Institute for Safe Environments Workgroup
Study Guide for Competency Based Training for Conducting the One Hour Face to Face Assessment of a Patient in Restraints or Seclusion

This study guide is to be used as a preview and/or concurrently with the APNA module. Each section includes a summary outline and may contain suggestions for further education or skill demonstration beyond this program.

When seclusion and restraint are utilized a required one hour face-to-face assessment must be performed by a licensed independent practitioner, physician’s assistant or a registered nurse. Use of the RN or PA is a change in the regulatory status occurring in 2006, therefore the registered nurse needs to be competent to perform the assessment of the patient in seclusion and restraint (Kontio, Valimaki, Putkonen, et al, 2009). In considering the components of the one hour face-to-face assessment the group charged with drafting this study guide used as their starting point the paper presented by Marlene Nadler-Moodie at the 21st annual APNA conference (Nadler-Moodie, 2007; Nadler-Moodie, 2009). In her presentation titled “Clinical Practice Guideline: One Hour Face-to-Face Assessment,” Nadler-Moodie pointed out the absence of specific parameters on what exactly constitutes “face to face assessment” but she identified four key elements of evaluation that were thought to be crucial. The Competency Based Training group used these four elements as a framework to develop discussion on the content of proposed competency based training relating to the one hour face-to-face assessment.

The four recommended elements were:

1. Physical risk of loss of life.
2. Physical dangers and discomforts.
3. Psychological state and mental status exam.
4. Legal and ethical considerations.

The content of each element was explored in relation to consideration of the justification for including the element within a one hour face-to-face assessment. If an element is included in the one hour face-to-face assessment, the appropriate use of that element for assessment would have to be taught within a system of competency based training.

The justification for the content of each of these four elements is explored along with the identification of possible teaching content themes and means of assessment for competency based training.

1. Physical Risk of Loss of Life

A number of life threatening risks were identified.

i) Asphyxia
Paterson et al (2003) refer to three possible means by which any mechanical device may contribute to death by asphyxiation. These are:

- The mechanical device itself strangulates
- Mechanical device causes thoracic and abdominal compression
- Compression of thorax and or abdomen caused by the position the client is placed in.

Increased risk associated with mechanical devices is also related to: obesity in clients; whether or not the client is physically unhealthy; the use of devices that may block the airway; the position used with the client; and the potential for suffocation caused by obstruction of nose and mouth simultaneously.

Some compelling research evidence justifies the importance of including the threat of asphyxiation in the one hour face-to-face assessment. Evans, et al (2003) discussed asphyxiation in persons strangulated by the device itself, such as vest restraints and bedrails. Paterson et al (2003) discuss how some deaths from restraint were shown to have been related to physical pressure to the neck. Paterson et al (2003) refer to earlier work by Reay & Eisle (1982), that provided evidence that when physical pressure is applied to the neck (in situations not unlike martial arts holds), there could be pressure to the carotid arteries, leading to unconsciousness, with a risk of death. Ball (2005), in an editorial in The Psychiatrist provided information regarding the death of a patient from “extreme exertion and pressure applied by the restraining nurses”, after being held in the prone position for 25 minutes. In a more recent example when completing a review as to the causation of death in an elderly person while restrained, Karger et al (2008) found cause of death to include mechanical asphyxia from strangulation or compression to the thorax/abdomen.

Parkes (2008) addresses the role that positional restraining plays in reduction in lung functioning whilst Paterson, et al (2003) described the significance of respiratory difficulty related to a variety of positions used in the restraint process. One such restraint related to this problem is the procedure known as “hobble-tying”, where the person is placed prone, and hands are secured behind the back, followed by the ankles and wrists being secured to each other. This was noted to place a person at risk for positional asphyxia because it interferes with pulmonary exchange: first the shoulders being pulled back causing the chest wall to hyper-extend, reducing the ability of the chest wall to expand and deflate; second, being face down could prevent the diaphragm from contracting, preventing the negative pressure needed for inspiration (this is more likely if person is obese).

Another position of concern noted by Paterson et al (2003) is placing a person in the seated restraint position in which the upper torso is bent forward, severely compromising respirations (basket hold).

