Outline of Conference

• Introductions
• History of the U.S. S/R Reduction Initiative
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• Core Constructs in Preventing the Use of S/R
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Introduction

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• Advanced Practice RN: 30 years
• 25 years in a variety of hospital and community settings/ general medical, substance abuse, & mental health
• 5 years in Washington, DC providing assistance to public state mental health agencies and providers on core issues in mental health service provision
History of the U.S. S/R Reduction Initiative

• 1996: PA starts state-wide reduction efforts
• 1998: Hartford Courant Reports
• 1999: U.S. GAO report on S/R use
• 1999: CMS Interim Rule (one-hour rule)
• 2000: Children’s Health Act (kids inpatient)
• 2002: NASMHPD S/R Curriculum Developed
• 2003: Success Stories (NAPHS, APNA)
• 2003: NASMHPD starts training initiative
History of the U.S. S/R Reduction Initiative

• 2004: State Hospitals begin to implement the NASMHPD Six Core Strategies and other interventions; successfully reduce use
• 2004: Definition of restraint changes to include “manual holds or any duration”
• 2005: 8 state/49 site research project starts
• 2005: AU, NZ, and Scotland request training
• 2007: CMHS launches second research project to build EBP to reduce use
Important Changes in the CMS Final Rule

• Interim Rule published in July, 1999
• CMS received 4200 comments on Interim Rule in comment period/ hearing held in MD
• CHA passed in 2000 for Part H & I (inpatient kids)
• Note: PRTS facilities (child group homes and other community settings) are not under final rule yet. Should be published this year.
Important Changes in the CMS Final Rule

1. **Combined Standards**: One set of CMS rules now applies to S/R in all federally funded hospitals including medical / surgical and behavioral health.

- One difference is in the use of S/R for violent or self-destructive behaviors regardless of setting.
- Onus now on behavior for which S/R is used
Important Changes in the CMS Final Rule

2. Definitions: Restraint definition not much changed

“any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage.

• The final rule excludes (as restraint) “orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient to conduct routine physical exams or test, or to permit the patient to participate in activities. This does not include physical escorts.”
Important Changes in the CMS Final Rule

Seclusion Definition, in final rule, is broader and includes clarification between “time outs” (voluntary only) and “seclusion” (involuntary).

Seclusion also includes being put in a room, alone and not allowed to leave, whether locked or not.
Important Changes in the CMS Final Rule

3. Restrictions on Use: The Final Rule defines that S/R “may only be used to ensure the immediate physical safety of the patient, staff, or others. Hospitals must first use least restrictive interventions before using S/R. In situations of imminent danger the hospital must consider the use of alternatives and document these.”

In addition, the restrained person must be afforded privacy, as is possible.
Important Changes in the CMS Final Rule

4. **Written Orders**: Has not changed. S/R may only be imposed only upon the written order of a physician or licensed independent practitioner (state, local and facility regulations apply).

5. **Plan of Care**: S/R may only be used with a written modification to the pt’s care plan.
Important Changes in the CMS Final Rule

6. **Duration of Order**: No change from Interim Rule. The time limit for S/R for adults is 4 hours, youth ages 9-17 is 2 hours, under 9 yrs 1 hour. An order for S/R can be renewed with attention to these time lines up to a total of 24 hrs. At 24 hours the physician or LIP must see and assess the person before issuing another order.

• **S/R must be discontinued at the earliest possible time, regardless of the order time.**
Important Changes in the CMS Final Rule

7. Monitoring: The Interim Final Rule stated that the patient must be *continuously* assessed, monitored, and re-evaluated. This changed in the Final Rule as CMS stated “that there was confusion”

• Now CMS allows a *trained staff member* to monitor the person “at an interval determined by hospital policy”
Important Changes in the CMS Final Rule

8. Face-to-Face, One-hour Rule: The private sector vigorously opposed the one-hour rule. As such, based on comments they received, CMS weakened the Final Rule and expanded the list of staff who could perform the one-hour face-to-face assessments. The Final Rule now allows trained RN’s and PA’s to conduct this assessment. The same expectations and liabilities apply.
Important Changes in the CMS Final Rule

