaluate the results, not to exceed 90 days from the occurrence of the fourth restraint occurring in the rolling 30-day period. The review schedule and factors that require an IDT meeting during this evaluation period are also determined, including under what conditions the IDT will meet if additional criterion occur during the evaluation period.

5. The IDT reviews and takes action, as needed and for other significant events related to restraints, including:
   a. Restraint use has not decreased over time and may be likely to continue at a stable rate unless action is taken.
   b. The individual’s characteristics (e.g., strength, size, medical contraindications) have changed and require that restraint procedures be adjusted to meet the individual’s specific needs.
   c. There is a consistent pattern of injuries to the individual or others as restraints are used.
   d. An individual has dangerous levels of self-injurious behavior, and crisis intervention restraints, supervision, and treatment have not been successful in reducing physical harm.
   e. An individual’s behavior is presenting a risk to medical or dental treatment or to healing.
   f. Restraint data accumulated over at least six months of attempts to fade the protective mechanical restraints for SIB that is voluntary or intentional have not been successful, suggesting that a protective mechanical restraint for involuntary dangerous behaviors may be appropriate.

6. The IDT must review at least annually and more frequently as necessary, any use of crisis intervention restraints, medical restraints, or dental restraints. The IDT must review the use of protective mechanical restraint for SIB at least monthly and more frequently as necessary.

6. For individuals participating in a program outside the state center (e.g., attending public school or working), the IDT:
   a. Coordinates with staff from the outside program to assess needs and risks and to develop interventions consistent with the ISP and any action plans; and
   b. Invites staff from the outside program to participate in IDT meetings at which interventions are discussed.

B. Crisis Intervention Restraint
1. Crisis intervention restraints include physical, mechanical, and drugs ordered as a chemical restraint.

2. The following must be met before a PCP or psychiatrist may order a crisis intervention restraint:
   a. Staff have determined that the individual is experiencing a behavioral crisis.
   b. Staff have applied a graduated range of less restrictive approved procedures, including any relevant PBSP procedures, as safety permits, and the actions have not reduced the risk of imminent physical harm to the individual or others.
   d. If the ordering of drugs as a crisis intervention chemical restraint is being considered, (i) the behavior service provider and nurse have consulted and agreed that lesser restrictive alternatives have been attempted and the psychiatrist or PCP has determined that early administration of the prescribed psychotropic medication is not an option. The consultation is documented on SSLC 001E Administrations of Chemical Restraint and Review Form.
      (ii) A request for chemical restraint has been made to the psychiatrist or PCP by the nurse and the psychiatrist or PCP verbally orders the medication prior to its administration and follows with a written order.
      (iii) The psychiatrist’s or PCP’s order for chemical restraint requires that the individual be evaluated by a licensed nurse every fifteen minutes for two hours or more following the medication administration and that one-to-one supervision be provided until the individual is determined by a nurse to be medically stable.
      (iv) The individual’s level of supervision remains at one-to-one until the individual is determined by a nurse to be medically stable.
   e. If a crisis intervention mechanical restraint is to be ordered, there is an approved crisis intervention plan in place describing the mechanical restraint procedures or if not, the prior authorization of the crisis intervention mechanical restraint has been completed, as follows:
      (i) The restraint monitor contacts the behavior health service provider or and a nurse to discuss:
         • What lesser restrictive alternatives have been attempted or considered and have been unsuccessful or contraindicated;
         • What type of mechanical restraint is being considered; and
         • How to place it on and the procedures and indicators for removal and inspections for maintenance and quality fit.
      (ii) After the behavior service provider and the nurse prepare this information, the administrator on call and the director of Behavioral Health Services are contacted for their approval.

3. If a crisis intervention plan is in place, staff follow, as closely as circumstances permit, the individualized instructions for applying restraint during a behavioral crisis. If there is no crisis intervention plan, PMAB-approved restraint procedures are applied.

4. If there is no approved crisis intervention plan and crisis intervention physical, mechanical, or chemical restraint is used, the application of a crisis intervention restraint is an emergency restriction, and the procedures for an emergency restriction must be
followed. (See statewide operational policy on Assuring and Protecting Rights and Consent and Authorization for Treatment and Services #045)

5. A crisis intervention plan is developed by a behavioral health service provider with input from direct support professionals and the IDT, and includes the following:
   a. The type of restraints authorized, including any conditions or factors that were indicated by the PCP and discussed by the IDT that warranted adjustments in the crisis intervention physical, mechanical, or chemical restraint;
   b. The maximum duration of crisis intervention physical and mechanical restraints, as applicable;
   c. A description of the behaviors that is indicative of a behavioral crisis and the behavioral situations for which the crisis intervention restraint may be used;
   d. The criteria for terminating the use of the crisis intervention physical and mechanical restraint described in behavioral terms;
   e. As applicable, the type of medication and other information on crisis intervention medication as written by the psychiatrist; and
   f. The clinical indicators that would indicate that the plan is no longer necessary and must be considered for discontinuation.