Evans, et al (2003) discusses the importance in ensuring that there is no obstruction within the upper and lower airways, and that respirations are free flowing. The need for appropriate ventilation is dependent on a number of factors, including; an active central nervous system; the ability for the rib cage to expand; and the ability for the diaphragm to descend (negative intrathoracic pressure producing inspiration).
ii) Agitated Delirium

Paterson, et al (2003) investigated unexpected deaths that occur in persons with a phenomenon referred to as agitated delirium, or excited delirium. The hypothesis is that an individual in an agitated delirium will struggle in the restraints until they either collapse or die, (it is believed that this condition may be fatal even if no restraints are used). In support of agitated delirium being a risk factor to be considered when conducting the one hour face to face interview, Pollanen et al (1998) did a case review and found that in 21 unexpected deaths associated with excited delirium. The deaths were held to be complications associated with restraints, the prone position, or pressure to the neck. Excited delirium was thought to be caused by psychiatric disorders and/or cocaine-induced psychosis.

The mechanism involved in this agitated process is hypothesized as resulting from the person with mental illness initially perceiving the self to be in great danger. This manifests as physiological changes such as catecholamine stress to the heart. When the person is restrained during this stressful time individuals are likely to continue to struggle against the restraints. This struggle will continue (since pain perception is altered) until the person collapses or dies.

Farnham and Kennedy (1997) recognized that other conditions increase the likelihood of collapse or death in such situations. These pre-existing conditions include obesity, impaired heart and lung function such as cardiac disease, asthma, and bronchitis. It was also reported that cocaine has been present in significant number of reports of excited delirium deaths.

iii) Cardiac Failure

Hick, et al (1999) discussed how metabolic acidosis can lead to cardiac arrest in restrained clients. In the case review it was noted that severe metabolic acidosis was a contributing factor in restraint associated death. Acidosis is associated with significant negative cardiovascular effects including arrhythmias and autonomic instability. Yet these findings must be considered in the context of the impact of physical exercise or use of cocaine prior to restraint, and remain controversial.

What is evident is that people with cardiac conditions are more susceptible to cardiac complications during restraints. Cardiac arrest during restraint can be associated with extensive cardiac history, including arrhythmias, stress, physical exertion, and certain drugs, all of which play a role in the development of cardiac problems. Therefore, in any face to face one hour assessment understanding any possible cardiac complications that the client may be susceptible to is of importance.

1.1 Summary Content Outline:

Considering the material relating to physical risk and loss of life it has been suggested that competency on how to conduct the one hour face to face assessment includes knowledge related to the following:
• The mechanisms of normal respiratory function
• How risk factors, such as obesity or airway blockage, can interfere with normal respiratory function
• The potential risks inherent in using mechanical restraints
• The correlation between position and changes in lung functioning
• The visible signs of respiratory distress
• Review of all risk factors noted above
• How to recognize agitated delirium
• Cardiac assessment
• Demonstration of assessment

1.2 Competency Assessment: In addition to completion of this module and the exam, on site at one’s own facility, one may perform a:

• Demonstration of
  o Respiratory function assessments, including O2 saturation levels, assessment of lung fields via auscultation, respiratory rate
  o Cardiac assessment, including heart rate, blood pressure
  o A description of the appropriateness of restraint techniques
  o Assessment of a patient’s mental health status

2. Physical Dangers and Discomforts

The recent paradigm shift in the practice of seclusion and restraint (S&R) has been due in large part to the recognition of the inherent physical dangers observed in association with practice. As noted previously the use of restraint can create life threatening events. Deaths involving both adults and children have brought the practice to the forefront and prompted review and revision. The dearth of evidence supporting the dangers associated with the practice (Evans, Wood, & Lambert, 2003), accompanied by little evidence relating its therapeutic value has resulted in a shift away from the practice of seclusion and restraint. Although the evidence does not support therapeutic value there are still instances when seclusion and restraint may be utilized; however, alternate methods are recommended (Sailas & Fenton, 2000).

