RESTRICTIVE MEASURES - - RIGHT TO BE FREE FROM

THE LAW

"...[patients] have a right to be **free from physical restraint and isolation except** for **emergency situations** or when isolation or restraint is a part of a **treatment program**. Isolation or restraint may be used **only when less restrictive measures are ineffective or not feasible** and shall be used for the **shortest time possible**. When a patient is placed in isolation or restraint, his or her status shall be **reviewed once every 30 minutes**. Each facility shall have a written policy covering the use of restraint or isolation which ensures that the dignity of the individual is protected, that the **safety** of the individual is ensured and that there is **regular, frequent monitoring** by trained staff to **care for bodily needs** as may be required.

Isolation or restraint may be used for **emergency situations** only when **it is likely that the patient may physically harm himself or herself or others**. The treatment director shall specifically designate physicians who are authorized to order isolation or restraint, and shall specifically designate licensed psychologists who are authorized to order isolation. If the treatment director is not a physician, the medical director shall make the designation... The **authorization for emergency use of isolation or restraint shall be in writing**, except that isolation or restraint may be authorized in emergencies for not more than one hour, after which time an appropriate order in writing shall be obtained from the physician or licensed psychologist designated by the director, in the case of isolation, or the physician so designated in the case of restraint. Emergency isolation or restraint may not be continued for more than 24 hours without a new written order.

Isolation may be used as part of a **treatment program** if it is part of a written treatment plan, and the rights specified in this subsection are provided to the patient. The use of isolation as a part of a treatment plan **shall be explained to the patient** and to his or her guardian, if any, by the person who provides the treatment. A treatment plan that incorporates isolation shall be **evaluated** at least once every 2 weeks.

Patients who have a **recent history of physical aggression** may be **restrained during transport** to or from the facility. Persons who are committed or transferred under s. 51.35(3) or 51.37 or under ch. 971 or 975, or who are detained or committed under ch. 980, and who, while under this status, are transferred to a **hospital**, as defined in s. 50.33(2), for medical care **may be isolated for security reasons within locked facilities** in the hospital. Patients who are committed or transferred under s. 51.35(3) or 51.37 or under ch. 971 or 975, or who are detained or committed under ch. 980, may be **restrained for security reasons during transport** to or from the facility.

§ 51.61(1)(i)1, Wis. Stats. [Emphasis added.]

[NOTE: Sec. 51.61(1)(i) allows use of **"isolation"** in only two circumstances--for emergencies or as part of a written treatment program. For greater clarity, the term **"seclusion"** is used to refer to the **emergency use** of isolation and the term **"time-out"** for the use of isolation as part of a written approved **treatment program**.]

"'**Isolation**' means any process by which a person is physically or socially **set apart** by staff from others but does **not include separation** for the purpose of **controlling contagious disease**." DHS 94.02(26), Wis. Admin. Code [Emphasis added.]

"ISOLATION, SECLUSION AND PHYSICAL RESTRAINTS. **Any service provider** using isolation, seclusion or physical restraints shall have **written policies** that meet the requirements of s. 51.61(1)(i), Stats., and this chapter. Isolation, seclusion or physical restraint may only be used in an **emergency**, when part of a **treatment program** or as provided in s. 51.61(1)(i)2., Stats. For a **community placement**, the use of isolation, seclusion or physical restraint shall be specifically **approved** by the department on a case-by-case basis and by the **county department** if the county department has authorized the community placement. In granting approval, a **determination** shall be made that use is **necessary** for continued community placement of the individual and that **supports and safeguards** necessary for the individual **are in place**."
DHS 94.10, Wis. Admin. Code [Emphasis added.]

"'**Emergency**' means that is **likely** that the patient may **physically harm** himself or herself or others." DHS 94.02(13), Wis. Admin. Code [Emphasis added.]

"1.Each inpatient shall have **unscheduled access to a working flush toilet and sink**, except when the patient is in **seclusion** or for security reasons or when medically contraindicated...