7. For each application of a crisis intervention restraint, the Crisis Intervention Restraint Checklist (form SSLC 001A) is completed by the staff initiating the restraint, as soon as possible after the restraint has been applied.

C. Medical or Dental Restraints

1. A medical or dental restraint is used as a health-related protection prescribed by a PCP or dentist that is necessary for the conduct of a specific medical or dental procedure; or as necessary for the purpose of preventing an individual from inhibiting or undoing medical or dental treatment. A medical or dental restraint used under these circumstances includes restraints necessary to protect the individual from involuntary SIB. (See also the statewide policy on Assuring and Protecting Rights and Consent and Authorization for Treatment and Services #045, regarding assurance of due process, including HRC review and approval and consent).

2. A medical or dental restraint does not include the use of physical guidance, positioning, touching, assisting, supporting, redirecting, protecting, or stabilizing to help an individual whose behavior is not dangerous during a routine medical or dental examination or medical procedure (e.g., blood pressure check; insulin check). If the individual intentionally and forcibly pushes away or resists the physical guidance, positioning, touching, assisting, supporting, redirecting, protecting, or stabilizing; and if the situation becomes dangerous, a medical or dental restraint may be used.

3. If a medical restraint or dental restraint is needed in order to perform a procedure(s) or to prevent an individual from inhibiting or undoing medical or dental treatment, the IDT must develop a medical or dental restraint plan. The plan must include a description of the rationale for the use of the medical or dental restraint, the type of restraint, duration of
the restraint, possible adverse effects and risk/benefits, procedure(s) for implementation, clinical indicators that would indicate when the IDT must consider that the restraint is no longer needed, and specific individualized instructions on how to safely and effectively implement the restraint, removal of the restraint, level of supervision while in and out of the restraint, monitoring parameters, and how to inspect the mechanical device for damages and proper fit.

4. The plan also must include supports, strategies, or other interventions to aid in the reduction of the use of medical restraints (e.g., using familiar staff and settings to make the person more comfortable.

5. The IDT must review at least annually, and more frequently (e.g., change of status), as necessary, to make recommendations depending on the effectiveness of the plan, including the need for medical restraints or dental restraints for the individual.

6. Medical and dental staff must strive to make the individual as comfortable and calm as possible, using informal techniques such as reducing noise levels, glaring lights, and speaking slowly.

7. If an individual has a diagnosed medical condition that indicates no intentional or voluntary control of behavioral movements that interfere with the safe completion of a specified medical or dental procedure and these movements might result in individual injury, the IDT may determine that the benefits of the medical restraint outweigh the risks, and development of desensitization activities may not be very effective.

8. Pretreatment Sedation (PTS) is used only as necessary in order to provide medical or dental treatment. The IDT determines the necessity of PTS for the individual; whether the PTS is used as a medical or dental restraint or not; and if desensitization activities are appropriate.

9. Annually and as needed, the IDT members, including medical or dental staff, must review and determine the need of PTS for medical or dental procedures, assessments, and treatments for all individuals emergently or for routine procedures during the 12-month period. Once the IDT determines the need for PTS, the IDT must consider relevant data and information in determining whether PTS is used as a medical or dental restraint or not, including at least the following:
   a. PTS is considered a chemical/medical restraint when used for procedures, assessments, or treatments that are routine and for which most people in the general population would not use a medication for PTS.
   b. PTS, including TIVA, is not considered a chemical/medical restraint when used for procedures for which most people in the general population would use PTS, such as anesthesia for tooth extraction.

10. Additionally, if the IDT, including medical or dental staff, determines that PTS is necessary as a medical or dental restraint, the IDT must then assess the appropriateness and risk/benefits of developing supports, strategies, and other interventions for the
individual with the intent of reducing or eliminating the need for the use of medical restraints (e.g., familiar staff and settings).

11. For some individuals, the IDT may not recommend desensitization activities due to the individual’s health status or because the procedure, assessment or treatment occurs infrequently so time will not permit desensitizing (e.g., annual mammogram, eye exam, pelvic exam) or for other reasons. These reasons must be documented in the ISP or an ISP Addendum. The IDT must also consider:
   a. The duration and discomfort of the procedure for the individual;
   b. Past history of any occasions in which the individual participated without the use of PTS and the individual’s response;
   c. Past history of attempts to carry out desensitization and the results; and
   d. Current diagnosis.

