

## **Instructions for Completing Restraint Forms**

### **Section I. Preliminary Items from All Restraint Forms**

**(Required Fields are preceded by an asterisk \* on the Form)**

- 1. Individual's Name:** Enter name of person subject to restraint use.
- 2. Reporting Provider:** Enter name of provider agency implementing restraint.
- 3. DDS Area/Facility:** Enter name of associated DDS Area Office or Facility
- 4. Provider Location:** Enter address of provider site where restraint took place, or provider location responsible for supporting individual at the time of restraint.
- 5. Order Date:** Date restraint began
- 6. Type of Restraint Order:** for physical or mechanical restraints choose between the three, for chemical restraints, only choose Initial Order.

**6A. Initial** – The first order required for the emergency incident requiring restraint

**6B. Renewal** – After an Initial Order has expired (two hours after an order authorized by the Head of the Provider, or one hour after a staff designated by the Head of the Provider to authorize the restraint) and the emergency continues a restraint must be renewed. No Renewal Orders should be entered for restraints that were initially ordered for less than one or two hours. If the provider attempts a release of the restraint and it is demonstrated that the emergency continues, the restraint should continue and the clock on the duration of the initial restraint also continues. If the individual is released and calm enough to go back to their activity but a new emergency evolves, a new initial restraint order must be submitted. If there is a question about this in a specific situation, staff should consult clinical staff, or their supervisors.

**6C. Hold** – This is a designation for a pilot project tracking holds being implemented under the auspices of a behavior modification plan. Only those agencies volunteering to use this feature should enter holds. A hold is an intervention in a behavior modification plan that has a *treatment purpose* and therefore is exempted from emergency restraint reporting per 115 CMR 5.14 (4) (a) 1.

**7. Time of:** Enter times for the following milestone events;

**7A. Initial Restraint:** Enter time restraint initially applied (for chemical restraints include here on electronic form the time of administration; on paper back-up form, enter in chemical restraint section C9.)

**7B. Restraint Renewal:** Enter time renewal began when applicable to physical or mechanical restraints, see 6. b. above for definition.

**7C. Restraint Removal:** Enter time restraint ended. Do not document times for failed efforts to release the restraint, just the final ending time.

**8. Name of Staff Identifying Emergency:** Enter such name.

**9. Position of Staff Identifying Emergency–** After giving the name of the person who identified the restraint, please note the staff position this individual holds in the agency.

**10. Describe Emergency Situation:** Give details of what behavior or other observations led staff to conclusion that emergency existed. Please be specific and not vague. For instance, “individual threatened to hit consumer and put face up to the face of consumer” is descriptive; “individual aggressed” is too vague. Likewise, “exhibited SIB” may be too vague; “hit head hard against wall” is more helpful.

**11. Categorize Emergency Situation –** These are the categories of emergency situations due to which restraints must be implemented. There is a new category, where the behavior is not truly self-injurious behavior or assault, but the individual puts their self in a position of significant risk of physical harm. It is felt that this fills a gap in the prior categories. Please check off all that apply, but not more than apply.

**11A.** Substantial Risk of Serious Physical Assault

**11B.** Occurrence of Serious Physical Assault

**11C.** Substantial Risk of Serious Self-Injurious Behavior

**11D.** Individual Placed Self at Imminent Risk of Significant Physical Harm.

**11E.** Occurrence of Serious Self-Injurious Behavior

**12. Describe the Individual’s Behavior or Other Antecedents Before Emergency Situation –** Describe what was going on just prior to the emergency. Also, where available, describe the behaviors exhibited by the Individual leading up to the emergency situation that represent indicators leading to emergency behavior, or clues that could tell you that an emergency may be evolving. This could include events, conditions or changes to the individual’s environment that may have led the individual to becoming upset; or known circumstances that typically lead to emergencies. For example, “individual hung up phone on family member who he has been mad at.”

**13. Describe Less Restrictive Methods Used Prior to Restraint:** Document attempts to assist individual with less intrusive or restrictive supports once impending crisis becomes apparent. Also document the response to this effort.

**14. Did the Restraint Result in Physical Injury?** Please check either yes or no. It may be useful to get permission to check the individual before answering this question.

**15. Was an incident report filed for this incident?** Please indicate yes, or no, for this question. For every episode of restraint that meets the requirements of a category of incident, there must be a complimentary incident report filed.

**Section II. Section of Restraint Forms for Different Restraint Modes** (physical, mechanical or chemical):

**P. Physical Restraints:**

**P1. Describe How the Restraint Intervention Was implemented:** Describe how control was approached and obtained.

**P2. Check Position of Person Being Restrained During Restraint (Select all that apply):** Select from list given.

- A. Standing;
- B. Standing and Against Wall/Mat;
- C. Sitting;
- D. Lying Supine (on back);
- E. Lying on side;
- F. Lying prone (on Stomach);
- G. Escort (please remember that an escort is only a restraint when physical force was used over active resistance and the intervention is not part of a Level II or III Behavior Modification Plan);
- H. Other; If Other Describe:

**P3. Was mechanical or chemical restraint also used?** Check and fill out any applicable answers.

**P4. Has Plan to Respond to This Emergency Behavior Been Developed in ISP?** Check Yes or No and give any necessary explanation.

