OREGON STATE HOSPITAL

PORTLAND – SALEM

POLICIES AND PROCEDURES

SECTION 6:	Patient Care	POLICY: 6.023
SUBJECT:	**Early Intervention Techniques, Including Use of Movement Restriction**	
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APPROVED:	GREGORY P. ROBERTS SUPERINTENDENT	DATE: February 7, 2012

I. POLICY

A. Oregon State Hospital (OSH) shall treat individual patients in the least restrictive manner that is consistent with person-centered care, treatment and safety, as well as providing safety for staff and public. In altering the environment, staff should allow for the person's self-control and let the person choose the way in which to make a change.

B. Graded early interventions, including pre-escalation techniques, should always be attempted before any movement restriction is considered.

C. Consistent with the hospital's mission and vision of hope, safety, and recovery, careful deliberation by a trained staff member with current knowledge of the patient's treatment, condition, current history, and circumstances should occur before any movement restriction.

1. Movement restriction shall not be used for the convenience of staff or as punishment.

2. Movement restriction is to be requested only by staff directly involved in or observing the undesirable behavior.

3. The movement restriction shall be in a safe and readily accessible area.

4. The patient's preferred or most comfortable environment shall be considered when implementing movement restriction.

II. DEFINITIONS

A. "Limited-Space Area" means any room at OSH which is not generally accessible to groups of patients and which is of small size in comparison with open spaces on the unit. Limited-space areas usually have one route of access. Examples include bedrooms (private or not), quiet rooms, sensory rooms, tub rooms, and unlocked seclusion rooms.

B. "Open-Space Area" means portions of the hospital that are accessible to groups of patients on a routine basis. Open-space areas often have more than one route of access. Examples include dayrooms, hallways, yards, air courts, courtyards, gym, commons, and dining areas.

C. "Pre-escalation Techniques" are a set of interventions designed to effectively preempt potentially negative or dangerous situations. These techniques utilize a good working relation with individuals served by the hospital and are paramount when intervening with an individual who is escalating.

D. "Movement Restriction" means the staff-initiated request for a patient to go voluntarily into an unlocked limited-space area for the purpose of giving the patient time to evaluate and modify their psychological discomfort and bring their behavior under control.

1. Examples of interventions which are **NOT** movement restrictions but which are allowable, when appropriate, include:

a. Locking the door to an entire unit to prevent escape;

b. Locking the door to a yard in order to manage patient movement between hospital buildings and yards;

c. Preventing patients from entering other patients' bedrooms;

d. Preventing patients from entering prohibited areas;

e. Locking a patient out of their bedroom for therapeutic reasons if included in the patient's Treatment Care Plan;

f. Escorting a patient to an open-space area or bathroom for purposes including but not limited to separating aggressive patients;

g. Encouraging personal hygiene (bathing), and respecting the privacy of other patients, etc.; Any use of hands-on must

comply with OSH Policy and Procedure 6.003, Use of Seclusion or Restraint

h. Preventing unmonitored access to bathrooms for patients who have problems related to use of bathroom facilities (e.g., polydipsia) if included in the patient's Treatment Care Plan.

III. PROCEDURES

A. Early Interventions (Pre-escalation Techniques)

All staff need to be alert for potential signs of impending unrest and use early interventions to prevent behavior problems. Redirection and verbal counseling such as motivational interviewing should be used initially as attempts to prevent loss of psychological or behavioral control in a less restrictive manner. Early interventions may include, but are not limited to, the following measures:

1. Change the environment: Stay calm, search for the person's trigger mechanisms, and be an active, not a judgmental, listener. Change the climate or mood (e.g., by changing the topic of conversation, or changing the music), alter ventilation or temperature;

2. Decrease or eliminate stimuli (e.g., music, lights, conversations), direct extraneous patients and staff from the area;

3. Make the environment more or less familiar (e.g., by adding or removing personal artifacts or offer a family phone call, or visitors);

