Massachusetts Department of Correction **POLICY**		Effective Date 2/23/2024 Annual Review Date 6/28/2024	Responsible Division Deputy Commissioner, Clinical Services and Reentry
Policy Name 103 DOC 651 USE OF SECLUSION AND RESTRAINT FOR BRIDGEWATER STATE HOSPITAL		M.G.L. Reference: M.G.L., Chapter 123, § 21, M.G.L., Chapter 124, § 1(q), M.G.L., Chapter 125, § 18, Chapter 1 of the Acts of 1988, Joint Commission Behavioral Health Care Standards; Wellpath PC 400-08 USE OF SECLUSION AND RESTRAINT	
		DOC Policy Reference: Click here to enter text.	
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Attachments Yes ☐ No ☒	Inmate Library Yes ☒ No ☐	Applicability: Staff	
Public Access Yes ☒ No ☐		Location: DOC Central Office Policy File Superintendent's Policy File Special Unit Directors' Policy File Health Services Division Policy File	

PURPOSE:
The purpose of this document is to establish standards that will govern the use of seclusion and restraint for Bridgewater State Hospital (BSH) person served, consistent with requirements of M.G.L. c. 123, § 21. All person served will receive all necessary treatments in the safest and most appropriate manner while maintaining their dignity and ability to be moved to a less restrictive treatment, consistent with requirements of M.G.L. c. 123, § 21.

RESPONSIBLE STAFF FOR IMPLEMENTATION AND MONITORING OF POLICY:
Deputy Commissioner, Clinical Services and Reentry
Assistant Deputy Commissioner of Clinical Services
Superintendent
Director of Behavioral Health
Medical Director
Hospital Administrator

CANCELLATION:
103 DOC 651, Use of Seclusion and Restraint for BSH cancels all previous bulletins, directives, orders, notices rules or regulations regarding seclusion and restraint.

SEVERABILITY CLAUSE:
If any part of this policy is, for any reason, held to be in excess of the authority of the Commissioner, such decision will not affect any other part of this policy.

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651.01 DEFINITIONS

Certified Physician's Assistant: A Certified Physician's Assistant who is deemed qualified and competent and designated by the Medical Director to order restraint, examine a person served in restraint, and discontinue orders for restraint.

Clinical Treatment Team Member: A Psychiatrist, Physician, Certified Physician's Assistant, Clinical Nurse Specialist, Registered Nurse, Licensed Practical Nurse**,** Licensed Mental Health Counselor**,** Clinical Social Worker, Psychologist, Activity Therapist, Mental Health Worker, Occupational Therapist, or Rehabilitation Therapist, any of whom are providing treatment to specific person served on a regular basis.

Credentialed Registered Nurse: A Registered Nurse who is deemed qualified and competent and designated by the Medical Director to order restraint, examine a person served in restraint, and discontinue orders for restraint**.**

Crisis Clinician: Licensed (or license eligible) Mental Health Professional (MHP) (e.g. Psychiatrist, Psychologist, Clinical Social Worker, Mental Health Counselor) or other licensed (or license eligible) Healthcare Professional Staff Member who is deemed qualified and competent by the Medical Director and who is tasked with the responsibility of assessing a person served from 5:00 PM to 10:00 PM on business days, and from 9:00 AM to 10:00 PM on Saturdays, Sundays and holidays.

Emergency: Any instance such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide.

Incident Report: Written documentation to be submitted via the Inmate Management System (IMS) by any staff member, detailing a circumstance or event.

Individual Crisis Prevention (ICP) Plan: An age and developmentally appropriate plan which identifies triggers and/or environmental factors that may signal or lead to agitation or distress in a person served. ICP Plans shall also identify strategies to help a person served and correctional and clinical staff to intervene with de-escalation, redirection, or other professionally supported techniques to reduce such agitation or distress to decrease and/or avoid the use of seclusion and/or restraint with the person served. Formulation of the ICP Plan shall solicit input from the person served. If the person served is adjudged incompetent, the person served's legal guardian (if any and if the guardian is known, available for input, and has authority to make ordinary medical treatment decisions) may be consulted. Formulation of the ICP Plan may also include consultation with entities such as the Department of Mental Health and the person served's family.