**P5. Describe Person's Behavior and Condition During Restraint and Safety Checks:** Was person continuing to struggle? Were they sweaty, or seriously laboring? Were they breathing freely? Was their face changing colors, or their skin clammy? Give any details that seem pertinent from observation. Indicate time of safety checks for any observation.

**P6. Reason for Permanent Removal –** The permanent removal of a restraint is the end of the restraint. While some times staff will attempt to release an individual from a restraint and it will be clear that an emergency continues to exist and the initial restraint will be reapplied. This is not a permanent removal, but the continuation of the initial restraint (see Section I, 6B. above). A permanent removal is when restraint is no longer needed, as noted by the individual's behavior, so the person is released from the restraint. Please detail factors leading to judgment to remove restraint.

**P7. Describe Behavior and Give Indicators of Individual's Condition After Restraint:** Detail behavior and any signs of physiological distress at end of restraint. Also summarize what individual did after restraint, such as: "went back to prior activity," "went to room and napped," or "went for walk with staff."

**P8. Print Names of Involved Parties:** Enter into the appropriate lines the names of persons filling the specific roles for:

**P8A. Authorizing Initial Restraint/Renewal;** Head of Provider (HOP), authorized physician, HOP designee or person delegated by the head of provider who formally authorized the initiation or renewal of restraint.

**P8B. Applying restraint;** the staff who participated in physically obtaining control of the individual.

**P8C. Specially Trained Monitor;** "staff in attendance" who observed individual being restrained for signs of distress. Staff in attendance may not apply the restraint while monitoring. At least once every 15 minutes someone not applying the restraint must monitor the individual's condition during the restraint. Staff in attendance is the regulatory name for this role.

**P8D. Authorizing Removal;** HOP, authorized physician, HOP designee, or person delegated by the head of provider to authorize restraint use, who authorized the removal of this restraint. An authorizer could also be a person involved in applying the restraint.

#### **M. Mechanical Restraint:**

**M1. Was Physical or Chemical Restraint Also Used?** Enter the appropriate responses as asked, yes or no, and if yes, what type, and at what time? If the answer is yes, you will need to fill out a restraint order for this event.

**M2. Type of Mechanical Restraint Used (Mitts only in the community absent a waiver from the DDS Office for Human Rights):** describe the mechanical device used.

**M3. Print Names of Involved Parties:** Enter into the appropriate lines the names of persons filling the specific roles for:

**M3A. Authorizing Initial Restraint/Renewal;** Head of Provider (HOP), authorized physician, HOP designee or person delegated by the head of provider who formally authorized the initiation or renewal of restraint.

**M3B. Applying Restraint;** person(s) involved in applying the device to/on the individual. If more staff involved note on form and document on back of form.

**M3C. Specially Trained Monitor;** "staff in attendance" who observes the individual's condition while individual is being restrained. Staff in attendance is the regulatory name for this role. Individual in mechanical restraint must be observed at least every 15 minutes, unless a staff in

attendance is not available. If not available, person can only be restrained for two hours and must be monitored every 5 minutes.

**M3D. Authorizing Removal;** Head of Provider (HOP), authorized physician, HOP designee or person delegated by the head of provider to authorize restraint use, who authorized the removal of the restraint.

**M4. Has Plan to Respond to This Emergency Behavior Been Developed in ISP?** Check the boxes that apply and give any necessary explanation.

**M5. Reason for Permanent Removal of Restraint:** Detail indicators of person's condition or behavior that led staff to determine it was safe to release restraint.

**M6. Describe Individual's Condition During Restraint and Safety Checks:** Give simple indicator's of condition at each point of observation during safety checks. Please note the time of the checks, as well as the condition and the name of the staff making observation.

**M7. Relief Periods:** Please give detail of any relief periods

#### **C. Chemical Restraint:**

**C1. Was mechanical or physical restraint also used?** Please complete as appropriate.

**C2. Involved Parties:** Fill in names of persons filling detailed roles, M.D. Ordering Medication, and Person Administering Medication. If physician present during chemical restraint, no one would be entered into section requiring name of "Person Obtaining Telephone Order," however, if M.D. not present, this will need to be filled in. When physician not present person administering and/or obtaining telephone order must be a registered nurse, nurse practitioner or certified physician assistant and must be present during the emergency to examine the individual.