9. Documentation: The Final Rule added documentation requirements including:

- The one-hour, face-to-face evaluation for S/R used for violent or self-destructive behavior
- A description of the patient’s behavior, the interventions used, and rationale
- Less restrictive interventions attempted
- The patient’s behavior or symptoms that warranted S/R use
- The patient’s response to S/R and rationale for continued use
Important Changes in the CMS Final Rule

10. Death Reporting: The Final Rule requires hospitals to report all deaths, *(to the CMS Regional Office by COB next day and documented in the MR)*, occurring while an individual is in S/R; deaths within 24 hrs after removal from S/R; within 1 week where it is *reasonable* to assume that S/R directly or *indirectly* contributed to a death. *Reasonable to assume* includes (not limited to) restriction of movement or breathing, asphyxiation or complications, compression of chest…

*Note JCAHO standards are more restrictive and include serious injury*
Important Changes in the CMS Final Rule

11. Training: TO BE COVERED NEXT

12. Enforcement: The Final Rule holds that non-compliance with the Final Rule or the CHA will result in the termination of federal funding (MHBG, Medicaid and Medicare dollars and any grant funding).
CMS Training Requirements
Who, How, When?

• CMS specifies that “all staff with direct patient contact must have ongoing education and training in the proper and safe use of S/R application, techniques, and alternative methods for handling behavior, symptoms, and situations that traditionally have resulted in S/R use.”
• This includes all medical and BH staff
• JCAHO requirements are more extensive for BH but NOT adequate for med-surg facilities.
CMS Training Requirements
Who, How, When?

• Hospitals need to increase training for med-surg staff while continuing to follow JCAHO requirements for BH staff.
• Training requirements only apply to staff that might apply S/R, who care for people in S/R, or who assess or monitor people in S/R.
• Training must start in new hire orientation and periodically thereafter. Most hospitals have interpreted this as “annually.”
• Training may take 15 to more hours annually.
• You do not have to hire outside people to train…
The 7 CMS Training Element One

1. What circumstances trigger conflicts that could result in S/R use?

- Patient/Staff Conflict = Violence = S/R = Trauma, Injuries + Deaths, in Inpatient Mental Health and other settings

- Some of the most common variables will be discussed here
Triggers for Conflict

- “Internal Factors” are related to the individual patient characteristics. Many research studies on people who become violent with regard to diagnosis, age, sex, race, etc.

- Other factors include history of foster care, homelessness, juvenile justice, other kinds of trauma, substance use, gang involvement etc.
Triggers for Conflict

- Literature on violence in inpatient settings is pretty scarce still.
- Some factors have been identified as higher risk than others, including recent history of violent behavior against self or others, paranoia, command hallucinations, homelessness, chaotic living conditions (abuse), and antisocial type behaviors.
- Medical issues can also be a factor, such as chronic pain.
Triggers for Conflict

- It is a fact that mental health staff have most often focused on the patient as the problem.
- However, recent research indicates that triggers for conflict often come from the setting or treatment environment.
- "External factors" include unit culture, the use of restrictive rules, availability of interesting treatment activities, staff attitudes / tone of voice, waiting times, noise, crowding, shaming.
Triggers for Conflict

- Organizations need to do everything possible to make their settings “sanctuary-like”, minimize rules, increase choices, train staff regarding therapeutic communication skills, empower staff to change rules in the moment, and teach pt’s emotional self management techniques e.g. “HALT”

- A first step is to put processes in place to facilitate “getting to know” every person ASAP during admission and through use of assessments, staff mentors, and peer specialists
Preventing Conflict

Recommended Interventions:
1. Brief violence risk assessment coupled with a Violence Reduction Protocol (Broset)
2. Assessment on Medical Risks for Death
3. Brief Trauma Assessment
4. Psychosocial Histories re home environment
5. Development of individualized safety or crisis plans (de-escalation checklist)
6. Post-acute event debriefing
2. Use Non-physical Intervention Techniques