12. If PTS is used for an individual with a diagnosis of a movement disorder (involuntary movements) that interferes with the safe completion of a specified medical or dental procedure, assessment, or treatment, it is not coded as a restraint. A desensitization activity is not required.

13. If the IDT recommends development of and assigns responsibility for implementation of desensitization activities for the individual, the IDT will develop desensitization activities for the procedures, assessments or treatments. The activities will be included in the individual’s ISP.

13. The IDT (PCP; psychiatrist, and pharmacist if on psychotropic medications) document the possible adverse effects, drug interactions that need to be monitored in the ISP and/or ISP Addendum of the medications used for PTS.

14. If the IDT recommends PTS for the individual, the PCP writes an order for the PTS prior to the scheduled procedure, assessment, or treatment. The PTS order must include the name, dosage, route of administration and the indication.

15. PRN orders for PTS are prohibited.

16. If an assessment, procedure or treatment is necessary in an acute situation to complete a medical assessment, procedure, or treatment, and there is no time to obtain the required written consent, the PTS may be utilized in response to the need, and the state center must initiate the emergency restriction procedure in compliance with the statewide policy on Assuring and Protecting Rights and Consent and Authorization for Treatment and Services #045. An IDT meeting must occur as soon as possible, but not later than one business day after the administration of the restraint to discuss the use of the emergency restriction, including actions to be taken when the assessment, procedure, or treatment is scheduled in the future.
17. Following the application of a PTS, the individual will be assessed and monitored until full recovery in accordance with the current #010 Nursing Services statewide policy on pre and post PTS.

18. The PCP or dentist evaluates post-medical or dental PTS outcome and effectiveness using SSLC 001E Pre-Consultation and Follow-up Review Form for Psychiatric Medication Emergency Treatment or Chemical Restraint For Behavior Management. The PCP or dentist will make written recommendations for future medical or dental PTS needs, reduction or elimination as appropriate.

18. The staff person who provides any of the types of medical or dental restraint initiates the Medical/Dental Restraint Checklist (SSLC 001B) for each restraint episode.

D. Medical and Dental Restraint Plans For Involuntary Dangerous Behaviors
1. A medical or dental restraint plan must be written for individuals with a diagnosed medical or dental condition that includes involuntary behaviors of a biological origin that places the individual in imminent danger. Due to imminent danger, these individuals require mechanical restraint devices that restrict freedom of movement or normal access to the body, and the devices cannot easily be removed due to protection from harm, such as SIBs in those with Lesch-Nyhan Syndrome or the dislodging of abdominal binders due to spasticity. The medical or dental restraint plan is not a protective mechanical restraint plan for SIB, since the medical or dental restraint plan stabilizes involuntary behaviors that place the individual in imminent danger.

2. The IDT, including medical or dental staff, the individual, and the LAR, if applicable, must document the following prior to developing a medical or dental restraint plan:
   a. Review of the current structural and functional assessment, including a discussion of the influences on the dangerous behaviors and the impact of applied behavior analysis techniques on the behavior;
   b. Discussion and determination that less restrictive interventions have proven ineffective;
   c. Discussion and elimination of the use of a protective device that can be easily removed by the individual because it does not provide adequate safety from imminent harm due to injurious behaviors related to the diagnosis;
   d. Discussion and elimination of the use of protective mechanical restraint for SIB procedures with attempts to fade the mechanical device because it does not provide adequate safety from imminent harm due to injurious behaviors related to the diagnosis or evidence that attempts to eliminate the restraint have been unsuccessful;
   e. Discussion of any other empirically supported treatments and their risk/benefits in terms of reducing or eliminating the need for the mechanical restraint due to the injurious behaviors related to the diagnosis;
   f. Discussion and consideration of the risk/benefits of the mechanical restraint and any possible contraindications;
   g. Review by the PCP that agrees with the IDT’s recommendation for the use of a mechanical restraint and a written indication that the device is not medically contraindicated; and
h. Development of an IHCP for the individual that describes the need for medical or dental restraint for involuntary, dangerous behaviors.