Factors relating to physical dangers to consider when assessing the patient in restraints include:

• positioning
• restraints
• clothing/bedclothes
• obesity
• nerve damage
• head trauma
• pressure ulcers
• medical problems
• vital signs
• review of medical record
• labs results

There is some obvious overlap with the factors identified previously in relation to the risk of loss of life.

When seclusion is utilized the assessment should include:

• evaluation of the environment
• safety hazards
• patient’s medical condition
• review of record and labs

The patient restrained in a prone position is at risk for choking (D’Orio, Wimby & Haggard, 2007). An obese patient can have difficulty breathing therefore positioning should be carefully evaluated to ensure that respirations are not impaired (Nadler-Moodie, 2009). Improper body alignment (positioning) can lead to nerve damage, increase the risk of pressure ulcers and leave the patient traumatized by feeling vulnerable to attack by others. Patient clothing and bedclothes can become entangled and cause circulatory and respiratory restrictions leading to choking and nerve damage. The placement of the restraints should not be too tight to impede circulation and should be assessed to ensure the restraint is not causing injury associated with friction.

The act of placing the patient in restraints requires humane physical control of the patient; however, during this process injury to patient limbs, head, or organs have occurred. Some patients have suffered self inflicted head trauma while in restraints (Nadler-Moodie, 2009) therefore assessing for dangerous behavior is warranted. Vital signs should be assessed as soon as possible as this can prevent further morbidity and/or mortality.

Special note should be made of:
• Fever
• Abnormal blood pressure
• Abnormal pulse and respirations
• Altered skin color
• Breath odor

These can signal that all is not well and perhaps something further needs to be done for the patient. The medical record and recent labs should be reviewed to determine any preexisting metabolic/physical problems that could be exacerbated by the restraint or lead to the behavior prompting seclusion and restraint. More than twenty five years ago Tupin (1983) pointed out that patients involved in psychiatric emergencies have a high risk of “…physical illness and illicit drug use” that can add to risk of injury (p.83). In the 2007 position paper by the American Psychiatric Nurses Association it was noted that the patient’s behavior could be recognized as a “…manifestation of an organic or physiological problem…” requiring further intervention (p. 2).

The patient who is placed in seclusion warrants similar safety considerations. The room should be free of hazards and implements that can be used for self or accidental harm to the patient. The
patient’s clothing can pose a danger so the nurse should be aware of these dangers when making the assessment. The patient should be checked for any object/piece of clothing that the patient can use to inflict self harm. Fluids should be offered to avoid dehydration and the client should be permitted to use the bathroom (or bedpan/urinal) to avoid problems associated with incontinence. These factors should be included in the assessment of both restrained and secluded patients.

All of these assessments require the application of a basic nursing knowledge included in nursing curricula and addressed in licensure exams. The ability to perform basic cardiopulmonary resuscitation is a job requirement for all nurses caring for patients and should routinely be evaluated by qualified personnel according to facility policy and procedure. However, certifying bodies often have clear guidelines that should be adhered to. Kontio et al (2009) also suggest that “…infrastructural and managerial support, complimentary to an effective educational program, may have beneficial effects on seclusion and restraint practices (p. 205).” The use of an educational approach was also promoted some time ago by Lion (1987) who wrote that, “…physical restraint techniques should be taught and learned with the same precision and reliability as cardiopulmonary resuscitation. Thus trainees who complete the course are certified and allowed to teach the techniques to other nurses (p.883).”

At that time it was suggested that recommendations for a standard and evidence based technique should be implemented thereby allowing uniform evaluation standards.

Regarding the trainer, this should be a Registered Nurse who is actively employed in the inpatient environment for at least one year prior to training and evaluating other nurses with sufficient proficiency in the skill of conducting the one hour face to face assessment techniques and knowledge of adult teaching methodology. In a study by Kontio et al (2009) nurses “…acknowledged a need for continuing practical on-ward education on seclusion and restraint (p. 204).” This training should be done annually with semi-annual review to include practice and evaluation.