Medical Director: The Medical Director of Bridgewater State Hospital, or any physician acting as their designee.

Person Served: Any person who has been admitted or transferred to BSH pursuant to the provisions of G.L. c. 123.

Person Served Medical Record: The person served medical record, including but not limited to current behavioral assessments, mental status examinations, problem lists, progress notes, treatment plans, physician's orders and medication administration records.

Physician: The Medical Director, or a Medical Doctor who is designated by the Medical Director to order restraint, examine a person served in restraint, discontinue orders for restraint, and provide coverage for person served in seclusion and restraint**.**

Restraint: Bodily physical force, mechanical devices, confinement in a place of seclusion other than the placement of a person served in his room for the night, or any other means which unreasonably limit freedom of movement. Medications may be used:

A. In an emergency to prevent immediate, substantial and irreversible deterioration of serious mental illness, or

B. For other treatment purposes when administered pursuant to a court approved substituted judgment treatment plan.

1. Bodily Physical Force: Use of bodily physical force through a manual hold to limit a person served's freedom of movement, subject to the following exceptions:

    a. Physical holding of a person served by a staff member manually for purposes of transporting a person served from one area of the hospital to another.
    b. Physical holding of a person served by a staff member for purposes of placing a person served in seclusion or restraint.
    c. Pursuant to a physician order, temporarily holding a person served in the shower or bathtub in order to assist with hygiene.

2. Mechanical Restraint: Any physical device used to restrict the movement or normal function of a portion of a person served's body. However, mechanical restraint does not include any of the following:

a. The temporary use of mechanical or physical devices, including but not limited to orthopedically prescribed appliances, surgical dressings and bandages, protective helmets and supportive body bands, for safety or security purposes to prevent injury to a person served as a result of any medical or physical impairment.
b. Other physical holding when necessary for routine physical examinations and tests, or for orthopedic, surgical, and other similar medical treatment purposes or when used to provide support for the achievement of functional body position or proper balance or to protect a person served from falling out of bed or to permit a person served to participate in ongoing activities without the risk of physical harm.
c. Use of any mechanical device which limits freedom of movement during transportation of a person served to or from Bridgewater State Hospital.
d. The temporary use of any mechanical device to restrain a person served for safety or security purposes when the person served is being transported within Bridgewater State Hospital.

3. Seclusion: The involuntary confinement of a person served in a room alone either by means of a locked door which cannot be opened from the inside, or where the person served reasonably believes that they will be prevented from leaving by other means. Seclusion does not include any of the following:

a. Placement of a person served in their room on a housing unit for the night at the regular hour of sleep.
b. Temporary placement of a person served alone in a room for no longer than ninety (90) minutes to await medical assessment and/or treatment.
c. Placement of a person served, at their request, in their own room on a housing unit.
d. Placement of a person served, at their request, their own room on a housing unit as outlined in the Quiet Time Procedure.
e. Temporary placement of a person served in a room for person served and inmate counts and movement.

Specially Trained Observer ("STO"): An employee who is designated by the Medical Director, and who has been specially trained to understand, assist, observe and afford therapy to (*i.e.* engage with) a person in seclusion or restraint.

Superintendent: For the purposes of this policy, the Superintendent of Bridgewater State

Hospital. For purposes of section 651.02 of this policy only, Superintendent shall mean the medical director of Bridgewater State Hospital. All other references in this policy to Superintendent shall mean the chief correctional administrative officer of Bridgewater State Hospital as defined by G.L. c. 125, section 1 and appointed by the Commissioner of Correction under section 2.

651.02 GENERAL PROVISIONS

A. It is the policy of Bridgewater State Hospital to prevent, reduce, and strive to eliminate the use of seclusion and restraint in a way that is consistent with its mission, and its commitment to provide a safe environment for its person served, staff, and visitors. Toward this end, BSH is committed to the prevention of emergencies that otherwise might have the potential to lead to the use of seclusion and restraint. BSH is committed to using seclusion and restraint only in an emergency and discontinuing its use in accordance with M.G.L. c. 123, § 21.

