RESPONDING TO ILLEGAL RESTRAINT

Beth Mitchell
Supervising Attorney

Disability Rights Texas

Liz Logsdon
Managing Attorney

Disability Rights California

2020 NDRN CONFERENCE

Topics to Cover

- What Is an Illegal Restraint?
  - Federal Law
  - State Law
- Uncovering Illegal Restraint
- Responding to Illegal Restraint
  - Recommendations
  - Administrative Complaints
  - Public Reports

What Is an Illegal Restraint?

Federal Law

- Federal Law Controls if it provides More Protection
- Look for the State Operations Manual - Survey Protocol, Regulations and Interpretive Guidelines. Usually an Appendix
- Requires Order before or within minutes after the restraint
- Need separate Order for physical hold and emergency medication
- Release once the unsafe situation ends
- If the overall effect of a medication is to reduce the patient's ability to effectively or appropriately interact with the world around the patient, then the drug or medication is **not** being used as a standard treatment or dosage for the patient's condition.

State Law

- Like federal law, statutes and regulations govern use of restraint
- Can often be located by focusing on type of facility
- In CA, vast majority in California Code of Regulations – find appropriate Title for type of facility in question

Things to Look for in State Law

- State laws often provide additional protections
- Prohibitions on prone or supine restraint
- Example: ICF
  - Federal regulation requires checks every 30 minutes
  - CA regulation for “habilitative” ICF requires checks every 15 minutes

Uncovering Illegal Restraint

Monitoring & Records

- Monitoring
  - Hanging out at facilities
  - Talking with staff/clients
  - Talking to family

- Records
  - Don’t review records for one issue
  - Ask for restraint data at the facility
  - Ask for CMS 2567

What to Review

- Immediately request to preserve video
- Client records
  - Doctor orders (or other LPA) and notes
  - Restraint/seclusion logs
  - Nursing notes
  - PNA notes
  - MARS
  - Staff training logs
- Investigatory reports via P&A
  - Abuse/neglect agency, JACHO, peer review
- Interviews – client, other residents, staff, EBI trainer
- Facility policy, procedures, and EBI training
- Autopsy reports
- Staff personnel/credentialing files

Media

- Example: highly publicized death in restraint chair in county jail
- One highly publicized event means there are likely many more – opportunity to initiate monitoring project, probable cause determination, facility investigation, etc.

Verification Code # 1 for Attorney CLE Credit

_____

For attorneys who wish to be credited with attending this session for Continuing Legal Education (CLE) purposes, **send verification codes # 1 and # 2 along with the name of this session to NDRNvirtualCLE@ndrn.org within 12 hours of completion of this session.**

Please see the conference website for full information regarding CLE credit.

Scenario

Client, who is noticeably pregnant, approaches a female staff in what appears like an attempted attack mode. Immediately, several staff members converge on the client and intervene between Client and the female staff. A male staff puts Client in a personal hold for about 1.5 minutes during which time Client is upset, struggling, and cursing. While in the personal restraint a mechanical chair is brought into the hallway and staff attempt to restrain the client into the chair. At this point, Client intensifies her efforts to get loose from the personal hold and is spitting at staff, verbally aggressive and threatening. When the Client realizes her efforts are fruitless she cooperates with putting her feet and arms in the chair restraint. The client is restrained in the chair and taken to a private room.

The doctor's order for the physical and mechanical restraint states: "attacking staff, threatening to hit staff, using foul verbal curse words, saying male staff raping her."

At 12:05 pm Client is still upset/angry, but she calmly takes her right arm out of the restraint strap to wipe spit off her face and brush her hair out of her face. Client then puts her hand back in the strap. Staff witness this and two female staff members come into the room to secure her arms straps tightly to prevent her from taking her hands out of the restrain straps again. At this point, she spits in the direction of one of the staff. Staff leave the room and the Client continues to yell, spit and threaten staff while confined to the restraint chair until 12:18 pm when she is given involuntary medication which she cooperates with the administration of the injection.

For the medication order, the doctor's order states: "aggressive behaviors, spitting at staff, attacking staff, threatening to hit staff, using foul verbal curse words, saying male staff raping her.

