SENATE BILL 325 REPORT

Reduction of Restraint and Seclusion Practices in Behavioral Health Emergencies

Submitted to the Texas Legislature

As Required by
Senate Bill 325
79th Legislature, Regular Session, 2005

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Texas Health and Human Services Commission
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To submit comments on this report, e-mail HHSC at **SB325ReportComments@hhsc.state.tx.us**. Please include your name and organizational affiliation in your e-mail message.

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EXECUTIVE SUMMARY

Over the last several years, there has been an increased concern over the use of restraint and seclusion for behavioral intervention in public and private facilities. Reports of serious injury, or death in some cases, have sparked providers, regulatory agencies and advocacy groups to begin examining the factors that lead to the use of restraint and seclusion. While the body of literature does not provide empirical evidence regarding the success of different practices, there are many instances in which facilities have significantly reduced the need to use restraint and seclusion as a behavioral intervention. While some states have had targeted efforts in specific agencies or facilities, Texas is the first state to attempt to address the reduction of restraint and seclusion from a cross agency perspective.

To address the use of restraint and seclusion, the Texas Legislature passed S.B. 325, during the 79th Legislature, Regular Session, 2005. This legislation directed the Texas Health and Human Services Commission (HHSC) to establish a work group to review and provide recommendations regarding best practices in policy, training, safety, and risk management that could be used to govern the management of facility residents' behavior related to restraint and seclusion practices.

The work group was comprised of representatives from the relevant state agencies, providers, advocates and consumers. The work group developed a set of principles to: (1) Document the current trends recognized in the industry; (2) provide a starting point for reducing the use of restraint and seclusion; and (3) offer alternative behavioral interventions to reduce the use of restraint and seclusion. Sections of this report that require state agency action should be addressed by each state agency through subsequent rule making or other appropriate administrative action. This report reflects those efforts and resulted in the following recommendations.

RECOMMENDATIONS

1. Each agency will develop rules for reporting instances of restraint and seclusion that include, at a minimum, the data found in Appendix D. This information will be reported to HHSC in the aggregate, by facility type, in a format to be developed by HHSC. At least annually, each health and human services agency will provide a report to individual facilities that summarizes the use of restraint and seclusion by facility type for the purposes of the individual facilities performing a self evaluation of their restraint and seclusion practices. Agencies shall develop rules requiring regulated facilities to perform self-evaluations related to restraint and seclusion usage. (See Section I)

2. All agencies should work together to develop a format for collecting the same information at the time of intake (or earliest practical time), related to individualized advance agreements and/or the individual's preferences for procedures during emergency behavioral situations. Such intake information should be secured from the

facility resident[1] or that resident's Legally Authorized Representative (LAR) or guardian, when applicable. (See Section II)

3. State agencies should develop procedures for field-testing the best practices, promising practices, and consensus thinking identified in this report at facilities that are regulated by them. Incentives should be developed to encourage facilities to voluntarily participate in the field-testing of best practices or other innovations that reduce the use of restraint and seclusion. (See Section II)

4. Each agency will develop rules requiring the facilities under its purview to review and revise staff (including contract staff) training protocols to ensure that training is competency-based, appropriate for populations served, and incorporates a range of early intervention techniques, de-escalation techniques, and appropriate use of restraint and seclusion as a last resort. Facilities under the purview of the agency should be required to submit their proposed curriculum to the agency for review and approval in accordance with a schedule to be defined by each agency's rules. (See Section II)

5. Texas should recommend that the Center for Mental Health Services (CMHS), or other appropriate federal agency, should develop a national certification process for training programs, trainers, and trainees in order to provide states with reliable and state of the art and best practice training programs. (See Section II)

6. A follow-up work group should be convened that will develop practice guidelines for the use of emergency medical interventions, including the use of medication, and other medical restraints. The work group should be sponsored by the Department of State Health Services and should include representatives from the Texas Medical Association, the Texas Hospital Association, the Texas Pharmacy Association and other groups that represent entities that use emergency medication/medical interventions for the purposes of modifying behavior. (See Section III)

7. Individual health and human services agencies should work with constituents and stakeholders and develop rules that defines what constitutes a "small facility" for the purposes of exemption from the requirement of the presence of an observer during the administration of prone or supine holds identified in Section 322.051(b)(3) of S.B. 325. (See Section III).

[1] There are many terms utilized by agencies, advocates, and facilities to identify individuals receiving services such as consumers, clients and facility residents. The term "facility resident" is used throughout this report to represent individuals receiving services, as this term is consistent with language in S.B. 325.

BACKGROUND

Senate Bill 325, 79th Legislature, Regular Session, 2005, outlined requirements for certain facilities and programs that utilize restraint and seclusion for behavior management of facility residents. The legislation also required the Texas Health and Human Services Commission (HHSC) to establish a work group to review and provide recommendations regarding best practices in policy, training, safety, and risk management to govern the management of facility residents' behavior related to restraint and seclusion practices.

S.B. 325 required that the work group include members representing the Department of State Health Services (DSHS), the Department of Aging and Disability Services (DADS), the Department of Family and Protective Services (DFPS), the Texas Youth Commission (TYC), the Texas Education Agency (TEA), the Texas Juvenile Probation Commission (TJPC), and Advocacy, Inc. Additional members were also required as recognized experts or to represent the interests of facility residents, including advocates, family members, physicians, representatives of hospitals, social workers, and psychiatric nurses. Appendix A provides the complete text of S.B. 325, 79th Legislature, Regular Session.

Applicants seeking membership on the work group as recognized experts provided expertise and experience:

- in training in the use of techniques to prevent the use of restraints and/or seclusion in facilities;
- in training related to situations that may require the use of restraint and/or seclusion in facilities;
- with specific populations including adults/elderly, children/adolescents and persons with disabilities.

Applicants seeking membership on the work group to represent the interests of facility residents also provided the following.

- Specific experience with restraint and seclusion practices.
- Whether they were a family member, advocate (including the organization represented), or professional with experience with this issue such as physician, social worker, or psychiatric nurse.

Appendix B provides a list of work group members.

The work group convened to study and make recommendations on: (1) developing a comprehensive reporting system for the collection and analysis of data related to behavior management interventions; (2) the prevention of death or serious injury to facility residents related to physical intervention or restraint; (3) de-escalation techniques and minimum standards to manage the behavior of residents in an emergency situation;

(4) best practices for physical, behavioral, and de-escalation interventions; (5) best practices related to specific populations; and (6) best practices related to use of seclusion with facility residents.