B. Seclusion and restraint of a person served may only be used in cases of emergency when non-physical intervention would not be effective. Neither seclusion nor restraint shall be used for punishment, convenience, discipline, or failing to take non-court-ordered medication.

C. Correctional staff are prohibited from authorizing any form of seclusion or restraint. Seclusion and restraint must be authorized by a physician who is present at the time of the emergency. If the physician is not available in the event of an emergency, seclusion may be ordered by a licensed healthcare professional, licensed mental health professional, registered nurse or a certified physician's assistant for a period of up to one (1) hour, following a personal assessment of the person served, and upon an order by that clinical staff member; however, placement in restraints may only be ordered for such a period following a personal examination of the person served by, and upon an order of, a registered nurse. Such an order must be documented. Within the one (1) hour period, the person served should be examined by a physician. If such examination does not occur within the one (1) hour period, the person served may be secluded or restrained for an additional one (1) hour period, following a personal examination of the person served by, and upon a written order of, a registered nurse until the person served is examined by a physician. In the event that seclusion or restraint is extended beyond one (1) hour by a non-physician, the physician shall attach to the seclusion or restraint form a written report as to why their examination was not completed by the end of the first hour of seclusion or restraint.

D. No order for seclusion or restraint issued by a physician shall be valid for a period of more than three (3) hours beyond which time it may be renewed upon personal examination of the person served by a physician or, as set forth in this policy, a registered nurse, or a certified physician's assistant (consistent with M.G.L. c. 123, § 21). Any order for seclusion or restraint issued by a registered nurse or a certified physician's assistant shall not be valid for more than three (3) hours,

after which any renewed order must be issued upon a personal examination of the person served by a physician (consistent with M.G.L. c. 123, § 21).

E. A personal examination of a person served should include, unless clinically contraindicated, entrance into the room where the person served has been placed in seclusion or restraint. Such an examination, unless contraindicated for clinical or security considerations, shall be private. If a person served placed in seclusion is asleep during normal daytime hours, a personal examination shall include an attempt to arouse the person served verbally unless clinically contraindicated, and such contraindications are documented. No attempt to wake a secluded person served shall be required for any person served who is asleep between 9:00 pm and 7:00 am. In all instances, however, a personal examination shall require the physician, registered nurse, or certified physician's assistant to make visual rounds and, if necessary, renew or terminate orders for seclusion, and update progress notes.

F. Every order to initiate or continue the use of seclusion and/or restraint with a person served shall identify the grounds for such order, including but not limited to the emergency necessitating the use of seclusion and/or restraint. All seclusion and restraint orders shall document that less restrictive alternatives, including strategies identified in the person served ICP plan, if any, would be inappropriate or were ineffective under the circumstances. Such orders shall be legible. Every person served medical record shall document medical contraindications to placement in four-point restraints.

G. Safety and clinical leadership of the hospital shall conduct Risk Management meetings each weekday morning to discuss the status of each person served who is currently being secluded and/or restrained, including any steps that can be taken to facilitate the release of such person served from seclusion and/or restraint.

H. No person served shall be kept in seclusion or restraint without being under the observation of a Specially Trained Observer (STO). Any person served placed in seclusion will be monitored on one-to-one observation by an STO for the first hour of seclusion. Thereafter, STO's will remain present in the area where the person served is secluded and will check each seclusion person served at least every ten (10) minutes for signs of respiration and other activity. STO's shall document their observations and make reports directly to the clinical staff as specified in this policy. A Person Served in seclusion may be monitored remotely under constant observation via Audio/Visual equipment if direct monitoring causes them distress or agitation, or if they obscure the window precluding direct observation. Remote monitoring may only be conducted if it is authorized by the Medical Director or designee, and this is documented in the medical record. The STO must be located so that they are within verbal contact of the person served at all times**.** All person served in restraints will be continuously observed by an STO**,** therefore, may not be monitored remotely via Audio/Visual equipment.