**C3. Individual's Current Medication Orders per ISP:** Detail all medication orders currently used in ISP.

**C4. Special Instructions (Including Significant Medical Problems):** Give details of special instructions of physician authorizing use of medication for chemical restraint, i.e. monitoring breathing, heart rate, etc., whatever is appropriate to the medication used. This should include information regarding instructions derived from care and treatment of particular medical conditions or problems of individual.

**C5. Has Plan to Respond to This Emergency Behavior Been Developed in ISP?** Please fill in boxes as appropriate and provide explanations, if needed.

**C6. Name of Medication Used:** Give details as requested. Electronic form will provide drop down list of Mass Health approved medications to choose from.

**C7. Dosage:** Give information on dosage of medication as given

**C8. Route:** Detail route of medication given, i.e. oral, intramuscular injection, etc.

**C9. Time of Administration:** Time medication given to individual in crisis.

**C10. Describe Person's Condition at Time Intervals Ordered by M.D.:** For each time interval identified by physician as necessary for observation of individual, give simple indicator of effects of medication on behavior of individual and individual's condition. Examples could include "still agitated and trying to assault staff," "slowing down, a bit groggy" or "sedated and sleeping." Also, record time and name of staff performing observation/monitoring.

### **Section III. All Restraints - Interview of the Individual:**

**Interview of the Individual:** For all types of restraint please interview individual to obtain comments about their feelings about the restraint, and any indications of injury or distress from experience. Staff comments section should only be filled out if individual is not capable of commenting, declines comment, or if ISP team has identified in the ISP that to interview this individual would be contraindicated. The staff's comment section would be a proper place to document this. Staff should reflect on their interpretation of individual's response to restraint and whether they indicate any insights of the individual regarding restraint experience. Please note that any person who applied the restraint is usually not the right person to perform this interview.

### **Section IV. All Restraints - Finalizing Initial Report:**

- 1. Signature of Person Completing Initial Form:** Signature of designated person.
- 2. Date:** Date of submission of initial form to Restraint Manager

### **Section V. All Restraints - Reviews:**

**Restraint Manager (HOP) Review and Comment:** This adopts the HCSIS Role reflecting the DDS regulatory requirement for the Head of Provider review, which must be delegated to a person with executive authority at a site or the agency. This review should focus on any explanations necessary, including when the restraint manager identifies that some aspect of the restraint did not meet regulatory or policy standards. If needed, restraint manager could anticipate changes to practice to prevent recurrence of lack of compliance.

**A. To The Best Of Your Knowledge, Were All Procedures And Protocols Followed For This Restraint Action?** In your best judgment and knowledge did restraint incident and response of agency follow all required procedures and protocols of agency and DDS regulations in 115 CMR 5.11?

**B. If No, areas where this Restraint Action needs improvement (select one or more):**

- ☐ Authorization of restraint    ☐ Renewal Order  
☐ Monitoring of restraint    ☐ Restraint training of staff  
☐ Physical examination of person restrained  
☐ Other    (please describe in Comment Section)

This section will help detail areas that Restraint Manager believes could use improvement. The category of “Other” could be used for specific issues the manager finds, such as concern about whether an emergency existed, or less restrictive measures that should have been given a chance to work.

**C. Comment or Explanation:** Explain any variance from regulation, policies, or individual treatment program, or issues that came up that warrant further explanation. In addition, any exceptional performance, including positive interactions that are evidenced in the restraint report could be reported here. The follow-up needed due to this occurrence, or concerns about the on-going needs of the individual could also be documented here. This section gives the restraint manager an opportunity to explain these types of irregularities and give insight as to how they may be prevented from reoccurrence, or to advocate for the individual’s needs.

**D. Date of Review:** Date review is completed.

**E. Signature:** Signature of person serving as Restraint Manager/HOP.

**Service Coordinator/Area Office – QMRP/Facility Review and Comment:** Depending upon whether restraint takes place in community or DDS facility setting, local DDS personnel should evaluate the restraint and determine if follow up action is needed.

**A. Complete?** In judgment of DDS personnel is the record complete.

**B. If No, Give Reason:** List given for response to this question, check all that apply.

**C. Once Status is “Complete,” please review below:** Enter observations about the proper responses of staff involved Restraint Definitions for

HCSIS06130may.docor the needs for additional team meetings or other follow-up required by incident or by needs of individual.

**D. Date Received by DDS:** Enter proper date.

**E. Date of Area/Facility Review:** Enter proper date for this event.

**F. Signature for Area/Facility Review:** Proper official should sign form.

**Human Rights Committee Review and Comment:** HRC of provider agency should indicate any comments, recommendations for follow-up needed, or concerns regarding restraint.

**Commissioner's Review and Comments:** Human Rights Specialist shall submit comments or concerns regarding restraint. Please contact Area Office/Facility and Provider before finalizing comments.

#### **Section VI: Closing the Record:**

**Date Closed:** Date restraint document completed and closed because all reviews are completed, or the HRC comments are completed and 120 days have expired since date of restraint.

**Closed by:** Signature of person closing restraint record.