3. The medical or dental restraint plan must include the following:
   a. The schedule and instruction on applying and removing the mechanical restraint;
   b. The level of supervision required when the restraint is in place and when it has been removed;
   c. Instructions on how to inspect and maintain the restraint;
   d. The method for recording inspections, action taken to maintain the restraint in proper order, times when the restraint is applied and removed;
   e. The schedule for nurse or dental checks on the proper fit of the mechanical restraint and adherence to the schedule;
   f. Any change in the condition of the individual for which the medical or dental should be notified; and
   g. The method to document injuries.

4. The IDT must have a face to face meeting to review the medical or dental restraint plan:
   a. As needed and at least annually at the meeting where all restraints from the previous annual period are reviewed;
   b. Whenever changes in the individual’s involuntary movements or physical conditions occur that impact the dangerous behaviors;
   c. Whenever there are changes in the fit or the individual’s acceptance of the device; or
   d. Upon request by the individual or LAR.

5. The IDT must develop a specific monitoring and documentation schedule by the medical or dental staff, not to exceed a monthly monitoring, and identify where the monthly documentation will be located.

E. Protective Mechanical Restraint Plan for SIB

1. The protective mechanical restraint plan for SIB is used when the dangerous self-injurious behaviors may be related to environmental conditions and the protective mechanical restraints may be eliminated with the application of behavior change techniques and fading procedures.

2. The following conditions must be met prior to the use of this restraint:
   a. A PCP has assessed the individual and determined that the self-injurious behavior is at an intensity and frequency that presents an imminent risk of serious physical injury, there is no current diagnosis that would warrant a medical restraint plan, and due to safety, there is a need for protective mechanical restraints for self-injurious behavior;
   b. The IDT has developed an IHCP for the individual that describes the need for protective mechanical restraint for SIB;
   c. A structural and functional assessment has been completed or revised that identifies possible functions of the self-injurious behavior;
   d. A PBSP has been completed or revised that includes procedures, for teaching and strengthening alternative behaviors to self-injurious behaviors a that will help prevent
self-injurious behavior as the time without the use of protective mechanical restraints increases;
e. The IDT has identified other clinical plans, as applicable, such as habilitation plans supported by an assessment or evaluation, to reduce the need for protective mechanical restraint;
f. The instructions for applying the protective mechanical restraint for self-injurious behavior have been developed by a psychologist or designee, including a schedule for removing and replacing the mechanical restraint that safely increases the time out of protective mechanical restraint;
g. A PCP has assessed the individual and determined that the self-injurious behavior is at an intensity and frequency that presents an imminent risk of serious physical injury and there is a need for protective mechanical restraints for self-injurious behavior; and
h. A system for monthly reviews of data by the IDT has been established, including the PCP’s continued reevaluation as to whether the intensity and frequency of the self-injurious behavior warrants continuing the restraint plan.

3. A fading schedule must be included in the Protective Mechanical Restraint plan in order to gradually increase the time out of the protective mechanical restraints while reinforcing alternative behaviors, safety permitting.

4. If SIB becomes infrequent and does not produce serious injuries when the mechanical restraints are removed, the IDT, along with the individual and the LAR, must consider the discontinuation of the protective mechanical restraint for SIB plan. A crisis intervention plan may be considered as an alternative, using the protective mechanical device as one of the alternatives to respond to imminent harm due to self-directed behavior.

5. If the fading schedule and the PBSP are implemented at 80% or better treatment integrity and there is no indication that the dangerous behavior is changing to permit more time out of restraints, the IDT with medical participation may discuss the implementation of a medical or dental restraint plan.

8. The Protective Mechanical Restraint for Self-injurious Behavior Checklist (form SSLC 001C) is completed for each 24-hour period by staff, including entries by the restraint monitor and the licensed nurse, who check the functioning of the mechanical device used to protect the individual from self-injury.

F. Required Level of Supervision
1. Restraints used in behavioral crisis interventions require continuous one-to-one supervision.
   a. If physical restraint is applied, the person carrying out the restraint is considered as the one-to-one if there are no additional staff present.
   b. If a restraint monitor arrives and applies the physical restraint, he or she is no longer in the role of restraint monitor. Another restraint monitor must be contacted to monitor the restraint.
2. Individuals receiving medical or dental restraint must receive supervision as ordered by the PCP or dentist in accordance with the center’s policies or individualized in regards to the individual’s needs.

3. Restraints used as part of a protective mechanical restraint plan for self-injurious behavior requires one-to-one unless an exception is approved by the PCP, there is clinical justification from the participants of the IDT, and it is authorized by the director.

IV. Release from Restraint
A. The individual who is restrained as a result of a behavioral crisis must be released from restraint as soon as he or she no longer poses an imminent risk of physical harm to self or others.