In recommending best practices, the work group focused on: (1) the physical, behavioral, and de-escalation interventions used by facility employees to manage the behavior of facility residents in an emergency; and (2) supporting uniformity in definitions, reporting, and training used by the Texas Youth Commission, Texas Juvenile Probation Commission and health and human services agencies.

The following policy statement guided the work group:

The focus of the work group is to develop practices to decrease the frequency of use of restraint and seclusion by addressing physical, behavioral, and de-escalation interventions, and supporting uniformity in definitions, reporting, and training used by the Texas Youth Commission, the Texas Juvenile Probation Commission, and health and human services agencies.

The work group gathered information from many sources to develop a comprehensive review of the research and trends related to restraint and seclusion. While some elements of the information presented in this report were drawn from that research, many have been adapted to create a more comprehensive picture of current practices in the reduction and use of restraint and seclusion. Additional information was drawn from work group members' experience in Texas facilities. Resources used to gather the information contained in this report are listed in Appendix C as a reference.

Finally, it should be noted that there is a great deal of information on the use of restraint and seclusion. However, the work group did not find large national empirical studies on the subject, which would warrant conclusory "best practices". Rather, the report focuses on current trends and consensus thinking in the reduction of restraint and seclusion, with many associated positive outcomes.

SECTION I: DATA COLLECTION AND REPORTING

Senate Bill 325 Issues

Senate Bill 325 requires the development of a comprehensive reporting system that collects and analyzes data on:

- *physical, behavior and de-escalation interventions;*
- *medications administered without consent in an emergency; and*
- *death and serious injuries of individuals or employees related to restraint and seclusion.*

The reporting system must comply with federal reporting requirements.

To begin systematically identifying the frequency of restraint and seclusion interventions across service providers, the work group identified reporting elements with which facilities will document all instances of emergency restraint and seclusion related incidents. The reporting elements can be found in Appendix D.

To provide a common basis for further identifying reporting requirements and best practices or common trends, the work group developed definitions upon which the remaining elements of the process could be based. Annotated definitions can be found in Appendix E.

State agencies and their respective facilities should use the collected data to facilitate the following activities:

- Aggregate data on the use of restraint and seclusion interventions for analysis of trends in current practice. This analysis should include serious injuries and deaths related to the use of restraint and seclusion.
- Set improvement goals and monitor use and changes over time.
- Conduct internal reviews, including quality assurance reviews, to identify trends in restraint and seclusion use within a facility.
- In compliance with federal regulations and current practice, each facility should notify the appropriate agency of each death that occurs at each facility that is related to a restraint or seclusion.

A number of data collection efforts related to restraint and seclusion are already required by Texas state agencies. This includes the Department of Family and Protective Services, the Department of Aging and Disability Services, the Department of State Health Services, and the Texas Youth Commission. However, these data collection efforts currently lack uniformity.

The Department of Family and Protective Services (DFPS) collects data related to child deaths, suicide attempts, emergency medications, restraints, and seclusion incidents.

DFPS collects additional documentation related to the type of restraint used, precipitating circumstances, and specific behaviors that led to the restraint or seclusion.

Reporting for the Department of Aging and Disability Services (DADS) distinguishes between individuals in a nursing facility, assisted living facility, and those receiving services from a Home and Community Services Waiver program (HCS) or residing in an Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR). In nursing facilities, data is collected on the prevalence of daily physical restraint. For Home and Community Services Waiver programs and ICF/MR programs, data are collected if a behavioral plan authorizes use of seclusion or restraint. Multiple uses of emergency restraint for the same facility resident within the same month are only reported once.

The Department of State Health Services (DSHS) has completely redesigned their data collection efforts for psychiatric hospitals through the Restraint and Seclusion Reduction Work Group, a Subcommittee of the Texas State Hospital Clinical Oversight Committee, with involvement from consumers, advocates and mental health professionals. The DSHS system is a model for other agencies and systems to consider. The system incorporates reporting of incidents, injuries or deaths of facility residents or staff related to restraint or seclusion, de-briefing after incidents occur, focused training in techniques to avoid the need for seclusion and restraint, performance improvement targets, and safety measures in the event that emergency restraint or seclusion occurs.
The Texas Youth Commission collects data on incidents of restraint, incidents of death or serious injury, alleged mistreatment, and youth injuries due to restraints or altercations between youth. The alleged mistreatment database captures reports where someone alleges the physical restraint resulted in abuse or was by its nature abusive. The records show how many such complaints were made and how many were found to have been abusive. The data is analyzed and reviewed and a process improvement plan is developed to reduce the occurrence of such incidents.

Recommendation and Explanation

Recommendation 1: Each agency will develop rules for reporting instances of restraint and seclusion that include, at a minimum, the data found in Appendix D. This information will be reported to HHSC in the aggregate, by facility type, in a format to be developed by HHSC. At least annually, each health and human services agency will provide a report to individual facilities that summarizes the use of restraint and seclusion by facility type for the purposes of the individual facilities performing a self evaluation of their restraint and seclusion practices. Agencies shall develop rules requiring regulated facilities to perform self-evaluations related to restraint and seclusion usage.

Senate Bill 325 requires the development of a comprehensive reporting system on restraint and seclusion use in behavioral emergency situations. State agencies and facilities can utilize this data to facilitate efforts for the reduction of restraint and seclusion. Although a number of data collection efforts are already required by State agencies, these currently lack uniformity. The data will provide the State with uniformity

in the data and the subsequent ability to evaluate the effectiveness of restraint and seclusion reduction efforts.

SECTION II: MANAGEMENT COMMITMENT AND PREVENTION OF RESTRAINT AND SECLUSION

Senate Bill 325 Issues

- *De-escalation techniques and minimum standards to manage the behavior of facility residents in an emergency situation.*
- *Best practices for de-escalation interventions by employees.*
- *Best practices related to specific populations, including any consideration that should be given to a facility's community or institutional setting.*
- *Best practices related to seclusion of facility residents.*

There are a number of elements for facilities to consider in order to successfully reduce the use of restraint and seclusion. The most critical and necessary of these is a visible and strong commitment by the leadership of a facility to implement a cultural and philosophical change within the organization. The foundation of this philosophical change must be one that identifies restraint and seclusion as a measure of last resort rather than a routine practice. Restraint is a negative outcome for the person who experiences it. Our facilities should safeguard the right of individuals to be free from unnecessary restraint.

To reduce restraint and seclusion, management should be committed to implementing measures throughout the facility that reflect commitment to restraint and seclusion reduction at every level of the organization. The commitment should be visible through human resource policies, staff training, and a proactive communications philosophy that includes facility residents, family members and advocates.