- Key is to intervene at the first sign of crisis.
- Staff must respond “fast” to any signs and implement what they “know” about that person e.g. crisis plan choices
- The more comfortable the staff feel with the person and vice versa, the more likely S/R can be avoided
- This needs to be covered in new hire and follow-up training and individual staff performance
Non-Physical Interventions

Recommendations:
1. Leaders need to carefully review S/R application training curricula. Most time should be spent on non-physical interventions, not application techniques.
2. Non-physical intervention expectation expectations need to be inserted into staff job descriptions.
3. Staff need to be highly accessible.
Non-Physical Interventions

4. Train staff on how to avoid power struggles and put in place interventions such as “Tap Out” (Explain)

5. Recognize and reward staff who are skilled at defusing crisis, make them “field trainers”

6. Develop comfort rooms on units for voluntary use

7. Implement sensory modulation tools
Non-Physical Interventions

8. Make sure that the senior nurse on the unit coordinates all responses to behavioral issues and that all staff know their roles.

9. Use a stat team of staff skilled in mediation and de-escalation to respond when someone starts to escalate. (Pros & Cons - Discuss)

10. Document “near misses” and hold unit mini-grand rounds to discuss what happened and what worked.

11. Track staff involved in events to be able to provide individual supervision and training.
The 7 CMS Training
Element Three

3. Assess the individual and select the least restrictive intervention possible

- Assessment is easier if staff have developed a previous relationship
- All behavior has meaning
- Staff may think they need to “win” power struggles, the don’t
- Younger or less experienced staff use more restrictive interventions
Choose least restrictive intervention

Recommendations

1. Train staff to avoid “premature” use of physical interventions by discussing the different levels of behavior and how those relate to safety:

• Agitated*
• Disruptive*
• Destructive* (* denotes still in control)
• Dangerous+
• Lethal Threat+ (+ requires physical intervention)
Choose least restrictive intervention

2. Review patient’s safety plan, if you have time. See what they requested in a crisis and remind them of that.

3. Assure that staff know how to document in a way that “tells a story.” Statements such as “Jack was aggressive” or “Jane was psychotic” does not provide useful information. Teach staff to write down, in plain language, what happened.
Choose least restrictive intervention

4. Seclusion, restraint and involuntary medications use varies considerably in similar facilities across the country. Facility policy needs to be clear on the rationale for the use of any one of these interventions and describe when these safety measures should or should not be used.
5. Develop less restrictive options such as going for a walk, taking a shower, have something to eat or drink, have a one-to-one with staff, using the comfort room, listening to music, using weighted blankets or stuffed animals, working out, talking on the phone. Staff are often very creative in identifying least restrictive alternatives but need encouragement to do that.
The 7 CMS Training
Element Four

4. **Safely Use S/R**

- Understand the facts. That there are research identified, significant risk factors when performing take-downs or putting someone into seclusion or restraint, involuntarily.

- Understand that we will never know all the risk factors, and as such, S/R remain high risk, dangerous and problem-prone procedures.
Using S/R Safely

- Key risk factors for people in inpatient settings include abdominal obesity or large abdominal girth; any respiratory complications including a common cold, asthma, COPD, chronic cough, history of bronchial spasms, lung cancer, diminished lung function for any reason, trouble breathing.

- Traumatic life experiences including PTSD, acute stress disorder, panic and dissociation episodes, cutting or other patterned self-harm behaviors.
Using S/R Safely

- Must know the people you are serving in the minute.
- Other risk factors associated with negative outcomes is the recent ingestion of food or fluids that can lead to aspiration
- Recent surgery that contraindicates hands on take downs or pregnancy
- All of these factors need to be assessed on admission
Using S/R Safely

Recommendations

1. Revise nursing admission forms to highlight risk factors as noted above. This can be done with a few questions and not a lot of time.

2. Revise social work psycho-social assessments to capture traumatic life experiences that go beyond physical abuse.
Using S/R Safely

3. Create a process that captures any positive responses on these issues and transfers these immediately, as high risk factors, to the treatment plan and Kardex (shift report).