2.1 Summary Content Outline:
Considering the material relating to physical dangers and discomforts it has been suggested that competency on how to conduct the one hour face to face assessment includes the following knowledge and awareness related to:

- positioning of client
- clothing/bedclothes
- risk factors such as obesity
- trauma or injury
- identification of relevant medical problems
- indications of physical discomfort
- experiential learning
- reviewing the medical record
- labs results
- review of possible medication interactions
2.2 Competency Assessment: In addition to completion of this module and the exam, on site at one’s own facility, one may engage in:

- Simulation exercise
- Role play

3. Psychological Status and Mental Status

Included in the key elements for the one hour face-to-face evaluation are the psychological state and the psychiatric condition of the patient. Patients are placed in restraint or seclusion because of dangerous behavior or the risk of harm after other alternatives have been attempted. Patients who have been placed in restraints or seclusion have shared the psychological distress that they have experienced as a result of these interventions. Literature describes the numerous psychological effects of being placed in seclusion and restraints. The majority of patients have reported negative reactions to being restrained or secluded. They have reported feeling angry, helpless, trapped, depressed, punished, frustrated, and embarrassed (Bower, McCullough, & Timmons, 2003; Letizia, Babler, & Cockrell, 2004). Bowers et al. al. (2003) also reported patients experiencing hallucinations and delusions while restrained. Molasiotis (1995) reported that patients in restraint are subject to the psychological effects of immobilization experiencing severe levels of anxiety, increased dependency, tension, apathy, low self-esteem, stupor, and confusion. Letizia et al. al. (2004) also reported patients in restraints being confused, disoriented, and agitated. Mohr and Anderson (2001) studied children’s reactions to restraints and physical holding. They found that children often responded by crying, shouting, and struggling and expressed feelings of fear, anger, and confusion.

Molasiotis (1995) reported that patients who were already angry or frightened when placed in restraints experienced intensification of these feelings during the restraint process. Moylan (2009) also reported that patients in restraints may experience an escalation of feeling out of control, calling for nurses to use a caring and compassionate approach with restrained patients. She also emphasized the need for inclusion of information not only on the mechanical techniques of restraining in education programs on restraints and seclusion, but also on the psychological effects of the restraint experience on patients.

Nadler-Moodie (2009) provides the only information in the literature about aspects of the one hour face to face assessment of patients in restraints or seclusion. She discusses the importance of the inclusion of a thorough mental status examination (MSE) in the one hour assessment. Information about current symptoms and the psychiatric condition of the patient should be obtained through this examination. Nadler-Moodie also pointed out the need to compare findings from the present MSE to previous findings, therefore reviewing the medical record would be an important part of the assessment. Scott, Quanbeck and Resnik (2007) note that a history of violence is the best predictor of future violence. The findings of the MSE should also be compared to behaviors expected of the patient in order to warrant release from restraints or seclusion. These expected behaviors should be reviewed by the staff along with the patient at the time of the assessment if the patient’s condition allows this. Bower et al (2003) found that patients often reported a lack of communication from nurses regarding the reasons for the
restraint intervention, the length of time they would be in restraints, and the expected behaviors for restraints to be discontinued. Nadler-Moodie (2009) also advocates debriefing of the patient and staff as part of the one hour assessment. This may not always be possible given the condition of patient and the availability of the professional when the patient is ready for debriefing but all attempts should be made to do so at the earliest time possible. Information from any debriefing sessions should be made available to the nurse conducting the one hour face-to-face assessment.

With regard to psychological status and mental status, special note should be made of:

- anxiety
- fear
- anger
- depression
- hallucinations or delusions
- anxiety
- disorientation
- confusion
- stupor

Also to be considered is the specific behavior at the time of the incident that led to restraint or seclusion and whether this behavior is still present or could be readily reproduced. Access should also be made to the information obtained in the debriefing session relating to the incident in question. It is important to engage the staffs regarding the patient’s readiness for restraint removal to ensure all involved are now feeling safe.