4. Review physician's medical orders;

5. Review the patient's Initial RN Assessment Behavior Management section for individual calming techniques;

6. Listen for the patient's perspective: actively listen and provide reality testing, listen more than talk, speak softly, use short words. Use good nonverbal and verbal skills, give reassurance, find out what the problem is, communicate with the team;

7. Encourage the patient to identify and implement use of a calming technique;

8. Offer basic, goal-directed options: Avoid either/or choices, communicate understanding, allow the person to exercise his/her personal freedom and rights, use diversion and/or distraction, channel feelings into a positive direction or creative activity such as music;

9. Interact in a positive manner: Focus on the goal, stay calm, don't overreact, control voice tone and choice of words;

10. Encourage cooling off: Removal of or from stimulus, e.g., provide time out, a walk, time alone, diversion and/or distraction, humor, food, one-to-one time, read a book, write in a journal. Avoid either/or choices;

11. Reassure support: Allow for rest and quiet time, give reassurance, help the person to understand their feelings, allow the person to save face, and maintain dignity.

B. Movement Restriction

Movement restriction shall be a voluntary choice by a patient to go to or remain in a limited-space area at the request of staff as a specific management technique for unremitting psychological agitation and loss of behavioral control. Examples are persistent or repeated swearing at staff and peers, intrusiveness which interferes with the treatment of others or disrupts the milieu for peers, fighting, throwing objects, and repeated breaking of rules (once they are satisfactorily explained).

1. Movement restriction can be requested by any direct care staff who are in proximity and familiar with behavior patterns being exhibited or have personally observed the behavior that needs to be modified. Once they have attempted to use less restrictive methods and have found that such methods do not restore a patient to a safe and manageable state, staff can request the patient to go to a limited-space area. Under no circumstances can it be used for punishment or coercive purposes. Staff shall assist the patient in determining behavioral changes that shall achieve the patient's desire for increased control.

2. A patient may be escorted to a limited-space area and then be offered movement restriction on a voluntary basis; however, it must be explained to the patient that the movement restriction is voluntary and this explanation must be documented in the patient record. A patient may not be placed in seclusion simply due to their refusing a

movement restriction. Any use of hands-on must comply with OSH Policy and Procedure 6.003, Use of Seclusion or Restraint.

3. A patient may not be involuntarily placed in and prevented from leaving a limited-space area except as per OSH Policy and Procedure 6.003, on use of seclusion and restraint.

4. If movement restriction extends longer than 15 minutes, it must be reviewed, approved, and supervised by the registered nurse (RN). Patients may release themselves from voluntary movement restriction when calm.

5. When movement restriction for a particular behavior is needed more than twice daily or in excess of four cumulative hours in any given month the patient's Treatment Care Plan shall include measures designed to reduce or to eliminate the behavior that leads to movement restriction.

6. Any movement restriction shall not prevent adequate access to bathrooms or nutritional needs. If movement restriction continues beyond 15 minutes, reasonable access to writing materials and to the attorney phone and personal items should be allowed unless specifically contraindicated by safety or a documented treatment issue.

7. Movement restrictions shall end at the patient's discretion or upon debriefing between patient and staff.

8. All incidents of movement restriction shall be accompanied by documentation in the medical record of the following:

   a. Beginning and ending times;

   b. Observations of precipitating behaviors;

   c. Notification of the RN in charge of the shift;

   d. Restrictive Event Data Worksheet completed for each event.

9. All incidents of movement restriction shall be reported to the attending physician at the next nursing report with the unit physician in attendance.

IV. REFERENCES

The Joint Commission, Comprehensive Accreditation Manual for Hospitals, 2010
Montana State Hospital Policy and Procedure TX-16, Use of Seclusion and Restraint
OSH Policy and Procedure 6.003, Use of Seclusion and Restraint

Replaces Oregon State Hospital Policy and Procedure 6.023, *Use of Movement Restriction*, dated 05/21/2010.