South Carolina Department of Corrections

SCDC POLICY

NUMBER: HS-19.08

TITLE: MENTAL HEALTH SERVICES - CLINICAL USE OF RESTRAINTS FOR MENTAL HEALTH PURPOSES

ISSUE DATE: June 1, 2016

RESPONSIBLE AUTHORITY: DIVISION OF MENTAL HEALTH SERVICES

OPERATIONS MANUAL: HEALTH SERVICES

SUPERSEDES: SCDC POLICY HS-19.02 (dated July 1, 2008) - NEW POLICY

RELEVANT SCDC FORMS/SUPPLIES: 19-11, 19-29, 19-45, 21-6, M-53, M-122, M-123, M-131, M-132, M-140 Attachments A, B, and C

ACA/CAC STANDARDS: 4-ACRS-5A-08, 4-ACRS-6A-11, 4-ACRS-7D-07, 4-4095, 4-4098, 4-4099, 4-4256, 4-4277, 4-4285, 4-4286, 4-4305, 3-4330, 334336, 3-4344, 3-4350, 3-4355, 3-4367, 3-4369, 3-4377, 4-4428, 4-4429, 4-4430, 4-4431, 4-4433, 4-4434, 4-4435, 4-4436, 4-4438, 4-4439, 4-4440, 4-4441, 4-4442, 4-4446

STATE/FEDERAL STATUTES: None

PURPOSE: SCDC to support the physical and emotional safety of inmates who require use of restraints for clinically determined reasons. Clinical use of restraints should occur only when there is an imminent danger that the inmate may harm himself and/or others, and no less restrictive alternative is likely to be effective in managing the risk of harm. The use of restraints is never to be used as punishment and will be used for the minimum time possible to manage the situation safely.

POLICY STATEMENT: It is the policy of the Department that inmates can be placed in clinical restraints when it is deemed necessary for mental health management/safety purposes. Clinical restraints will only be used after all lesser alternatives have proven to be ineffective. Any use of clinical restraints will be supported by appropriate documented clinical justification that use was in accordance

with accepted professional standards. Unless otherwise noted, policy information is applicable to both male and female inmates.

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SPECIFIC PROCEDURES:

1. GUIDELINES:

1.1 Conditions for placing an inmate in clinical restraints include at least one of the following:

- the inmate poses serious risk of self-harm or harm to others by actual or threatened behavior;
- the inmate inflicts injury upon self or others;
- the inmate becomes violent or displays signs of imminent violence that may cause harm to self and/or others; or
- other less restrictive interventions are not effective or appropriate to control the risk of the situation

1.2 When an inmate has been identified as an immediate threat of harm to self or others, mental health staff (Psychiatrist, Psychologist, other QMHP, Psychiatric Nurse Practitioner, or Psychiatric Nurse) must be notified to conduct an immediate assessment of the inmate and make recommendations.

1.3 After hours, the on-call QMHP should be contacted. If no QMHP is on-site, an on-site QHP (i.e., Physician, mid-level Practitioner, nurse) will assess the situation and contact the on-call QMHP for consultation. However, in a non-emergent situation, the only person who can initiate restraints is a nurse on orders from a physician. In an emergent situation, a correctional officer may initiate restraints, but a nurse must attempt to obtain orders as soon as possible from a Physician authorizing the restraints.

1.4 Every effort will be made by security and clinical staff to de-escalate the inmate.

1.5 Appropriate use of medication can be considered to assist in managing the inmate.

1.6 A Psychiatrist or other privileged QHP must provide a written or verbal order for the use of clinical restraints. A Psychiatrist will be consulted as soon as possible if the initiation of the restraint process was done by a practitioner who is not a Psychiatrist.

1.7 The dignity and well-being of the inmate shall be preserved at all times during the period of restraint.

2. DOCUMENTATON AND PROCEDURES:

2.1 An order must accompany every use of clinical restraint(s). At a minimum a verbal order must be obtained within one (1) hour of initiation of use of restraints.

2.2 Documentation should include: date and time, duration of the order, purpose of or reason for the order, and release criteria.

2.3 A physician must sign verbal orders no later than the next business day.

2.4 Orders for restraints cannot be written as standing orders or on an as needed basis. Initial restraint orders can be written for a period of no longer than four (4) hours. An inmate should not be restrained any longer than is clinically necessary (restraint should be discontinued once the inmate meets the criteria for release). A face-to-face interview by a clinician privileged to conduct that assessment (this may include RN privileged to do so) must be completed within four (4) hours. Orders may be renewed for up to four (4) hours with a face-to-face assessment by a clinician privileged to order restraints required at a minimum of every 24 hours. The four (4) hour assessments between the ordering clinician's on-site assessments may continue to be done by a nurse privileged to do so as long as phone consultation with a Psychiatrist concerning the decision to continue restraints is documented.