3.1 Summary Content Outline
Considering the material relating to psychological and mental status it is suggested that competency on how to conduct the one hour face to face assessment should include the following:

- The MSE
- Reviewing the medical record
- Evaluation of behavior leading to seclusion/restraint
- Use of multimedia case studies
- Communicating with the patient
- Assessing the level of dangerousness of the patient
- Expected patient behavior following release from seclusion and restraint
- Information available from the debriefing carried out on the staff and patient

3.2 Competency Assessment: In addition to completion of this module and the exam, on site at one’s own facility, one may engage in:

- A completion of a Mental Status Exam for a patient
- Simulation exercise
- Role play
4. Legal and Ethical Considerations
Any discussion on the use of seclusion and restraint should include adherence to the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) standards along with state and federal guidelines. Haimowitz, Urff, and Huckshorn (2006), in “Restraint and Seclusion, A Risk Management Guide”, present a number of cases of successful litigation when these standards were not met. They point out that courts have long recognized that people with mental illnesses have the right to be free from the improper use of restraint and seclusion, citing 1982 case Youngberg v. Romeo, in which the Supreme Court upheld this opinion.

Haimowitz, Urff, and Huckshorn (2006) note that the legal consequences of inappropriate use of seclusion and restraints can include civil damages, administrative damages (including loss of Medicare and Medicaid certification), and criminal prosecution. Therefore providers and facilities that use restraint and seclusion are vulnerable to litigation. Individual facilities are encouraged to develop policies around these guidelines, to ensure staff is aware of the standards of care in their facilities, and leadership ensures that they follow these standards.

Therefore, any person performing the one hour face to face assessment must be cognizant of the state and federal guidelines in the use of restraint and seclusion, and their own institution’s policies. They must ensure that these guidelines are being applied, that the techniques used are appropriate, the least restrictive alternative is being utilized, and the documentation reflects this adequately. In doing so the risk of litigation is minimized, the welfare of clients are assured and attempts to decrease the use of seclusion and restraint are supported.

LaFond (2007) points out that an ongoing training process is the key to creating a violence and coercion free treatment environment. He draws on evidence produced by the literature review by the Crisis Prevention Institution (2006) that highlighted instances where a training program in non-violent crisis intervention reduced or eliminated the use of seclusion and restraint across a range of settings.

The APNA 2008 position statement on Workplace Violence builds on findings by Currier and Allen (2000), who noted that the criteria for admission to psychiatric units has shifted to a “level of dangerousness model.” The concentration of aggressive and assaultive patients has increased, making the units an increasingly dangerous place. Therefore the concerns about the negative impact of seclusion and restraint on the patient need to be balanced with the need of nursing staff to provide a safe environment for all. Seclusion and restraint are seen by nursing staff as a last resort to maintain a safe environment, and that studies of the impact of assault on those who care for patients must be taken into consideration when developing standards for practice and when addressing organizational strategies to assure equal commitment to worker as well as patient safety.

Given the complex range of issues that nurses can potentially be exposed to during the course of their work caring for clients, it is imperative that as an essential part of the one hour face to face assessment, nurses must be cognizant of legal and ethical issues. They should dialog with staff around the event that led to the use of seclusion/restraint, be supportive of staff, assess for staff signs of physical and psychological trauma, and allow a venue for staff to decompress and
problem solve. Staff should be encouraged to report all episodes of assaults, even those that are “minor” so that risk management supervisors can be aware of the number that are occurring, and administration can be involved in problem solving the solutions.

4.1 Considering the material relating to legal and ethical considerations it has been suggested that competency on how to conduct the one hour face to face assessment should include the following knowledge:

- The appropriate use of seclusion and restraint techniques
- CMS and JCAHO standards
- State and local regulations
- Institutional policies
- The use of legal case studies
- Developing “best practice”.
- Addressing issues to decrease the use of seclusion and restraint
- Handling and reporting safety issues and debriefing staff

4.2 Competency Assessment: In addition to completion of this module and the exam, on site at one’s own facility, one may engage in:

- Review of the facility’s relevant policy and procedure
- Simulation exercise
- Role play
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d) Other |
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e) Nerve damage  
f) Head Trauma  
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c) Adherence to state and local laws  
d) Adherence to institutional policies  
e) Recognition of “best practice” |
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References