I. Any seclusion or restraint of a person served for more than eight (8) hours in any twenty-four (24) hour period must be authorized by the Superintendent, or a physician specifically designated to act in the absence of the Medical Director**.** Authorization that occurs in the absence of the Medical Director must be reviewed by the Medical Director upon their return to the Hospital.

J. Within twenty-four (24) hours after the conclusion of the seclusion or restraint event, the person served shall be afforded the opportunity to provide written comment on the circumstances leading to the use of seclusion or restraint and the manner of the seclusion or restraint utilized. The person served shall be provided a flex pen along with a copy of the initial seclusion or restraint order on which to comment prior to physical discharge from seclusion. Upon completion of any comments by the person served**,** the form shall be filed in the medical record.

K. All other documentation pertaining to a person served placed in seclusion and restraint shall be included in the person served's medical record.

L. There shall be no seclusion or restraint of a person served under the age of eighteen (18).

651.03 STAFF TRAINING

A. To minimize the use of restraint and seclusion, all staff shall be trained regarding:

1. Legal and clinical requirements for seclusion and restraint; de-escalation techniques; application and monitoring of seclusion and restraint and approaches to facilitate the earliest possible release from seclusion and restraint. BSH State Sentenced Units' staff who are correctional employees must demonstrate their competencies in such training.

2. The use of acute intervention strategies, which is trauma-informed and focuses on how to attempt to manage difficult person served behaviors on the housing units without transfer to seclusion or restraint.

3. The use of positive behavioral interventions for seclusion and restraint with a curriculum that includes:

    a. Identifying the impact of seclusion and restraint through the lens of the person served.
    b. Recognizing trauma and its impact on persons served.
    c. Creating cultural change by identifying and addressing the myths of mental illness.
    d. Case study review and hands on activities based on real stories.

B. In addition, staff shall not be allowed to be involved in the use of seclusion and restraint, unless they first receive training in, and demonstrate an understanding of

the following:

1. The underlying causes of threatening behaviors exhibited by the person served.

2. The fact that persons served sometimes exhibit aggressive behavior that is related to their medical condition and not related to their emotional condition.

3. How staff behavior can affect the behavior of the person served.

4. De-escalation, mediation, self-protection, and other techniques.

5. Signs of physical distress in persons served who are being restrained or secluded.

C. Correction officers and other correctional staff authorized to apply mechanical restraints or place persons served in seclusion shall be trained and demonstrate competence in the topics cited in 651.03(A)(1) above. These staff members shall also receive ongoing training in and demonstrate competence in the safe use of restraint and other use of force situations as well as the application and removal of all mechanical restraints, including but not limited to use of the Humane Restraint System, and the requirement that clinical staff check for medical contraindications prior to authorization of mechanical restraints. With regard to mechanical restraints, such correctional staff shall both receive refresher training and demonstrate their competency in mechanical restraint to the DOC on an annual basis, prior to such staff's placement of persons served in seclusion and/or restraint and/or in the monitoring and assessment of patients in and/or for release from seclusion and/or restraint.

651.04 QUALITY MONITORING AND IMPROVEMENT

A. **Commissioner's Review and Signature of Monthly Reports Regarding Seclusion and Restraint Records**

The Superintendent shall designate a person or persons who shall, on a monthly basis, prepare copies of all restraint and seclusion forms and any attachments that pertain to:

1. The reasons for the original use of restraint and/or seclusion, the reason for its continuation after each renewal, and the reason for its cessation.

2. The person served's post-restraint comments on the circumstances leading to the use of restraint and on the manner of restraint used.

These records shall be made available to the Commissioner or designee, along

with a Report prepared by the Superintendent's designee. This Report shall identify patients by their commitment numbers and shall include, at a minimum, data pertaining to multiple uses of seclusion or restraint on the same patient, lengthy instances of seclusion or restraint, and aggregate statistical data on the uses of restraint and seclusion for the preceding month. This Report shall be provided to the Commissioner, who shall review it along with any of the above records deemed necessary. The Commissioner shall sign this report within thirty (30) days of being provided it.