2.5 The medical record of any inmate placed in restraints must be reviewed by a nurse or physician prior to the use of restraints or promptly after any emergency use of restraints, in order to determine if there is a contraindication to use of restraints (i.e., morbid obesity, known history of cardiac or respiratory disease, history of spinal injury, amputee, fractured or injured extremity, recent history of emesis, pregnancy, seizure disorder, or history of DVT). Identification of a contraindication requires that restraints not be utilized or be removed and an alternative management plan be implemented.

2.6 Inmates shall be placed on their backs when four point restraints are applied unless clinically contraindicated.

2.7 A nurse will assess the inmate immediately upon placement in restraints and every hour, or more often if clinically indicated, after the inmate is placed in clinical restraints. Nursing staff will check the restraints for rubbing and excessive looseness or tightness to ensure proper circulation is maintained. A restraint note will be made in the AMR record to include the inmate's condition, behavior and monitoring activities.

2.8 QMHPs assessing the situation will determine if admission to GPH is warranted. If admission is warranted the inmate will be transported when it is safe to do and will be placed on CI status and kept under constant observation until moved.

2.8.1 Type of Restraints:

- Four point restraints: can be used at GPH; must be of soft type (leather/cloth) fabric to prevent unnecessary risk of injury to the inmate;
- Restraint chair: may be used as an alternative to four point restraints within institutions where the chair is available, but all restraints must be in a healthcare setting.

2.8.2 Observation while in Restraints:

- Staff will provide continuous observation for any inmate in clinical restraints. In-person observation is required. If video monitoring is utilized it will be in addition to in-person monitoring and any video recordings will be preserved for 30 days.
- The in-person observer will document their observations every 15 minutes and this will continue until all restraints are removed.
- The inmate will be allowed to exercise each limb at least every two (2) hours. One limb will be released at a time and placed back in restraint before the next limb is released.
- The restrained inmate will be offered water and allowed use of the bathroom at a minimum of every two hours. These activities will be documented.
- Meals will be served on a schedule that approximates that for other inmates. The restrained inmate will be provided with any necessary assistance with eating and will be fed in a position with the head elevated.
- The inmate will remain clothed while restrained. If the inmate is on crisis intervention or has removed his/her clothing, a blanket will be provided to use for cover once the inmate is safely restrained. Attention will be paid to room temperature to assure the inmate is neither too hot nor too cold while in restraints.

2.8.3 Mental Health Assessments:

- Nursing staff will assess the inmate hourly and document in the AMR the inmate's mental status and any recommendations based on behaviors observed. A face-to-face interview by a clinician privileged to conduct that assessment (this may include RN privileged to do so) must be completed at least every four (4) hours. Orders may be renewed for up to four (4) hours with a face-to-face assessment by a clinician privileged to order restraints required at a minimum of every 24 hours. The four (4) hour assessments between the ordering clinician's on-site assessments may continue to be done by a nurse privileged to do so as long as phone consultation with a psychiatrist concerning the decision to continue restraints is documented.
- The Treatment Plan will address criteria for getting out of restraints and the inmate must be informed of these criteria. The criteria will focus on resolution of the reason for being placed in restraints. Once the criteria has been met, the inmate will be released from restraints.

2.8.4 Release from Restraints:

- The nursing staff or any QMHP may make recommendations for an inmate to be released from restraints. Information provided by any staff member will be considered in the decision-making process.
- Upon release, the inmate will remain under constant visual observation for at least thirty minutes to monitor for continued appropriate and safe behavior.
- Once the inmate is released from restraints, a face-to-face mental health assessment will be conducted by a QHP (i.e., Psychiatrist, Psychologist, Physician Assistant or Nurse Practitioner) on the next business day or sooner if clinically indicated.

2.8.5 Training:

- All staff will be appropriately trained before participating in clinically restraining an inmate. Training shall be relevant to the individual's role in the process of using clinical restraints.

2.8.6 Audit:

- Data on frequency and efficacy of use of restraints will be collected monthly as part of the CQM program.

3. DEFINITION(S):

Medical Restraint Chair refers to a chair equipped with soft restraints which is utilized when needed for inmates housed in the Self Injurious Behavior Unit and Gilliam Psychiatric Hospital (GPH).

Qualified Healthcare Practitioner (QHP) refers to a Physician, Physician's Assistant, or Nurse Practitioner.

Qualified Mental Health Professional (QMHP) refers to a Psychiatrist, licensed Psychologist, licensed Professional Counselor, licensed Professional Counselor-Supervisor, licensed Independent Social Worker, licensed Marital and Family Therapist (LMFT), or Psychiatric Nurse Practitioner. It also includes a licensed Master Social Worker and licensed Professional Counselor-Intern, and LMFT-Intern with appropriate supervision.

Soft Restraints refers to soft restraints SCDC possesses and maintains for those individuals identified by Physicians who indicate hard restraints could cause physical injury to a brittle patient, a pregnant patient, or a patient that may be suffering from a condition (i.e., Steven Johnson disease, that may worsen the inmate's condition). In such cases, the attending physician must issue an opinion indicating whether soft restraints are an option or if the inmate must remain restraints free.

SIGNATURE ON FILE

s/Bryan P. Stirling, Director

Date of Signature

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