At 12:30 the Client begins throwing up several times over herself. Staff come in and provide a trash bin which they hold to the client's mouth as she continues to throw up. Client is cooperative when staff then take off the Client's vomit-soaked top while still strapped in the chair. Staff leave the room, and the client is seen rocking, talking incoherently, yelling, cursing. The client becomes calm and is finally released at 1:45 pm.

Responding to Illegal Restraint

Recommendations

- Changes to policy and practice
  - To conform to state and federal laws
  - Changes in forms
- Improved training
  - Initiating restraint
  - Applying/monitoring restraint
- Audits of future restraints
- Confirmed abuse/neglect or systems issue
- Firing/counseling staff

Administrative Complaints

CMS Complaint – Standing Order for Restraint

Kenneth is a teenage boy with autism. He was sent to an acute care hospital on a psychiatric hold where a physician entered a standing order for four-point restraints to be renewed every 24 hours (rather than every two hours as per CMS regulations). He had successfully lived without restraints in the past. DRC staff visited Kenneth and he presented as calm. Kenneth was restrained like this for approximately two months until he was transferred to another facility.

The hospital insisted they were in compliance with CMS regulations. DRC filed a CMS complaint on Kenneth's behalf and upon completion of the investigation CMS confirmed "non-compliance identified with investigation."

Administrative Complaints

State Licensure – Restraint as Abuse

- Lack of injury or excessive force
  - Staff took client to the ground in a prone position. Died. Autopsy report showed blunt force trauma to spleen, no positional asphyxiation.
- P&A and Texas definition of abuse
  - Contains three enumerated, disjunctive definitions, one which does not require injury or excessive force
    - The use of chemical or bodily restraints on a person served not in compliance with federal and state laws and regulations
- Appealed investigatory agency finding of unconfirmed
  - Staff confirmed for abuse, placed on employee misconduct registry, and cannot be employed in a state run facility

Administrative Complaints

Facility Grievance – Handcuffs as Restraint

- Client taken to the emergency room by police under an emergency detention order. Handcuffed to a bench in the waiting room due to aggression. Doctor orders emergency medications at 9:15 am, staff administers the medications while still handcuffed at 9:30 am
  - Between the time of the order and the administration of the medication, the hospital gave the client a glass of water, placed a wristband on the client, and gave the client a pair of slippers – at no time did the client become aggressive
- Complaint to facility
  - Facility will no longer administer emergency psychiatric (IM or PO) medications to patients in handcuffs
  - Changes to policies and procedures related to timing and justification for emergency medications
  - Staff trained on all new policies, procedures, and order forms concerning emergency medication

Administrative Complaints

State Abuse/Neglect Investigatory Agency

- Client at SSCL has a behavior plan that allows the use of blocking pads when the Client becomes aggressive, self-injurious, or tries to make an unauthorized departure. Client was eating at the kitchen table. Client urinated on herself and was beginning to smell. Staff asked Client to go to the restroom, the Client refused and started moving to the living room. Two staff members used the blocking pads to force the Client away from the living room and into the bathroom.

- *"any device* attached or ***adjacent to an individual's body*** *that he or she cannot easily remove* ***that restricts freedom of movement*** *or normal access to his or her body."*

- Appealed APS finding:
  - In-services were completed on the unit for appropriate use of blocking pads, storage of blocking pads, and staff adherence to PBSP instructions with client
  - Staff terminated

Verification Code # 2 for Attorney CLE Credit

_____

For attorneys who wish to be credited with attending this session for Continuing Legal Education (CLE) purposes, **send verification codes # 1 and # 2 along with the name of this session to NDRNvirtualCLE@ndrn.org within 12 hours of completion of this session.**

Please see the conference website for full information regarding CLE credit.

Public Report

Restraint chairs in county jails

- Extensive request for policies from each county
- Review state regulations
- Monitoring visits to three different jails
- Retention of expert to review policies and assist in development of recommendations
- Invitation to join Board of State and Community Corrections working group to revise state regulations

Questions

Thank You!

Beth Mitchell
Disability Rights Texas
BMitchell@disabilityrightstx.org

Liz Logsdon
Disability Rights California
Liz.Logsdon@disabilityrightsca.org