B. If a crisis intervention plan is in place, the plan must describe the maximum duration of each type of restraint authorized in the plan, and a description of the behaviors that signal there is no longer an imminent risk of physical harm to self or others.
   1. The maximum time in physical restraint as specified in the individualized crisis intervention plan is not to exceed 30 minutes before attempting a release
   2. If mechanical restraint is included in an individualized crisis intervention plan, the maximum time in restraint prior to attempting a release is 50 minutes.

C. For a behavioral crisis for which there is no crisis intervention plan in place:
   1. The maximum time in physical restraint for crisis intervention, prior to attempting release, is 15 minutes.
   2. The maximum time in mechanical restraint for crisis intervention prior to attempting release is 30 minutes.

D. The PCP or appropriate provider must determine the release criteria for an individual restrained in response to imminent harm resulting from a medical or dental procedure.

E. For mechanical restraints used for protection from self-injurious behavior, removal of restraints must follow the individual’s protective mechanical restraint plan for SIB. A fading schedule, which is designed to attempt to phase out the use of the restraint device, is reviewed by the IDT, including the PCP and appropriate therapist(s), each month and adjusted to permit the maximum safe time out of restraints. The plan must include allow an opportunity for motion and exercise, safety permitting, for a period of not less than 10 minutes during each two hour period in which restraint is employed (ICF, 483.450(d)(6

F. For a person with a medical or dental restraint plan, the IDT with medical or dental participation must determine the schedule for application and removal, not to exceed a continuous 50 minutes for any one application.
V. Reporting, Tracking, and Documentation

A. For emergency restraints used in a behavioral crisis with an individual who does not have a crisis intervention plan, the individual's LAR or the person listed in the individual's record as primary correspondent must be notified that the individual was restrained, the reasons for the use of restraint, and the individual’s response and condition after the restraint was used. The notification and information shared during the notification must be documented in the integrated progress note in the individual’s record.

B. For individuals with a crisis intervention plan, the IDT, along with the individual and the LAR, will determine who and under what circumstances timely notification must take place, along with the restraint review schedule.

C. Staff must report and investigate a serious injury or death occurring during restraint or within 24 hours after the release from a restraint in accordance with statewide operational policy on Incident Management #001.

D. A psychologist must begin processing a debriefing with staff on the use of a crisis intervention restraint within 24 hours of the initiation or the next business day if it is on the weekend or holiday.

E. The state center must review the use of each restraint in a timely manner to determine whether the application of restraint was justified, the restraint was applied correctly, injuries occurred, or factors exist that, if modified, may prevent the future use of restraint.

4. A crisis intervention restraint used for which there is not an approved restraint plan is considered an emergency restriction and must be reviewed and approved by the HRC within the timeframe specified in the statewide operational policy on Assuring and Protecting Rights and Consent and Authorization for Treatment and Services #045 in order to be continued.

2. If an assessment, procedure or treatment is necessary in an acute situation to complete a medical assessment, procedure, or treatment, and there is no time to obtain the required written consent, the PTS may be utilized in response to the need and the state center must initiate the emergency restriction procedure. (See DADS policy on Assuring and Protecting Rights and Consent and Authorization for Treatment and Services #045.

2. Within three working days of the start of each episode of restraint used in response to a behavioral crisis, the circumstances under which the restraint was used must be reviewed at the unit level and at the Incident Management Review Team (IMRT) meeting.

3. The unit team and IMRT must follow-up with the IDT if there are concerns about the restraints or insights on actions to eliminate the circumstances that led to the restraint. If necessary, the ISP containing information for eliminating restraint is revised as appropriate.
4. The IDT must review at least annually and more frequently as necessary, any use of crisis intervention restraints, medical restraints, or dental restraints; and review the use of protective mechanical restraint for SIB at least monthly and more frequently as necessary, to assess progress in changing the circumstances that lead to the use of restraint.

F. The IDT, with a determination of risk of physical harm made by the PCP, must review the continued application of restraint in response to risk from documented self-injurious behavior monthly to determine whether current risk warrants continuing the protective mechanical restraint, to analyze the effectiveness of the fading plan, and to adjust the time without restraint, if possible to safely do so. The PCP’s determination of continued risk is documented in the Integrated Progress Notes.

G. The pharmacist and psychiatrist must conduct a clinical review of each chemical restraint used in response to a behavioral crisis or as a medical restraint to determine whether the restraint was used in a clinically justified manner and what, if any, potential medication-related risks should be considered, and document any recommendations. This review is completed within 10 working days of the application of the chemical restraint and is documented on the Administration of Chemical Restraint Consult and Review form (SSLC 001E).