4. Do personal safety plans for people at high risk to attempt to avoid any crises that might lead to a take down or the use of restraint or seclusion.
5. Release from S/R when no longer necessary

- Most common problem here is the staff expectation that persons served will be able to “prove” that they no longer require S/R.

- Think about this expectation. We serve people who are in crisis, whose symptoms are florid and exacerbated, who are often on a lot of medication, who require inpatient care. And we want them to do what?
Release from S/R

- It is inappropriate, in these settings, to expect persons in either seclusion or restraint to be able to articulate “why they do not have to be there any longer.” It may be malpractice.

- It is incumbent upon professional staff to use their observation skills and knowledge to ascertain when a person no longer needs to be in S/R. Period.
Release from S/R

Recommendations

1. Revise your S/R policy to make clear that it is not “the patient’s responsibility to prove to staff that they are able to be released.”

2. Instead, make clear to staff that this is their responsibility and should be made based on clinically supported observations of the person’s behavior.
3. The S/R policy also needs to be clear on what staff are to do when people fall asleep in seclusion or restraint. It is recommended that the policy direct staff to unlock and open seclusion room doors while maintaining constant checks. For people restrained it is recommended that the restraints be released and if the person does not wake up, same as above.
The 7 CMS Training Element Six

6. *Closely monitor people in S/R*

- The new CMS Final Rule weakened monitoring requirements. But facilities need to understand that CMS rules are considered, by CMS, to be minimum standards and not best practices. With regards to monitoring people in seclusion and restraint the following best practice guidelines apply.
Careful Monitoring

- Persons in seclusion and restraint should be monitored continuously and be face up, if in restraint. It is impossible to see respiratory distress in a person that is restrained prone (face down). It is also impossible to note emerging signs of problems from A/V monitors. It is best to have a person in restraint monitored one to one. For people in seclusion, 15 minute checks suffice.
Careful Monitoring

Recommendations

1. Revise your S/R policy with regard to monitoring. Make clear that persons should not be in prone restraint unless there is a clear medical rationale that the ordering physician indicates in the order.
Careful Monitoring

2. Hospital policy needs to assure that people in restraint receive consistent, if not continual monitoring. If you are already providing continual monitoring, do not change or weaken this. If you are not be sure that the people monitoring restraint understand that people in restraint need to be seen, face to face, every 15 minutes and that skin color and temperature, respirations, and Level of Consciousness needs to be checked.
The 7 CMS Training
Element Seven

7. Use First Aid when necessary
- All staff need to be trained and comfortable with emergency procedures. Nurses especially need to be able to respond competently to respiratory distress or cardiac emergencies.
- These competencies are even more important in mental health settings as they are rarely used and it is harder to keep skills current.
First Aid when necessary

Recommendations

1. Review policies on staff preparations and training on emergency first aid, including CPR, use of AEDs, suction machines, knowledge of how to call a code, and where to get the crash cart, if one is used/available.

2. Understand that for mental health staff, including nurses, medical responses may be relatively unused, less understood, and require more training.
Core Constructs in Preventing S/R Use

• Prevention Umbrella
• Trauma-informed Foundation
• Develop a written and organized plan
• Use *Six Core Strategies©*
  - Leadership Responsibilities
  - Use of Data
  - Workforce Development
  - Prevention Tools
  - Consumer Inclusion
  - Rigorous Debriefing
Core Constructs in Preventing S/R Use

• NTAC currently coordinates the National S/R Reduction Coordinating Center
• Also managing an 8 state, 49 site research project to build best practices based on Six Core Strategies©
• Provide training and onsite consultation for states and facilities
• Work with child, youth, adult, and forensic populations
References, Resources, and Links

• http://www.nasmhpd.org/ntac.cfm
• MA Health and Human Services Restraint/Seclusion Reduction Initiative
• PA OMHSAS Seclusion and Restraint
• www.SAMHSA.gov/matrix/matrix_seclusion.aspx
• NAMI Seclusion and Restraint
• Success Stories Seclusion and Restraint
Available Resources

• www.gao.gov/archive/1999/he99176.pdf
• https://www.cms.hhs.gov/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf
• kevin.huckshorn@nasmhpd.org