Organizational Change

Reduction of restraint and seclusion must be advanced from the organization's leadership through:

- implementation of a restraint and seclusion reduction plan, including issuing policy statements that define restraint and seclusion reduction rationale;
- mandating the inclusion of all stakeholders, including consumers and advocates; and
- reviewing and modifying facility restraint and seclusion policies and procedures when appropriate.

Because of the complexities involved in cultural change at facilities attempting to reduce restraint and seclusion, consensus thinking and best practice indicate that facilities should first assess their readiness and level of commitment to change if a reduction program is to be effective.

As previously mentioned, state hospitals have developed an effective system for addressing restraint and seclusion. The readiness tool that the hospitals have used is the *Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint* by David Colton, Ph.D (See Appendix C). This instrument and others like it would assist Texas facilities in assessing their readiness for implementing a framework to reduce the use of restraint and seclusion.

Following assessment, a facility should address ways to effectively implement an organizational shift that will lead to the prevention of restraint and seclusion. Consensus thinking and best practice indicate that the following elements are necessary to develop a program that will reduce or eliminate the need for emergency restraint and seclusion:

- Define and articulate a vision, values, and philosophy.
- Articulate that reduction is a high administrative priority within the overall treatment program.
- Develop and implement a performance improvement plan with the guidance of a performance improvement team or taskforce.
- Hold people accountable for the plan.
- Ensure that innovative clinical approaches are employed, from the admission process onward.
- Conduct debriefings after each use of restraint or seclusion.
- Collect, analyze, and use data to guide the reduction of restraint and seclusion incidents.
- Conduct independent monitoring.

Beyond top layers of management, the reduction philosophy should be included in the organization's human resources (HR) policies and procedures:

- HR practices should incorporate restraint and seclusion reduction measures and philosophy in all new hire procedures.
- New staff orientation should include the facility's written philosophy, rules, policies, procedures, intervention modalities, and the expectations for everyone who is working with facility residents. In addition, specific attention should be paid to articulating the unique needs of the population the facility is serving.

Training

Competency-based staff training and continuing education is integral to any effort to reduce the use of restraint and seclusion and should include:

- educating all staff on the use of nonphysical intervention options (such as de-escalation and active listening) that can be used to prevent emergency restraint and seclusion;
- ensuring that staff is aware of facility residents' rights;
- requiring training for all staff;

- focusing on staff competencies through experiential training directed toward the use of restraint and seclusion as a last resort;
- addressing the unique needs and characteristics of the facility residents served and the facility size and type;
- requiring staff to be trained and competent in restraint and seclusion techniques and facility philosophy prior to working with facility residents; and
- providing basic safety training including cardiopulmonary resuscitation techniques, and addressing employee safety training as well as safety of facility residents.

The work group indicated a need to build the capacity and expertise in state agencies to provide guidance about the prevention of restraint and seclusion, in order to provide consistent oversight and technical assistance.

The work group noted several training programs that might prove effective, and that state agencies should play an active role in further identifying these programs. Training programs identified are included in the Resources in Appendix C. It was also noted that a significant impediment to successful training is the lack of a national certification program that would identify effective training techniques and programs.

Communication

Many successful reduction efforts have recognized the importance of conducting a thorough intake and assessment where facility resident, LAR, or guardians are involved. This is most effective if facility residents or guardians are asked during the admissions process or at other clinically appropriate times to identify measures that staff can use to reduce the need for restraint and seclusion. For this to be effective:

- Facility residents should be continually educated about their rights.
- Facility residents should be involved at the earliest possible time.
- Special circumstances should be considered, including a history of sexual, physical, or emotional abuse; other trauma, including trauma related to seclusion and restraint; other prior psychiatric treatment; the presence of co-occurring disorders or physical contraindications such as obesity, heart conditions, brittle bones, or asthma. Considerations during assessment should include the special population needs of the facility resident.
- Physicians and nurses should consult with qualified pharmacists to assess the effects that medications may have on facility residents (e.g., gait problems, incontinence), including the use of psychotropic medications, multiple medications, and frequency of use.
- Ongoing efforts to assess a facility resident's status should occur throughout the facility resident's stay in the facility or program and particularly during debriefing.
- Facilities should consider the use of advance agreements.

Broadening the communications strategy of a facility will ensure the sustainability of change necessary to reduce the use of restraint and seclusion. Such a strategy should

recognize the importance of including not only facility residents, but all affected parties in the reduction of restraint and seclusion efforts through the full and formal inclusion of consumers, families, advocates and staff. More specific administrative strategies that should be considered are:

- Formalized communication with family or legal guardians following a restraint or seclusion event to encourage transparency and full inclusion in treatment plan development and reviews.
- The availability of resident information related to advance agreements and effective de-escalation techniques to all pertinent staff.
- Communication should be tailored to the needs of the specific population. The level of communication should take into account the level of comprehension of the facility residents.
- Prior to or at admission, and on an ongoing basis, a caregiver should explain to the facility resident or guardian, based on their level of functioning and comprehension, the facility's policies and practices on the use of restraint. The explanation should include who can use a restraint, the actions staff must use first to attempt to defuse a situation and avoid the use of restraint, the kinds of situations in which restraint may be used, the types of restraints authorized by the agency under which the facility operates, when the use of a restraint must cease, what action must be exhibited to be released from the restraint, and the way to report an inappropriate restraint. This explanation should be documented in the facility resident's record.
- Prior to or at admission, the facility resident, LAR, or guardian, based on their level of functioning and comprehension, should be informed of their right to voluntarily provide comments on any restraint or seclusion. This includes the incident that led to the restraint or seclusion and the manner in which staff intervened, in which they are the subjects or to which they are a witness. This notification should include an explanation of the process for submitting such comments, which must be easily understood and accessible. This notification need not be made after every restraint and seclusion that occurs at the facility as long as the process for submitting such comments has been made clear.
- Families, custodians and/or guardians should be informed (in a timely manner as determined by the regulatory agency) of any restraint or seclusion incident with an opportunity to participate in debriefing.

Specific administrative practices should be considered to reduce the use of restraint and seclusion. Some suggestions include:

- Executive management should be notified immediately or on a daily basis of all seclusion and restraint events. Management should examine and consider the possible causes of the need for intervention, review facility policy and procedures that may lead to conflict, look at workforce development issues, and evaluate staffing issues.
- The issues identified by management should be addressed and recommendations for change made by a restraint and seclusion reduction team made up of key staff and advocates.

- Conduct two separate debriefings: one involving the facility resident; and one involving staff after each restraint or seclusion event.