VI. Staff Training

A. Each person whose work responsibilities involve direct contact with individuals must be informed of his or her roles and responsibilities as stated in this and related policies and procedures.

B. State center policies must require, and practice must reflect, that, before working with individuals, all persons responsible for applying restraint techniques must have successfully completed competency-based training and stay current on the annual refresher training for:
   1. Approved verbal intervention and redirection techniques;
   2. Overview and use of approved restraint techniques; and any special individualized restraint instructions as described in an ISP action plan
   3. Adequate supervision to any individual in restraint;
   4. Prevention and de-escalation strategies, such as verbal intervention and redirection techniques to avoid resorting to undue use of restraint during behavioral crises;
   5. Sections of the PMAB curriculum as appropriate for the person’s position and responsibilities;
   6. Person-specific procedures designed to reduce or prevent the use of restraints as contained in skill acquisition plans, PBSPs, or desensitization supports or strategies. and
   7. Policies and procedures as appropriate to the staff person’s position and responsibilities.

C. A restraint monitor must have successfully completed:
   1. Those sections of the PMAB curriculum that address the procedures used at the state center and subsequent annual refresher training; and
   2. Training in the following:
      a. Cardiopulmonary resuscitation (CPR) and successful completion of refresher training every two years;
b. Rights of an individual and successful completion of refresher training annually;
c. Abuse and neglect prevention and successful completion of refresher training annually;
d. Use of restraint, including specific instructions for use of any mechanical devices used by the state center, and successful completion of refresher training annually; and
e. Conducting and documenting the face-to-face assessment of the restraint and making the determination that multiple restraints in a 60 minute period of time are identified as a continuous behavioral crisis episode

D. Before a nurse or PCP assumes work responsibilities that require participation in requesting, ordering, evaluating, or documenting restraint, he or she must have successfully completed training and demonstrate competence in:
1. Carrying out policies and procedures for requesting, ordering, evaluating, or documenting restraint;
2. Recognizing approved restraint procedures and mechanical restraint devices;
3. Identifying contraindications specific to restraint procedures; and
4. Following and reporting procedures for restraint-related injuries or deaths in accordance with policies on Incident Management and Death of an Individual.

E. Documentation of training and demonstrated competence for each staff person is maintained in the Competency Training and Development (CTD) department and includes:
1. Name of the training;
2. Date of training;
3. Name of the instructor or person who assessed competence;
4. A list of successfully demonstrated knowledge and skills; and
5. Date knowledge and skills were assessed.

VII. Data Collection & Analysis

A. Documentation of each restraint checklist only must be entered into the state center's restraint database within five working days of the restraint. Finalization of each restraint checklist entry must occur no later than 10 working days following the application of the restraint. All other documentation regarding restraint application is retained and data entry is optional.
1. Behavioral Health Services staff are responsible for checking and finalizing restraint forms documenting the use of crisis intervention restraints and protective mechanical restraint for SIB.
2. Medical staff are responsible for checking and finalizing restraint forms documenting the use of medical restraints.
3. Dental staff are responsible for checking and finalizing restraint forms documenting the use of dental restraints.

B. Data analysts at the state centers provide reports on missing data elements to the state center staff, and the state center takes any necessary action to reduce the errors.
C. Using data collected via the restraint checklists, the facility must trend, and analyze restraint data on at least a monthly basis and make recommendations, as needed, to the individual’s IDT. The IDT reviews and implements these recommendations as appropriate and necessary.

D. The state center must trend and analyze at least the following each month:
   1. The frequency and duration of restraint application by type of restraint (crisis intervention, medical, dental, protective mechanical for SIB) and form of restraint (physical, chemical, mechanical), including a display of these data in a rolling 12 month time period;
   2. The number of injuries that occur during restraint application by type of restraint;
   3. A ranking of the individuals from most to least use of crisis intervention, medical, and dental restraints respectively for the month, including pretreatment sedation/medical and pretreatment sedation/dental;
      a. The individual’s name and home, along with the number and type of restraints used and the percentage of days in the month that the individual was restraint free for the different types of restraints;
      b. The locations where restraints were applied; and
      c. The days and times of day when restraints were applied;
   4. The staff involved in each restraint;
   5. The number of individuals with a protective mechanical restraint plan for SIB and the amount of time each of these individuals was in restraint for the month; and
   6. The number of individuals with a crisis intervention.