3. Every patient in isolation or seclusion shall be provided an **opportunity for access to a toilet** at least every **30 minutes**."
DHS 94.24(2)(i), Wis. Admin. Code [Emphasis added.]

DECISIONS

1. A patient at a county psychiatric hospital **complained about a seclusion incident**. He raised issue about whether there was **justification for the initial use of seclusion** and whether he was **released in a prompt and timely manner**. There was a discrepancy between a verbal report of one staff and the documentation form that was completed while he was in seclusion. In the Level I grievance decision, the Client Rights Specialist (CRS) made a suggestion that staff more carefully document anything of concern that may be displayed while a patient is in seclusion. The **improvements in documentation** made by the hospital in response to his complaint were noted. The patient **withdrew his complaint** at Level III. (Level III decision in Case No. 00-SGE-13 on 8/2/00.)

2. A patient being emergency detained complained about **being shackled by the sheriff officers during transport**. This is their standard practice. The grievance process has **no jurisdiction over the actions of law enforcement agencies**. (Level III decision in Case No. 00-SGE-04 on 4/9/01)

3. A client had used an **enclosed canopy bed** (manufactured and labeled as a "Vail 1000" bed) for several years for sleeping at night, occasional naps during the day, and as a platform for some personal cares. After an extensive review of the client's situation, it was concluded that **this particular canopy bed was appropriate and safe** for her use. Though technically a **restrictive measure**, it was found that the bed was the **least restrictive alternative to ensure her safety** while allowing her to get the sleep she needed. Therefore, the state and county decisions to discontinue their approval of the use of her Vail 1000 bed was a **violation** of the client's right to a **safe and humane environment** and an **arbitrary decision** because it **was not individualized** to this client's **exceptional safety needs and her unique situation**. This decision **does not set precedent for all Vail beds** or other canopy beds, but only for the bed as it was being used in this specific instance. Thus, the precedent is not binding for other provider agencies or other clients. (Level III decision in Case No. 07-SGE-03 on 12/19/07)

4. A patient complained about a restraint incident that occurred on an inpatient psychiatric unit. Based on the documentation, which indicated that he was combative at the time and his behavior escalated the situation, it was concluded that **staff did not use excessive force or abuse him.** His statements at the time and his stabbing motion with the pen indicated that he posed an imminent risk of harm to others. While staff must use the least amount of force necessary to physically stabilize or escort a patient who engages in dangerous behavior, the evidence did not indicate the restraint use was excessive or abusive in this instance. (Level III Decision in Case No. 08-SGE-11 on 2/23/10)

5. **Following an incident of restraint and seclusion**, a **prompt medical assessment** of the patient should always occur. (Level III Decision in Case No. 08-SGE-11 on 2/23/10)

6. After it was found that an inpatient psych unit did not adequately address a patient's needs after a restraint episode, it was **recommended** that the provider amend their policy to **include a "trauma informed" debriefing** with patients after the use of restraints, seclusion or the use of involuntary medication. This should include: 1) an immediate **'post-event' debriefing** that is done onsite and is led by the senior on-site supervisor (the goal being to assure that everyone is safe, that documentation is sufficient to be helpful for later analysis, and to check with all involved to gather information and return the milieu to pre-event status); and, 2) an **analysis** that occurs one to several days following the event and includes attendance by the involved staff, the treatment team, and perhaps a representative from administration (it is essential that the patient is involved in all debriefing activities by person or by proxy). It was also recommended that a **proactive intervention plan, or 'de-escalation preference**

survey' or 'individual crisis prevention plan' be developed, with input from the patient and staff. It should be personalized to capture the patient's unique history, strengths, vulnerabilities, needs, and preferences. This plan should minimally include triggers or 'threat cues' that could cause the patient to get upset, angry, aggressive, etc., and warning signs or physical precursors to escalation (i.e., bodily changes that indicate increased agitation). (Level III Decision in Case No. 08-SGE-11 on 2/23/10)

[See: "Introduction to Digest-Date Last Updated" page]