Minimizing Restraint and Seclusion

Best practices and consensus thinking that have been reported to minimize the need for restraint and seclusion include:

- Encouraging the use of established training programs that emphasize de-escalation and verbal intervention techniques.
- Providing early identification and assessment of facility residents who may be at risk of receiving these interventions is effective in reducing the need for restraint and seclusion.
- Ensuring high quality programs operated by trained and competent staff that effectively employs individualized alternative strategies to prevent and defuse escalating behavior.
- Providing adequate staffing levels.
- Developing treatment plans that include positive interventions to reduce the need for restraint and seclusion.
- Developing policies and procedures, that clearly stipulate that seclusion and restraint will be used only a last resort.
- Evaluating the treatment program and environment to determine what factors may contribute to repeated events of restraint and seclusion.

One method that is gaining popularity and is being implemented in educational settings is known as "Positive Behavior Support" (PBS). PBS is a process for understanding and resolving the problem behavior of children. PBS is based on values and empirical research. It offers an approach for understanding why students engage in problem behavior and identifies strategies for preventing the occurrence of problem behavior while teaching new skills. It is a holistic approach that considers all factors that impact the child and the child's behavior. It can be used to address problem behaviors that range from aggression, tantrums, and property destruction to social withdrawal. While PBS was developed for educational settings, it may also be utilized effectively in other settings with adults as well as children.

There is growing evidence on the effectiveness of PBS. A synthesis of the research has been conducted by the Center for Evidence-based Practice: *Young Children with Challenging Behavior* funded by the United States Office of Special Education Programs. (See Appendix C)

Recommendations and Explanation:

Recommendation 2: All agencies should work together to develop a format for collecting the same information at the time of intake (or earliest practical time), related to individualized advance agreements and/or the individual's preferences for procedures

during emergency behavioral situations. Such intake information should be secured from the facility resident or that resident's Legally Authorized Representative (LAR) or guardian, when applicable.

Many successful reduction efforts have recognized the importance of conducting a thorough intake and assessment where the facility resident, LAR or guardians are involved. This is most effective if facility residents or guardians are asked during the admissions process or at other clinically appropriate times to identify measures that staff can use to reduce the need for restraint and seclusion. A uniform process of identification of these measures provides consistency across agencies and facilities and the opportunity for reduction efforts for all residents, regardless of the type of facility.

Recommendation 3: State agencies should develop procedures for field-testing the best practices, promising practices, and consensus thinking identified in this report at facilities that are regulated by them. Incentives should be developed to encourage facilities to voluntarily participate in the field-testing of best practices or other innovations that reduce the use of restraint and seclusion.

The review of best practices and consensus thinking found that there were a great number of methods reported that have the potential to reduce the need for restraint and seclusion; however, the state of the art in restraint and seclusion use and reduction is early. The body of literature reviewed provides promising practices; it does not provide empirical evidence in all cases. The review further found that application of practices and the success of those applications depended on a number of variables: staffing, financial resources, clients served and facility type. By providing agencies and facilities the flexibility to work with practices that they believe will yield the best results, it affords the State the opportunity to improve outcomes for clients while establishing a database of sound, effective practices.

Recommendation 4: Each agency will develop rules requiring the facilities under its purview to review and revise staff (including contract staff) training protocols to ensure that training is competency-based, appropriate for populations served, and incorporates a range of early intervention techniques, de-escalation techniques, and appropriate use of restraint and seclusion as a last resort. Facilities under the purview of the agency should be required to submit their proposed curriculum to the agency for review and approval in accordance with a schedule to be defined by each agency's rules.

In the area of restraint and seclusion reduction, there are many training resources available. Some resources have demonstrated promise in educating staff in techniques that result in the reduction of restraint and seclusion. It is not enough, however to put staff through a training program. Until staff demonstrate competency in the necessary skills, programs will not be successful in the reduction of restraint and seclusion episodes. Competency-based staff training and continuing education is integral to any effort to reduce the use of restraint and seclusion. This recommendation would provide

for increased efforts to assure that training is focused on de-escalation techniques, as well as safety, regarding restraint and seclusion practices.

Recommendation 5: Texas should recommend that the Center for Mental Health Services (CMHS) or other appropriate federal agency, should develop a national certification process for training programs, trainers, and trainees in order to provide states with reliable and state of the art and best practice training programs.

As previously mentioned, there are numerous training programs available for facilities to choose from. Some of these programs have been found to be excellent in providing staff with the competencies they need to reduce restraint and seclusion. Other training programs have been found to be less effective. A certification program for training programs and trainers would provide facilities and states with the assurance that their training dollars would have the best impact on making staff competent and the individuals they serve safe.

SECTION III: WHEN USE OF RESTRAINT AND SECLUSION HAS BEEN DEEMED NECESSARY

Senate Bill 325 Issues

- *The prevention of the death or serious injury to facility residents related to physical intervention or restraint.*
- *Best practices for physical and behavioral interventions by employees that include specific holds and techniques for the physical restraint of facility residents.*

The work group recognized that, as a last resort, restraint or seclusion may need to be used in managing behavior of residents in an emergency. To address the risks involved in a restraint or seclusion event, it is critical that it is carried out in the safest and least restrictive method possible.

Senate Bill 325 includes provisions that prohibit or limit certain restraints and holds:

- Restraints that obstruct the resident's airway, including a procedure that places anything in, on, or over the resident's mouth or nose, impairs the resident's breathing by putting pressure on the torso, or interferes with the resident's ability to communicate.
- Limitation of the use of prone or supine holds that instructs the use of these holds only as a last resort, and using only when an observer is present that is aware of the risks associated with these holds. (Small residential facilities are exempt from the observer requirement.)

State agencies referenced in S.B. 325 have implemented rules related to these limitations and prohibitions

In addition to the requirements of S.B. 325, other areas of focus that serve to protect facility residents from death or serious injury related to the use of restraint or seclusion were identified. State agencies should provide guidance to facilities through policy or rule on the following:

- The conditions under which ordering and initiating a restraint or seclusion is warranted.
- The conditions and procedures for observation and monitoring during a restraint or seclusion event.
- Best practices for processing residents out of restraint or seclusion.
- Procedures for systematic review of death or serious injuries related to restraint or seclusion.

Senate Bill 325 also specifies that the work group provide recommendations to include information on "specific holds and techniques for the physical restraint of facility

residents." It is difficult to list specific holds because holds change over time and are closely associated with specific training programs. In addition, medical research may uncover previously unknown risks associated with particular holds.

There are four ways to restrain an individual: 1) Holding muscle groups close to the body; 2) holding muscle groups away from the body; 3) hyperextension of joints (also called hyper flexion), and 4) use of pressure points and pain. Professional consensus opinion indicates that approved holds all fall in the first category where the limbs are held close to the body.