E. Using these data, the state center must evaluate its effectiveness in reducing the use of restraints at the state center, both in terms of frequency and duration; the injuries associated with restraint use; and actions to be taken as needed to achieve the reduction goals.
**Definitions for Draft Revised Restraint Policy to be Added to Sharepoint’s Definition Dictionary  9/3/13**

**Behavioral crisis:** An imminent safety situation that places the individual or others at serious risk of violence or injury if no intervention occurs. (40 TAC §3.101(6))

**Chemical restraint:** Any drug prescribed or administered to sedate an individual or to temporarily restrict an individual’s freedom of movement for the purpose of managing the individual’s behavior, if the chemical, including a pharmaceutical, is not a standard treatment for the individual's medical or psychiatric condition. (See 40 TAC §3.101(8) and 40 TAC §9.229(a)(9))

**Crisis intervention:** The use of interventions, including physical, mechanical, or chemical restraint, in a behavioral crisis, after less restrictive measures have been determined to be ineffective or not feasible. (40 TAC §3.101(15))

**Crisis intervention plan:** A component of the individual support plan (ISP) that provides instructions for staff on how to effectively and safely use restraint procedures, as long as they are needed to prevent imminent physical injury in a behavioral crisis when less restrictive prevention or de-escalation procedures have failed and the individual's behavior continues to present an imminent risk of physical injury. The plan is developed with input from the primary care provider (PCP) and direct support professionals (DSPs) familiar with the individual and the individual and legally authorized representative (LAR) and includes a description of how the individual behaves during a behavioral crisis, along with information about the types of restraints that have been most effective with this individual, staff actions to be avoided because they have been ineffective in the past in preventing or reducing the need for restraints, the restraint’s maximum duration, a description of the behavioral criteria for determining when the imminent risk of physical injury abates, and reporting requirements. A crisis intervention plan is not considered a therapeutic intervention. It is implemented only to ensure that restraint procedures are carried out effectively and safely and may be adjusted depending upon the individual’s progress in the ISP. (see 40 TAC §3.101(16))

**Face-to-face assessment:** The restraint monitor’s on-site assessment of the individual to document and assess the application and results of a restraint.

**Legally adequate consent:** Consent received from a person who has legal status that meets the statutory requirements for comprehension of information and voluntariness as specified in THSC §591.006. (See 40 TAC §3.101(34) and Settlement Agreement, p. 8)

**Mechanical restraint:** Any device attached or adjacent to an individual’s body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body. The term does not include a protective device. The term does not include any device used to achieve functional body position or proper balance or to prevent injury due to involuntary movement (40 TAC §3.101(37) and Settlement Agreement, Section A.2.b.)
Medical emergency: Any illness or injury that requires immediate assessment and treatment by medical staff for conditions considered to be life threatening, including, but not limited to, respiratory or cardiac arrest; choking; extreme difficulty in breathing; status epilepticus; allergic reaction to an insect sting; snakebite; extreme pain in the chest or abdomen; poisoning; hemorrhage; loss of consciousness; sudden loss of function of a body part; injuries resulting in broken bones; possible neck or back injuries; or severe burns. (40 TAC §3.101(38))

Medical intervention: Treatment by a licensed medical doctor, osteopath, podiatrist, dentist, physician assistant, or advanced practice nurse in accordance with general acceptable clinical practice. (40 TAC §3.101(39))

Medical restraint: A health-related protection prescribed by a primary care provider (PCP) or dentist that is necessary for the conduct of a specific medical or dental procedure, or is only necessary for protection during the time that a medical or dental condition exists, for the purpose of preventing an individual from inhibiting or undoing medical or dental treatment or from injuries due to involuntary self-injurious behavior (SIB). Medical restraint includes pre-treatment sedation (PTS). (40 TAC §3.101(40))

Medical restraint plan: A component of the individual support plan (ISP) that provides instructions for staff on how to effectively and safely carry out medical restraint procedures. The plan is developed by the IDT, with input from the primary care provider (PCP) or dentist and meaningful input from the individual and legally authorized representative (LAR) and includes a description of the individual’s behaviors that do not allow for a safe and effective implementation of needed medical or dental procedures or protection from involuntary SIB information about the types of restraints that have been most effective with the individual, a description of the criteria for releasing the restraint, and reporting requirements. A medical restraint plan is not considered a therapeutic intervention and may be adjusted depending upon the individual’s progress in the ISP. (40 TAC §3.101(41))