Ordering and Initiating a Restraint or Seclusion Intervention

When ordering or initiating a restraint or seclusion intervention, the following guidelines should be followed:

- Individuals who authorize or initiate restraint or seclusion must be appropriately trained in restraint and seclusion procedures.
- Practitioners designated by the regulatory agency to order interventions should be specially trained to assess and monitor the facility resident's safety and the significant medical and behavioral risks inherent in the use of restraint and seclusion.
- When feasible, involve a physician or other licensed practitioner in ordering emergency interventions for a facility resident. However, in some instances, a facility or organization may need to authorize an individual who is not a licensed independent practitioner to order emergency restraint or seclusion use in response to a facility resident who poses an immediate danger to self or others.
- When emergency use is initiated, a licensed independent practitioner should be called within the time period specified by the regulatory agency. Continued use depends on authorization by a licensed independent practitioner.
- Written or verbal orders for initial and continuing use of restraint and seclusion should be time limited based on the requirements of the regulatory agency.
- Upon initiation of a restraint or seclusion intervention, executive management should be notified.

Size of facility, type of service, and financial constraints are factors for certain facilities when ordering and initiating interventions. For example, small ICFs/MR, Home and Community-based Services (HCS) Waiver and community-based programs receive Registered Nurse (RN) visits only two to three times weekly, which is a factor in developing ordering and initiating policies.

In the case of dealing with adolescents and children, restraint and seclusion decisions should be made using a developmental model, rather than just chronological age, taking into account a child's physical, cognitive, and developmental age. A child's cognitive development dictates their understanding of social interactions and situations and their sexual development must be considered to avoid or minimize trauma.

Observation and Monitoring

Appropriate observation and monitoring during a restraint or seclusion episode is critical to ensuring the safety of a facility resident. Deaths related to restraint and seclusion may occur after the initial emergency has passed but while the facility resident is still in restraint or seclusion. The stress on the facility resident may be exacerbated by the use of emergency medication, so this should be considered at the time of initiation of restraint or seclusion. Such consideration reduces the risk of death by asphyxiation or aspiration, which can occur under such circumstances. Recognizing that constant observation during certain interventions can lead to escalation of behavior in some populations, appropriate observation must be clarified in a facility's intervention policies and take into account a facility resident's particular circumstances and behavioral patterns.

Policies related to observation during a restraint or seclusion should be developed by each agency. The following policies were implemented by state hospitals and can serve as an example of effective observer and monitoring procedures:

- A staff member of the same gender as the facility resident must maintain continuous face-to-face observation of a resident in mechanical restraint, unless the resident's history or other factors indicate this would be contraindicated, e.g., sexual or physical abuse perpetrated by someone of the same gender, in which case a staff member of the opposite gender may be used.
- A staff member who is not physically applying personal restraint must maintain continuous face-to-face observation of a facility resident in personal restraint. This is particularly important in the instance of a child being restrained or secluded.
- A staff member must maintain continuous face-to-face observation of a facility resident in seclusion for at least one hour. After one hour, the staff member may monitor the resident continuously using simultaneous video and audio equipment in close proximity to the resident.
- A facility resident who is administered emergency medication in addition to being in restraint or seclusion should be observed continuously.
- A facility resident in mechanical restraints should be observed continuously to protect the resident from others as well as observing for any physical signs of distress.

In addition, the following areas should be addressed in policies for purposes of facility residents' health and safety:

- Health status of the facility resident must be monitored at all times.
- Staff training should be provided to identify facility residents' medical risk factors such as obesity, respiratory conditions, and sedation as it relates to specific restraint techniques.
- Staff training should be provided on the physical signs that a resident is in distress.

Following Restraint and Seclusion

Processing a resident out of restraint or seclusion continues to be a critical period and should be addressed in a comprehensive manner. As previously stated, facilities should also implement a review process and debriefings following each incident.

The following information is provided to assist facilities in developing guidelines and understanding for processing facility residents out of restraints:

- Facility residents should be released from restraint or seclusion as soon as safety allows. Appropriately trained staff should assess the resident to determine if he or she is a threat of harm to self or others.
- Staff training should ensure competence in the appropriate application and removal of restraints. This should include involvement of the practitioners ordering and initiating the restraint or seclusion based on the policies of the regulatory agency.
- Immediately following the release of a resident from restraint or seclusion, a staff member should take appropriate action to facilitate the resident's reentry into the social milieu by providing the resident with transition activities and an opportunity to return to ongoing activities.
- The resident's behavior during this transition should be observed and documented.

The following information is provided to assist facilities in developing debriefing guidelines and how debriefing can be used organizationally:

- Define debriefing and when it is necessary.
- Implement acute debriefing immediately following restraint and seclusion event to gather information, manage the environment, and assure safety of all involved parties.
- Implement formal debriefing, which is more detailed and focused on rigorous problem solving.
- Debriefing should focus on not re-traumatizing the resident. As such there should be two separate de-briefings - one with the resident and one with the staff
- Use debriefing to identify staff training needs and staffing patterns.
- Acute and formal debriefing should be facilitated by a lead staff person, preferably someone not involved in the event.
- Debriefing should use a template or checklist, use root cause analysis steps, be non-punitive, and establish goals to determine what happened, in order to mitigate and prevent future occurrences. New information should inform changes in practice, policies and operations.

Both debriefings should include:

- Involvement of appropriate individuals.
- Identification of what led to the episode and what could have been handled differently.

- Identification of strategies to prevent future restraint or seclusion, taking into consideration suggestions from the facility resident and the resident's advance agreement, if any.
- Determining whether the resident's physical well being, psychological comfort, and right to privacy were addressed.
- Addressing any trauma that may have resulted from the episode.
- When indicated, identifying appropriate modifications to the resident's treatment plan.
- When clinically indicated, or upon request of individuals who witnessed the restraint, debriefing persons who witnessed the restraint.

In The Event of Serious Injury or Death

Every step should be taken to safeguard residents. In the event of a death or injury from a restraint or seclusion event, a thorough investigation must be conducted. An identified group of clinical and administrative leaders should review each incident of death or serious injury related to restraint or seclusion, and determine what could have been done to prevent the death or injury. Thorough process analysis should provide assurances that safety and well being of all residents and staff will be guaranteed and every step will be taken to ensure that recurrence of an incident of death or serious injury will not occur in the future.

Recommendations and Explanation

Recommendation 6: A follow-up work group should be convened that will develop practice guidelines for the use of emergency medical interventions, including the use of medication, and other medical restraints. The work group should be sponsored by the Department of State Health Services and should include representatives from the Texas Medical Association, the Texas Hospital Association, the Texas Pharmacy Association and other groups that represent entities that use emergency medication/medical interventions for the purposes of modifying behavior.

As a last resort, the use of restraint or seclusion may be utilized in managing behavior of residents in an emergency. To address the risks involved in a restraint or seclusion event, it is critical that it is carried out in the safest manner possible. Emergency medications are sometimes utilized in these emergencies. A group of qualified medical professionals is required to review practices and provide recommendations on the safest use of emergency medications in reduction and safety efforts in relation to restraint and seclusion practices.

Recommendation 7: Individual health and human services agencies should work with constituents and stakeholders and develop rules that defines what constitutes a "small facility" for the purposes of exemption from the requirement of the presence of an observer during the administration of prone or supine holds identified in Section 322.051(b)(3) of S.B. 325.

The definition of “small facility” differs among facility types. This exemption was provided in S.B. 325 because some facilities may not have staff levels that would accommodate the ability to have an observer for each restraint and seclusion event. Of primary importance is to assure the safety of individuals, whether in a larger or smaller facility. Therefore, it was determined that each agency would work with constituents to determine the definition of “small facility.”

CONCLUSION

The elimination of the use of restraint and seclusion remains the ultimate goal for all members of the work group, but it is important to recognize that the process requires a very deliberate and targeted effort. There are numerous steps that state agencies and their regulated facilities can explore immediately to foster an environment that will ultimately lead to a reduction in the use of restraint and seclusion while creating a safer setting for all facility residents and staff.

The commitment of management to a shift in organizational culture can foster reduction in the use of restraint and seclusion. Training of staff to use non-physical interventions to manage the behavior of residents, including de-escalation and active listening techniques, can be used to prevent emergency restraint and seclusion. Training should be competency-based and provided prior to staff working with facility residents.

When the use of restraint or seclusion has been deemed necessary, it is critical that it is carried out using the safest and least restrictive method possible. Senate Bill 325 includes provisions that prohibit certain restraints and state agencies named in the legislation have implemented these restrictions in rule. The work group identified additional areas of focus that would serve to protect facility residents and staff from serious injury or death. Facilities should have specific policies for ordering and initiating restraint or seclusion, observation and monitoring during a restraint or seclusion episode, and follow-up after the episode.

In the event of serious injury or death, facilities should have a process to review the incident, understand the causes, and take any corrective actions necessary for future prevention. The recommendations for reporting regarding use of restraint and seclusion in behavior emergencies will provide more information for facilities to utilize in improvement efforts.

This report provides strategies for facilities to consider in addressing improvement efforts. In the case of a behavioral emergency, restraint should be an intervention of last resort, employed only where a situation of injury is actual or imminent, and when failure to do so would also constitute a failure to protect that individual or others from harm. We must be able to evaluate our system’s success or failure, by each individual’s attainment of, or movement toward, freedom from restraints. Therefore, the foundation for the recommendations in this report is to begin a consistent, systematic approach to reporting across agencies.

Appendix A

S.B. No. 325

AN ACT

relating to the management of behavior of residents of certain facilities; providing an administrative penalty.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle G, Title 4, Health and Safety Code, is amended by adding Chapter 322 to read as follows:

CHAPTER 322. USE OF RESTRAINT AND SECLUSION IN CERTAIN HEALTH CARE FACILITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 322.001. DEFINITIONS. In this chapter:

(1) "Facility" means:

(A) a child-care institution, as defined by Section 42.002, Human Resources Code, including a state-operated facility, that is a residential treatment center or a child-care institution serving children with mental retardation;

(B) an intermediate care facility licensed by the Department of Aging and Disability Services under Chapter 252 or operated by that department and exempt under Section 252.003 from the licensing requirements of that chapter;

(C) a mental hospital or mental health facility, as defined by Section 571.003;

(D) an institution, as defined by Section 242.002;

(E) an assisted living facility, as defined by Section 247.002; or

(F) a treatment facility, as defined by Section 464.001.

(2) "Health and human services agency" means an agency listed in Section 531.001, Government Code.

(3) "Seclusion" means the involuntary separation of a resident from other residents and the placement of the resident alone in an area from which the resident is prevented from leaving.

[Sections 322.002-322.050 reserved for expansion]

SUBCHAPTER B. RESTRAINTS AND SECLUSION

Sec. 322.051. CERTAIN RESTRAINTS PROHIBITED. (a) A person may not administer to a resident of a facility a restraint that:

(1) obstructs the resident's airway, including a procedure that places anything in, on, or over the resident's mouth or nose;

(2) impairs the resident's breathing by putting pressure on the torso; or

(3) interferes with the resident's ability to communicate.

(b) A person may use a prone or supine hold on the resident of a facility only if the person:

(1) limits the hold to no longer than the period specified by rules adopted under Section 322.052;

(2) uses the hold only as a last resort when other less restrictive interventions have proven to be ineffective; and

(3) uses the hold only when an observer, who is trained to identify the risks associated with positional, compression, or restraint asphyxiation and with prone and supine holds and who is not involved in the restraint, is ensuring the resident's breathing is not impaired.

(c) Small residential facilities and small residential service providers are exempt from Subsection (b)(3).

Sec. 322.052. ADOPTION OF RESTRAINT AND SECLUSION PROCEDURES. (a) For each health and human services agency that regulates the care or treatment of a resident at a facility, the executive commissioner of the Health and Human Services Commission shall adopt rules to:

(1) define acceptable restraint holds that minimize the risk of harm to a facility resident in accordance with this subchapter;

(2) govern the use of seclusion of facility residents; and

(3) develop practices to decrease the frequency of the use of restraint and seclusion.

(b) The rules must permit prone and supine holds only as transitional holds for use on a resident of a facility.

(c) A facility may adopt procedures for the facility's use of restraint and seclusion on a resident that regulate, more restrictively than is required by a rule of the regulating health and human services agency, the use of restraint and seclusion.

Sec. 322.053. NOTIFICATION. The executive commissioner of the Health and Human Services Commission by rule shall ensure that each resident at a facility regulated by a health and human services agency and the resident's legally authorized representative are notified of the rules and policies related to restraints and seclusion.

Sec. 322.054. RETALIATION PROHIBITED. (a) A facility may not discharge or otherwise retaliate against:

(1) an employee, client, resident, or other person because the employee, client, resident, or other person files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of restraint or seclusion at the facility; or

(2) a client or resident of the facility because

someone on behalf of the client or resident files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of restraint or seclusion at the facility.