Physical restraint: Any manual method that restricts freedom of movement or normal access to one’s body, including hand or arm holding to escort an individual over his or her resistance to being escorted. Physical restraint does not include brief and limited use of physical guidance, positioning, or prompting techniques used to redirect an individual or assist, support, or protect the individual during a functional therapeutic or physical exercise activity; response blocking and brief redirection used to interrupt an individual’s limbs or body without the use of force so that the occurrence of challenging behavior is prevented; holding an individual, without the use of force, to calm or comfort; hand-holding to escort an individual from one area to another without resistance from the individual; and response interruption used to interrupt an individual’s behavior, using facility-approved techniques. (40 TAC §3.101(46) and Settlement Agreement, page 6)

Positive behavior support plan (PBSP): A comprehensive, individualized plan that contains intervention strategies designed to modify the environment, teach or increase adaptive skills, and reduce or prevent the occurrence of target behaviors through interventions that build on an individual's strengths and preferences, without using aversive or punishment contingencies. (40 TAC §3.101(48))
Prevention and Management of Aggressive Behavior (PMAB): The Health and Human Service Commission’s proprietary risk management program that uses the least intrusive, most effective options to reduce the risk of injury for individuals and for staff from acts or potential acts of aggression. (See 40 TAC §7.503)

Primary Care Provider (PCP): A physician, advanced practice nurse, or physician assistant who provides primary care to a defined population of patients. The PCP is involved in health promotion, disease prevention, health maintenance, and diagnosis and treatment of acute and chronic illnesses.

Protective device: Any device used to protect the individual from involuntary self-injury (e.g., seatbelts, bedrails, and helmets) that the individual can easily access and easily remove without staff assistance. A protective device is not a restraint.

Prone restraint: Any physical or mechanical restraint that places the individual in a face-down position. Prone restraint does not include when an individual is placed in a face-down position as a necessary part of a medical intervention or when an individual moves into a prone position during an incident of physical restraint, if staff immediately begin an adjustment to restore the individual to a standing, sitting, or side-lying position or, if that is not possible, immediately release the individual. Prone restraint is prohibited. (40 TAC §3.101(52))

Protective mechanical restraint for self-injurious behavior: A type of mechanical restraint applied prior to the individual engaging in self-injurious behavior, for the purpose of preventing or mitigating the danger of voluntary or intentional self-injurious behavior because there is evidence that the targeted behavior can result in serious self-injury when it occurs and intensive, one-to-one supervision and treatment have not yet reduced the danger of self-injury. Examples include, but are not limited to, protective head gear for head banging, arm splints for eye gouging, or mittens for hand-biting. The term does not include medical restraints or protective devices. (40 TAC §3.101(54))

Protective mechanical restraint plan for self-injurious behavior: A component of the individual support plan (ISP) that provides instructions for staff on how to effectively and safely apply the protective mechanical restraint that is used to prevent or mitigate the effects of serious, intentional self-injurious behavior. The plan is developed with input from direct support professionals (DSPs) familiar with the individual and meaningful input from the individual and legally authorized representative (LAR), and includes a description of the individual’s self-injurious behaviors, the type of restraint to be used, the restraint’s maximum duration, and the circumstances to apply and remove the restraint. The plan must identify any low-risk situations when the restraint may be safely removed, what staff should do during those situations to continue to protect the individual from harm, and adjustments in staff instructions as progress is made for gradually eliminating the use of the restraints, including details on any specialized staff training and reporting. The plan is not considered a therapeutic intervention and is adjusted depending upon the individual’s progress in the ISP and the evaluation by the primary care provider (PCP) that the individual’s behavior is no longer at the dangerous level that is producing serious self-injury. (40 TAC §3.101(55))
Restraint debriefing: Interview of the individual and staff who were involved in the restraint episode to document why the restraint was used, what staff did to avoid the use of restraints, its effect on the individual restrained; whether the restraint procedure was implemented appropriately; and to identify factors that need to be addressed to reduce the need for use of such restraint in the future.

Restraint monitor: A designated facility employee who has received competency-based training and demonstrated proficiency in the application and assessment of restraints, who has experience working directly with individuals with developmental disabilities, and who is trained to conduct a face-to-face assessment of the individual who was restrained and the staff involved in the restraint to review the application and results of the restraint. (40 TAC §3.101(59))

Supine restraint: Any physical or mechanical restraint that places the individual on his or her back. Supine restraint does not include when an individual is placed in a supine position as a necessary part of a medical restraint or when an individual moves into a supine position during an incident of physical restraint, if staff immediately begin an adjustment to restore the individual to a standing, sitting, or side-lying position or, if that is not possible, immediately release the person. Supine restraint does not include persons who have freedom of movement in a hospital bed or dental chair that is at a reclined position. Supine restraint is prohibited. (40 TAC §3.101(63))