(b) A health and human services agency that registers or otherwise licenses or certifies a facility may:

(1) revoke, suspend, or refuse to renew the license, registration, or certification of a facility that violates Subsection (a); or

(2) place on probation a facility that violates Subsection (a).

(c) A health and human services agency that regulates a facility and that is authorized to impose an administrative penalty against the facility under other law may impose an administrative penalty against the facility for violating Subsection (a). Each day a violation continues or occurs is a separate violation for purposes of imposing a penalty. The amount of the penalty may not exceed the maximum amount that the agency may impose against the facility under the other law. The agency must follow the procedures it would follow in imposing an administrative penalty against the facility under the other law.

(d) A facility may contest and appeal the imposition of an administrative penalty under Subsection (c) by following the same procedures the facility would follow in contesting or appealing an administrative penalty imposed against the facility by the agency under the other law.

Sec. 322.055. MEDICAID WAIVER PROGRAM. A Medicaid waiver program provider, when providing supervised living or residential support, shall comply with this chapter and rules adopted under this chapter.

SECTION 2. Subchapter B, Chapter 242, Health and Safety Code, is amended by adding Section 242.0373 to read as follows:

Sec. 242.0373. RESTRAINT AND SECLUSION. A person providing services to a resident of an institution shall comply with Chapter 322 and the rules adopted under that chapter.

SECTION 3. Subchapter B, Chapter 247, Health and Safety Code, is amended by adding Section 247.0255 to read as follows:

Sec. 247.0255. RESTRAINT AND SECLUSION. A person providing services to a resident of an assisted living facility shall comply with Chapter 322 and the rules adopted under that chapter.

SECTION 4. Subchapter A, Chapter 252, Health and Safety Code, is amended by adding Section 252.0085 to read as follows:

Sec. 252.0085. RESTRAINT AND SECLUSION. A person providing services to a resident of a facility licensed by the department under this chapter or operated by the department and exempt under Section 252.003 from the licensing requirements of this chapter shall comply with Chapter 322 and the rules adopted under that chapter.

SECTION 5. Subchapter A, Chapter 464, Health and Safety Code, is amended by adding Section 464.0095 to read as follows:

Sec. 464.0095. RESTRAINT AND SECLUSION. A person providing services to a client at a treatment facility shall comply with Chapter 322 and the rules adopted under that chapter.

SECTION 6. Chapter 571, Health and Safety Code, is amended by adding Section 571.0067 to read as follows:

Sec. 571.0067. RESTRAINT AND SECLUSION. A person providing services to a patient of a mental hospital or mental health facility shall comply with Chapter 322 and the rules adopted under that chapter.

SECTION 7. Subchapter C, Chapter 42, Human Resources Code, is amended by adding Section 42.0422 to read as follows:

Sec. 42.0422. RESTRAINT AND SECLUSION. A person providing services to a resident of a child-care institution, including a state-operated facility that is a residential treatment center or a child-care institution serving children with mental retardation, shall comply with Chapter 322, Health and Safety Code, and the rules adopted under that chapter.

SECTION 8. (a) In this section:

(1) "Emergency" means a situation in which attempted preventive de-escalatory or redirection techniques have not effectively reduced the potential for injury and it is immediately necessary to intervene to prevent:

(A) imminent probable death or substantial bodily harm to the person because the person overtly or continually threatens or attempts to commit suicide or threatens or attempts to commit serious bodily harm; or

(B) imminent physical harm to another because the person overtly or continually makes or commits threats, attempts, or other acts.

(2) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

(3) "Facility" means:

(A) a facility as defined by Section 322.001, Health and Safety Code, as added by this Act;

(B) a facility under the jurisdiction of the Texas Youth Commission; or

(C) a public or private juvenile detention or correctional facility regulated by the Texas Juvenile Probation Commission under Chapter 141, Human Resources Code.

(4) "Health and human services agency" means a health and human services agency listed in Section 531.001, Government Code, that regulates the care or treatment of a resident of a facility.

(b) The executive commissioner shall establish a work group to recommend best practices in policy, training, safety, and risk management for the Texas Youth Commission, the Texas Juvenile Probation Commission, or a health and human services agency to adopt to govern the management of facility residents' behavior.

(c) The executive commissioner shall determine the number of members to serve on the work group. The executive commissioner shall appoint as members of the work group:

(1) a representative of the Department of State Health Services;

(2) a representative of the Department of Aging and Disability Services;

(3) a representative of the Department of Family and Protective Services;

(4) a representative of the Texas Youth Commission;

(5) a representative of the Texas Education Agency;

(6) a representative of the Texas Juvenile Probation Commission;

(7) a representative of this state's protection and advocacy system established as required by 42 U.S.C. Section 15043 who is appointed by the administrative head of that system; and

(8) additional members who are recognized experts or who represent the interests of facility residents, including advocates, family members, physicians, representatives of hospitals licensed under Chapter 241 or 577, Health and Safety Code, social workers, and psychiatric nurses.

(d) The work group shall study and make recommendations on:

(1) the development of a comprehensive reporting system that:

(A) collects and analyzes data related to the use of:

(i) physical, behavioral, and de-escalation interventions by employees of a facility to manage the behavior of facility residents in an emergency; and

(ii) medication administered by employees to a facility resident without the resident's consent in an emergency;

(B) complies with federal reporting requirements;

(C) documents the death or serious injury of a facility resident related to physical intervention, seclusion, or restraint, including the administration of medication, by an employee; and

(D) documents the death or serious injury of an employee during a physical intervention, seclusion, or restraint;

(2) the prevention of the death of or serious injury to facility residents related to physical intervention or restraint;

(3) de-escalation techniques and minimum standards to manage the behavior of facility residents in an emergency situation;

(4) best practices for physical, behavioral, and de-escalation interventions by employees that include specific holds and techniques for the physical restraint of facility residents;

(5) best practices related to specific populations, including any consideration that should be given to a facility's community or institutional setting; and

(6) best practices related to seclusion of facility residents.

(e) In recommending the best practices, the work group shall:

(1) focus on the physical, behavioral, and de-escalation interventions used by facility employees to manage the behavior of facility residents in an emergency; and

(2) support uniformity in definitions, reporting, and training used by the Texas Youth Commission, the Texas Juvenile Probation Commission, and health and human services agencies.

(f) The executive commissioner shall:

(1) not later than November 1, 2005, establish the

work group under Subsection (b) of this section;

(2) not later than June 1, 2006, adopt rules necessary to implement Chapter 322, Health and Safety Code, as added by this Act;

(3) not later than July 1, 2006, file with the appropriate committees of the senate and the house of representatives a report that describes the work group's recommended best practices;

(4) not later than November 1, 2006, adopt rules necessary to implement the best practices recommended by the work group; and

(5) not later than January 1, 2007, file with the appropriate committees of the senate and the house of representatives for consideration by the 80th Legislature a report that describes the actions taken by the Texas Youth Commission, the Texas Juvenile Probation Commission, and health and human services agencies to implement the best practices recommended by the work group.

SECTION 9. This Act takes effect September 1, 2005.

_____ _____

President of the Senate Speaker of the House

I hereby certify that S.B. No. 325 passed the Senate on April 21, 2005, by the following vote: Yeas 31, Nays 0.

_____

Secretary of the Senate

I hereby certify that S.B. No. 325 passed the House on May 25, 2005, by a non-record vote. _____

Chief Clerk of the House

Approved:

_____

Date

_____

Governor

Appendix B
Work Group Members

State Agency Members

Department of State Health Services
- Peggy Perry, Assistant Director for State Hospitals Section

Department of Aging and Disability Services
- Corliss Powell, Lead Policy Specialist, Policy Development and Oversight

Department of Family and Protective Services
- Sasha Rasco, Director of Policy and Program Operations

Texas Youth Commission
- Corinne Alvarez-Sanders, Ph.D., Assistant Deputy Executive Director for Rehabilitation Services

Texas Juvenile Probation Commission
- Scott Friedman, Director of Field Services

Texas Education Agency
- Kathy Clayton, Director of IDEA Coordination

Additional Members

Jodi Heatly, RN, Psychiatric Nurse

Valarie Garza, Family Member

Laurel Blackman, D.O. Psychiatry Resident

Angelo Giardino, M.D., Hospital Physician

Sam Bell, LMSW – ACP, Child Welfare

Gayle Jensen-Savoie, LPC, Hospital

Lynda Frost, Ph.D. J.D., Hogg Foundation

VirGene Adams, Pharmacist, Long Term Care

Advocacy Inc. Member

Aaryce Hayes, Policy Specialist, Adult Mental Health

Appendix C

Reference and Resource List

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Appendix D

Seclusion/Restraint/De-escalation Reporting

Number of Seclusion Episodes

Number of Personal Restraint Episodes

Number of Mechanical Restraint Episodes

Number of Involuntary Emergency Medication Orders

Description of De-escalation Techniques Employed

Did the intervention result in an incident of serious injury or death? If so reference incident report.

Appendix E
Definitions

Category	Term	Definition	Annotation
Emergency	(Behavioral) Emergency	A situation in which severely aggressive, destructive, violent or self injurious behavior exhibited by an individual poses a substantial risk of imminent probable death of or substantial bodily harm to the individual or others; has not abated in response to attempted preventive de-escalatory or redirection techniques.	There was discussion that property damage that puts a person at risk of injury or death, or that puts others at risk, is considered an (behavioral) emergency. There was discussion regarding property insurance issues are not included in this definition, but are acknowledged as a significant issue in the provision of services to individuals.
Restraint	Restraint	Application of physical or mechanical force, or chemical intervention, to an individual served with or without his or her permission, to restrict the individual's freedom of movement or to modify behavior.	There was discussion that the definition includes both voluntary and involuntary restraint. For the purposes of developing a uniform reporting system, only involuntary will be used. There was discussion about what is a restraint, an escort, or a support on holding, moving, etc. Whether or not the action is a restraint is determined by whether or not it is voluntary for the individual. If the individual resists by statement or action, then it is considered a restraint.
	Chemical Restraint	The use of any chemical, including pharmaceuticals and medication, through topical application (which includes agents such as pepper spray and tear gas), oral administration, injection, or other means, for purposes of restricting the movement of an individual or modifying maladaptive behavior and which is not a standard treatment or intervention.	There was discussion that the definition does not include the purpose of chemical restraint or justification for its use or non-use. The definition does not differentiate between voluntary or involuntary. There was discussion that chemical restraint or intervention should be seen as a measure of last resort. The definition assumes the term "condition" to include medical psychiatric and behavioral conditions of an individual. The definition does not address when an emergency exists, nor does it include emergency use of medication.
	Emergency Medication	Pharmaceuticals administered (involuntarily) to an individual that meets the definition of emergency.	
	Mechanical Restraint	The application of a device restricting or aiding in the restriction of the movement of the whole or portion of an individual's body to control physical activity.	
	Protective Devices	A device that cannot be removed by the individual, to prevent injury or permit wounds to heal.	There was discussion that examples of Protective Devices are helmets, bed rails, and seat belts. Protective devices include any device that cannot be removed.
	Supportive Devices	Mechanical interventions that, when properly used, posturally support the individual or assist the individual who cannot obtain or maintain bodily functioning.	There was discussion that Supportive Devices may be used to help an individual have better support, sitting or standing up, or to help develop and maintain normal body functioning.
	Personal Restraint	The application of physical force alone, restricting the free movement of whole or a portion of an individual's body to control physical activity.	

Category	Term	Definition	Annotation
Seclusion	Seclusion	The separation of an individual from other individuals and the placement of the individual alone in an area from which egress is prevented.	Definition found in SB325.
	Egress Prevention	The blocking of an individual's ability to exit a space.	There was discussion among the group regarding physical prevention, verbal prevention and non-verbal prevention (an implied barrier that is not physical, but understood as a barrier to the person whose egress is being prevented). No consensus could be reached regarding a nonverbal barrier. Individual agencies will be allowed to develop this definition to fit their specific population and facility type.
Separation	Separation	The isolating of an individual from other individuals.	
	Time Out	A behavior management technique in which the individual is separated from other individuals for a limited period in a setting that is not locked and from which the exit is not physically blocked and egress is not prevented.	
	Restriction	The involuntary separation of a young individual from other individuals, and from which egress may be prevented through communication to the individual (but not physically prevented) for a limited duration of time.	
	Quiet Time	A procedure in which an individual, voluntarily, under their own initiative, or complying with a request, enters and remains for a period of time in a designated area from which egress is not prevented.	
	Continuous, Face-to-Face, one to one Observation	Maintaining an in-person line of sight that is uninterrupted and free of distraction.	There was discussion that the definition assumes the phrase "free of distraction" to mean that the observer will not be assigned other concurrent duties while serving as the observer.
Injury	Injury	Any physical damage done to the body from violence or accident.	
	Non-serious injury	Any injury requiring minor first aid and determined not to be serious by a practitioner identified by the regulatory agency.	
	Serious injury	Any physical damage requiring medical intervention or hospitalization or any injury determined to be serious by a practitioner identified by the regulatory agency.	